FORM B2:

NORspine

Norwegian Registry for Spine Surgery
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Questionnaire for patients 12 months after back surgery V3.0

The purpose of this questionnaire is to give doctors, nurses and physiotherapists a better understanding of the health issues of patients with back problems and to evaluate treatment. The answers you provide in this questionnaire will be very useful in the delivery of the best possible care for patients with back problems in the future.

Date of completion ☐☐ ☐☐ ☐☐

What benefit have you experienced from the operation (specified in the cover letter)?

(check only one box)

- ☐ I am completely well
- ☐ I am much better
- ☐ I am slightly better
- ☐ No change
- ☐ I am slightly worse
- ☐ I am much worse
- ☐ I am worse than ever before

How satisfied are you with treatment you have had at the hospital?

(check only one box)

- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Dissatisfied

Complications after the procedure? (More than one option is possible)

- ☐ Was there any unexpected bleeding that resulted in blood transfusion or new surgery?
- ☐ Were you treated with antibiotics for urinary tract infection during the 4 weeks after the operation?
- ☐ Were you treated with antibiotics for pneumonia during the 4 weeks after the operation?
- ☐ Have you been diagnosed with deep vein thrombosis within 3 months after the operation and been treated for this?
- ☐ Have you been diagnosed with pulmonary embolism within 3 months after the operation and been treated for this?
- ☐ Were you treated with antibiotics for superficial infection in the surgical wound during the first 4 weeks after the operation?
- ☐ Have you been or were you treated for more than 6 weeks with antibiotics for deep infection in the surgical wound?

Have you had new illnesses or injuries after the back operation?

☐ No ☐ Yes

If so, what types of diseases and injuries are these? (More than one option is possible)

- ☐ Joint pain (such as osteoarthritis)
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Other disease of the nervous system
- ☐ Injury with sequelae
- ☐ Other significant disease

How severe was your pain last week?

How would you grade the pain you have had in your **back/hip** during the last week? Circle one

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

How would you grade the pain you have had in your **leg(s)** during the last week? Circle one

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

LUNDBLAD MEDIA AS, TROMSØ – O-92100

Oswestry Low Back Pain Disability Questionnaire:

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please check the statement which most clearly describes your problem

1. Pain intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

2. Personal care (washing, dressing etc)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage most of my personal care
- ☐ I need help every day in most aspects of self-care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

3. Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed eg. on a table
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ I can lift very light weights
- ☐ I cannot lift or carry anything at all

4. Walking

- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 1 mile (1 ½ km)
- ☐ Pain prevents me from walking more than 1/2 mile (¾ km)
- ☐ Pain prevents me from walking more than 100 yards (100 m)
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

5. Sitting

- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

6. Standing

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

7. Sleeping

- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

8. Sex life (if applicable)

- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

9. Social life

- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests eg, sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

10. Travelling

- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

Health Questionnaire (EQ-5D)

Under each heading, please check the ONE box that best describes your health TODAY.

1. Mobility

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

2. Self-care

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

3. Usual activities (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

4. Pain/discomfort

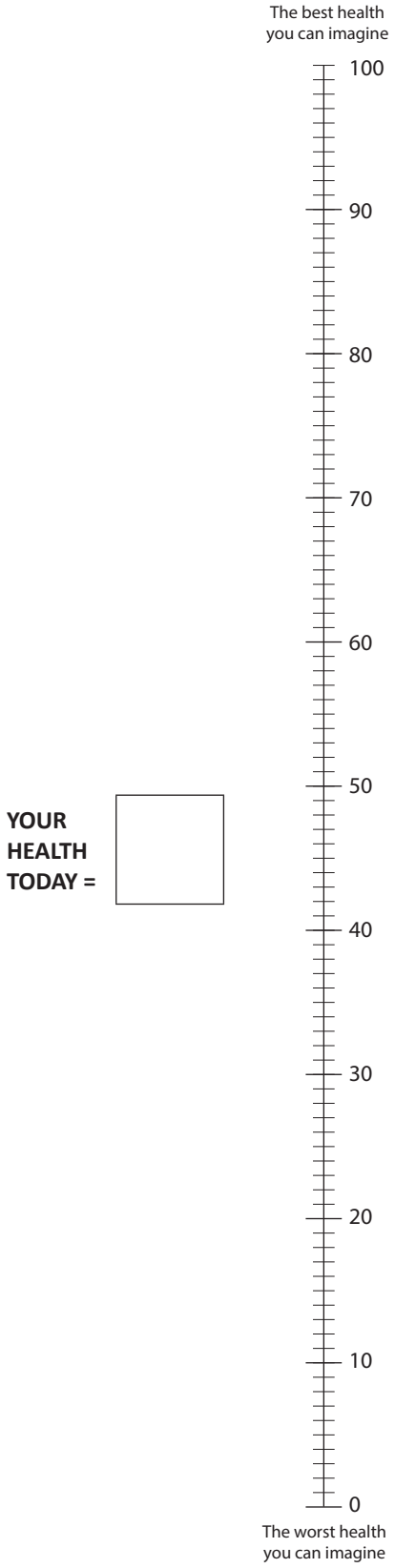
- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

5. Anxiety/depression

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

State of health

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine. 0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.



YOUR HEALTH TODAY = ☐

Painkillers

Do you use painkillers due to your back and/or leg pain?

☐ Yes ☐ No

If you answered yes: How often do you use painkillers? (check only one box)

☐ Less often than monthly
☐ Every month
☐ Every week
☐ Daily
☐ Several times a day

Work status

Check the box that best describes your situation:

☐ Working full-time
☐ Working part-time
☐ Student/pupil
☐ Retired
☐ Unemployed
☐ On sick leave
☐ On partial sick leave
_____ % sick leave
☐ Work assessment allowance
☐ Disability benefit
_____ % benefit

Do you feel that your employer would like to have you back at work?

☐ Yes ☐ No ☐ Do not know

Have you applied for a disability pension?

(check only one box)

☐ Yes
☐ No
☐ Planning to apply
☐ Has already been granted

Have you applied for compensation from an insurance company including the Norwegian patient injury compensation scheme or occupational injury compensation?

(check only one box)

☐ Yes
☐ No
☐ Planning to apply
☐ Has already been granted

Have you had further surgery on your back after the back operation? (date stated on the front page)

☐ No ☐ Yes

If so, specify numbers of operations: _____

If so, you were operated on in the same area (level) of your back?

☐ Yes, in the same area
☐ No, in another area
☐ In the same as well as a different area
☐ Do not know