

Soal Selidik Gangguan Bahagian Belakang – Pakar Perubatan

Back Disorder Questionnaire – Physician

No. Permohonan:

Application No.:

Tarikh:

Date:

Nama Penuh Pemohon

Full Name of Applicant

- 1) Sila nyatakan diagnosis yang tepat.
Please state the precise diagnosis.

- 2) Bahagian:
Site:

- a. Bahagian belakang mana yang terjejas?
Which part of the back is/was affected?

- b. Adakah terdapat sebarang abnormal neurologi seperti kebas atau masalah lemah kawalan kencing atau adakah organ atau sistem lain telah terjejas? Jika ya, sila berikan butir-butir penuh.
Were there any neurological abnormalities such as numbness or incontinence or has any other organ or system been affected? If so, please provide full details.

- 3) Kekerapan gejala-gejala:
Frequency of symptoms:

- a. Bilakah episod pertama terjadi?
When was the first episode?

- b. Bilakah episod terakhir terjadi?
When was the last episode?

- c. Berapa kerapkah gejala berlaku? Iaitu berapa banyak episod dalam tempoh 24 bulan yang lepas?
How frequently do symptoms occur? i.e. how many episodes in the last 24 months?

- 4) Punca dan kesan gejala:
Cause and impact of symptoms:
- a. Sila nyatakan tarikh dan tempoh bagi sebarang cuti rehat dari bekerja disebabkan oleh kesakitan bahagian belakang anda sejak tempoh dua tahun lepas.
Please advise dates and durations of any time off work due to your back in the last two years.
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- b. Sila anggarkan jumlah cuti rehat dari bekerja akibat daripada keadaan tulang belakang anda.
Please estimate total time off work as a result of your back condition.
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- | | Ya
Yes | Tidak
No |
|---|--------------------------|--------------------------|
| c. Adakah kerja pesakit termasuk apa-apa kewajipan yang boleh memburukkan lagi gangguan bahagian belakangnya?
Jika YA, sila berikan butiran penuh.
<i>Does the patient's job include any duties which may exacerbate the back disorder?
If YES, please give full details.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
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| d. Pernahkah pesakit menukar kerja atau selaraskan tugas berikutan daripada bahagian belakangnya?
Jika YA, sila nyatakan butiran penuh.
<i>Has the patient changed jobs or adjusted duties in any way because of their back? If YES, please advise full details.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
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- 5) Rawatan perubatan:
Medical care:
- a. Pernahkah pesakit melakukan sebarang siasatan seperti X-ray, imbasan CT, MRI, dan lain-lain? Jika YA, sila berikan butiran lengkap termasuk tarikh dan keputusan.
*Has the patient undergone any investigations such as X-ray, CT scan, MRI, etc?
If YES, please provide full details including the dates and results.*
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|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
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- b. Pernahkah pembedahan dijalankan atau pembedahan sedang dipertimbangkan?
Jika YA, sila berikan tarikh dan butiran lengkap termasuk nama-nama hospital dan pakar bedah serta berapa lama selepas pembedahan itu sebelum anda dapat kembali bekerja.
*Has surgery been carried out, or is surgery being considered?
If YES, please provide dates and full details including names of hospital and surgeon and how long after the operation was it before they were able to return to work.*
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|--|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|
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- | | Ya
Yes | Tidak
No |
|---|--------------------------|--------------------------|
| c. Adakah pesakit memerlukan, atau mengambil, ubat tahan sakit untuk gejala gangguan belakang berkaitan?
Jika YA, sila berikan nama ubat-ubatan, dos dan kali terakhir diambil.
<i>Does the patient require, or use, pain killers for back related symptoms?
If YES, please provide names of drugs, dosage and when last taken.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | |
|---|--------------------------|--------------------------|
| d. Adakah sebarang bentuk rawatan telah ditetapkan, contohnya rawatan anti-radang, fisioterapi, manipulasi kiropraktik atau osteopatik, dan sebagainya?
Jika YA, sila berikan butiran lengkap tarikh dan nasihat sekiranya rawatan itu masih diterima.
<i>Has any other form of treatment been prescribed, e.g. anti-inflammatory treatment, physiotherapy, chiropractic or osteopathic manipulation, etc.?
If YES, please provide full details and dates and advise if such treatment is still being received.</i> | <input type="checkbox"/> | <input type="checkbox"/> |
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- 6) Sila berikan butiran gejala semasa, jika ada.
Please give details of current symptoms, if any.
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- 7) Adakah terdapat mana-mana episod berkaitan kebimbangan atau kemurungan? Jika ya, sila berikan butiran.
Have there been any episodes of associated anxiety or depression? If so, please give details.
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Tandatangan Pakar Perubatan:
Signature of Physician:

Tarikh:
Date:

Sila tambahkan cop klinik
Please add clinic stamp