

Mode of Collection	
Self-Adminiered	<input type="checkbox"/>
Personal Interview	<input type="checkbox"/>
Telephone Interview	<input type="checkbox"/>
Mail	<input type="checkbox"/>
Other	<input type="checkbox"/>

101.1

Patient ID	<input type="text"/>
Physician ID	<input type="text"/>
Clinic/Site ID	<input type="text"/>

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Patient Questionnaire

Post-Operative

LOW BACK PAIN FORM 6.3

INSTRUCTIONS: This survey asks for your views about your low back pain and/ or leg pain (sciatica). This information will be summarized in your medical record and will help your doctors keep track of how you feel and how well you are able to do your usual activities. Answer every question by checking the box(es) next to the most appropriate answer.

TODAY'S DATE IS: _____ / _____ / _____ 104.49

1. Currently, do you have leg pain? (check one box) 104.249
- No
- Yes

Since your back surgery or the last time you filled out this form, please tell us how your low back and/or leg pain currently affects your average ability to perform the following daily activities. Mark the one statement that best describes your average ability.

2. Walking (In the last week): 104.267
- Pain does not prevent me from walking.
- Pain prevents me from walking more than 1 hour.
- Pain prevents me from walking more than 30 minutes.
- Pain prevents me from walking more than 10 minutes.
- I can only walk a few steps at a time.
- I am unable to walk.

3. Sleeping (In the last week): 104.270
- I sleep well.
- Pain occasionally interrupts my sleep.
- Pain interrupts my sleep half the time.
- Pain often interrupts my sleep.
- Pain always interrupts my sleep.
- I never sleep well.

4. Do you currently smoke cigarettes? (check one box) 104.280
- I have never smoked
- Yes
- No, I quit in the last six months
- No, I quit more than six months ago