CSC Physicians:
Ulrich Batzdorf, MD; David E. Fish, MD; Langston Holly, MD; Jae Jung, MD;
Duncan Q. McBride, MD; Don Y. Park, MD; Nick Shamie, MD; Daniel Lu, MD, PhD

COMPREHENSIVE SPINE CENTER

Don Young Park, M.D.
1131 Wilshire Blvd, Suite 100
Santa Monica, CA 90401
310-319-DISK (Appointment)
424-259-6930 (Fax)

Dear Esteemed Patient:

Thank you for choosing to make an appointment at the UCLA Spine Center located at 1131 Wilshire Blvd, Suite 100 in Santa Monica.

Please be sure to bring the following to your appointment:

- Your most current diagnostic films and reports (e.g. MRI, CT, plain x-rays; SSEP or EMG reports; Physical Therapy reports; Pain Medicine reports, etc.) pertaining to your current medical condition. (PLEASE NOTE: If your films were done within the UCLA system at Santa Monica or Westwood, our office will make sure that they are here for your visit and you do not need to pick up these films. However, if you had films done outside of UCLA, you do need to bring these with you).

- Prior medical records and consultations from your referring physician and any other specialist you've seen for your current condition. To help expedite your visit, please hand carry your reports to this office. Do not send them prior to your appointment.

- Your medical insurance card (s)

- If you have HMO Insurance: Please be sure to bring your "Letter of Authorization: from your HMO. If you do not bring your authorization letter and we do not have written authorization on file, you will be financially responsible and will be asked to pay the consultation fee on the day of your appointment.

- If you have HMO Insurance: Please be sure to bring your co-payment with you. We accept cash, check, or Visa/Mastercard.

Attached you will find a questionnaire and a map with directions to our location. Please bring in the completed paperwork to your appointment. If you have any questions, please feel free to contact the UCLA Spine Center Appointment Scheduling desk at (310) 319-3475. We look forward to seeing you.

PLEASE NOTIFY US OF ANY CANCELLATIONS AT LEAST 24 HOURS PRIOR TO YOURAPPOINTMENT

On your initial visit you will be seen by the Orthopaedic Spine Specialist, **Don Y. Park, MD,** who will, with or without a Spine Fellow and /or Resident and /or Physician's Assistant and /or Nurse Practitioner student, obtain a medical history and perform a physical examination. The SM/UCLA Comprehensive Spine Center advocates a multi-disciplinary approach to strive and attain the best possible healing and recovery for every patient. Because every patient is unique, we prescribe treatment based on a thorough evaluation, that we perform utilizing the latest technological advancements available. We believe in evaluating patients promptly and educating them on their diagnosis, so they can play an active role in the decision-making and treatment process. Our physicians' clinical experience has shown that patients who participate in their own health care decisions are far more likely to achieve an optimal level of healing and recovery.

Sincerely,

Patient Care Coordinator
SM/UCLA Comprehensive Spine Center

UCLA Health

MRN:
Patient Name:

(Patient Label)

Spine New Patient Questionnaire

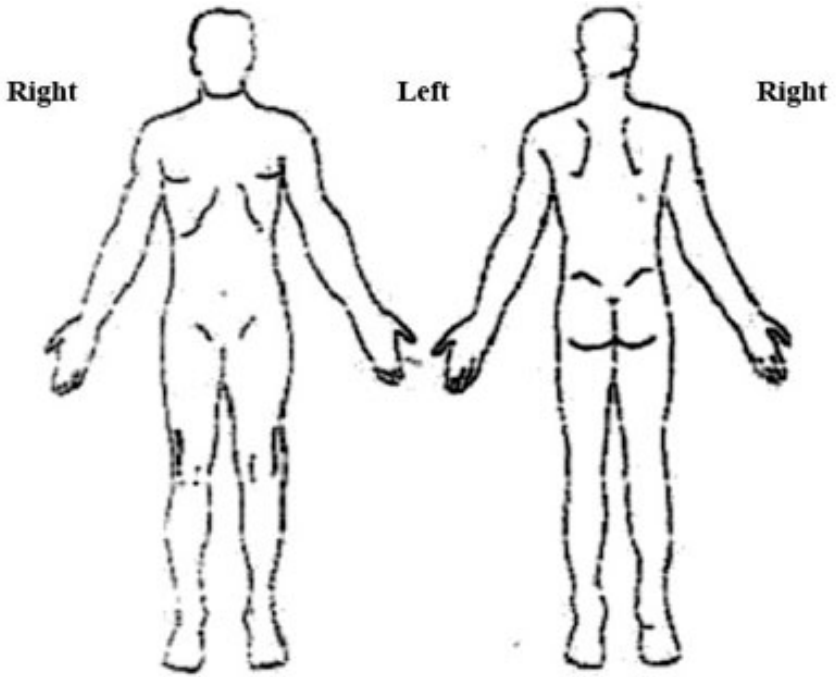
Don Young Park, M.D.
Department of Orthopaedic Surgery

Date:_____

Please take the time to answer a few questions regarding your symptoms.

Pain Diagram

Please draw out your symptoms on the diagram below using the following symbols:
Numbness: 00000 Pins & Needles: ------ Stabbing: ////// Burning: xxxxx



History:

Age:_____ Gender:_____ Chief complaint:_____

What is your dominant hand? ☐ Right ☐ Left Date of injury? _____

What is your current pain level? [0—1—2—3—4—5—6—7—8—9—10]

(Please circle; 0: no pain, 10: worst pain imaginable)

When did your symptoms first start?_____

When did your symptoms get worse?_____

What is worse:	☐your neck	☐back pain	☐your arm	☐leg pain?
Is your pain:	☐Constant	☐Intermittent	☐Occasional?	
Is your pain:	☐Getting better	☐Getting worse	☐Staying the same?	

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Spine New Patient Questionnaire

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Is your pain worse: When first getting up from bed? ☐Yes ☐No
At the end of the day? ☐Yes ☐No
When changing positions? ☐Yes ☐No

What makes your pain worse?_____
(sitting, standing, walking, bending forward, leaning back, twisting, etc)

What makes your pain better? _____
(sitting, standing walking, lying down, bending forward, leaning back, etc)

Are you having any of the following difficulties? (Please check if applicable)

☐Loss of bladder control ☐Urgent desire to urinate
☐Loss of bowel control ☐Loss of sensation in genitalia and anal region
☐Difficulty walking ☐Limping
☐Use of cane, crutch, or walker ☐Use of wheelchair
☐Problems with balance ☐I have none of these

Do you have any weakness? ☐Arms ☐Hand ☐Legs ☐Feet

Do you have numbness or tingling? ☐Yes ☐No Where? _____

Do you have headaches associated with your symptoms? ☐Yes ☐No

Are you having any difficulty handling small objects? ☐Yes ☐No
(pins, coins, needles, buttons, etc)

Have you had a steroid injection in the past? ☐Yes ☐No

When?_____ Did the injection help? ☐Yes ☐No

Have you had physical therapy in the past? ☐Yes ☐No

When?_____ Did physical therapy help? ☐Yes ☐No

Any previous treatments for your symptoms? _____
(Chiropractor, acupuncture, injections, previous surgery)
Any improvement? ☐Yes ☐No

What pain medicines are you using now?

_____

Any relief? ☐Yes ☐No

UCLA Health

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Patient Name:

(Patient Label)

Spine New Patient Questionnaire

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Department of Orthopaedic Surgery

Please take the time to complete this form to better understand your history.

Past Medical History (Please check YES or NO for any significant conditions)

Anemia	☐Yes	☐No	Heart Defect	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Attack	☐Yes	☐No
Arthritis	☐Yes	☐No	Heart Failure	☐Yes	☐No
Alcohol dependency	☐Yes	☐No	High Blood Pressure	☐Yes	☐No
Arrhythmia	☐Yes	☐No	High Cholesterol	☐Yes	☐No
Anxiety	☐Yes	☐No	Immune Disorder	☐Yes	☐No
Bleeding/Bruising	☐Yes	☐No	Intestinal Problems	☐Yes	☐No
Blood Disorder	☐Yes	☐No	Kidney Disease	☐Yes	☐No
COPD	☐Yes	☐No	Liver Disease	☐Yes	☐No
Chronic Bronchitis	☐Yes	☐No	Migraine/Headache	☐Yes	☐No
Cancer	☐Yes	☐No	Osteoporosis	☐Yes	☐No
Depression	☐Yes	☐No	Obesity	☐Yes	☐No
Diabetes	☐Yes	☐No	Stroke	☐Yes	☐No
Drug Abuse	☐Yes	☐No	Sinus problems	☐Yes	☐No
Epilepsy/Seizures	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Emphysema	☐Yes	☐No	Tuberculosis (TB)	☐Yes	☐No
Hay Fever	☐Yes	☐No	Stomach Ulcers	☐Yes	☐No

Other (Please list): -

Past Surgical History (Please list all surgeries and approximate dates)

Medications (Please list name, dose, and frequency of all medications)

Allergies (Please list all medication and latex allergies and describe reaction)

UCLA Health

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Patient Name:

(Patient Label)

Spine New Patient Questionnaire

Don Young Park, M.D.
Department of Orthopaedic Surgery

Social History

Do you smoke cigarettes? ☐Yes ☐No Packs per day? _____

How many years? _____ If you quit, when? _____

Do you use any other forms of tobacco? ☐Yes ☐No

What type? _____

Do you drink alcohol? ☐Yes ☐No How often and how much? _____

Do you use drugs other than prescribed or over the counter medications? ☐Yes ☐No

What do you use? _____

Birthplace? _____

Marital Status/Relationship? _____

Current Occupation: _____

Family History (Please list medical problems in your family)

	Age	Medical Problems	If decreased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____
Grand-Parent	_____	_____	_____

UCLA Health

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Spine New Patient Questionnaire

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Department of Orthopaedic Surgery

Review

Review of Systems:
(Please check if applicable)
☐**None are applicable**

General
☐ Good health
☐ Recent weight changes
☐ Fatigue
☐ Recurrent fever or chills
☐ Headache

Skin/Breast
☐ Rashes
☐ Lumps
☐ Itching
☐ Color changes
☐ Hair and nail changes
☐ Pain
☐Discharge

Ear/Nose/Throat
☐ Decreased hearing
☐ Ringing in ears
☐ Pain
☐ Drainage
☐ Stuffiness
☐ Discharge
☐ Nosebleeds
☐ Sinus pain
☐ Dry mouth
☐ Sore throat
☐ Hoarseness
☐ Non-healing sores
☐ Bleeding
☐ Swollen glands

Eyes
☐ Glasses or contacts
☐Pain
☐ Redness
☐ Blurry or double vision
☐ Glaucoma
☐ Cataracts

Respiratory
☐ Cough
☐ Sputum
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Painful breathing

Cardiovascular
☐ Chest pain or discomfort
☐ Tightness
☐ Palpitations
☐ Shortnessof breath with activity
☐ Difficulty breathing lying down
☐ Swelling
☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal
☐ Swallowing difficulties
☐ Heartburn
☐ Change in appetite
☐ Nausea
☐ Change in bowel habits
☐ Rectal bleeding
☐ Constipation
☐ Diarrhea
☐ Yellow eyes or skin

Genitourinary
☐ Frequency
☐ Urgency
☐ Burning or pain
☐ Blood in urine
☐ Incontinence
☐ Change in urinary strength

Male-
☐ Pain with sex
☐ Hernia
☐ Penile discharge
☐ Sores
☐ Masses or pain
☐ Erectiledysfunction
☐ STD's

Female-
☐ Pain with sex
☐ Vaginal dryness
☐ Hot flashes
☐ Vaginal discharge
☐ Itching or rash
☐ STD's

Vascular
☐ Calf pain with walking
☐ Leg cramping
☐ Varicose veins

Musculoskeletal
☐ Muscle or joint pain
☐ Stiffness
☐ Back pain
☐Redness of joints
☐ Swelling of joints
☐ Trauma

Neurologic
☐ Dizziness
☐ Fainting
☐ Seizures
☐ Weakness
☐ Numbness
☐ Tingling
☐ Tremor

Hematologic
☐ Ease of bruising
☐ Ease of bleeding

Endocrine
☐ Heat or cold intolerance
☐ Sweating
☐ Frequenturination
☐ Excess thirst
☐ Change in appetite

Psychiatric
☐ Nervousness
☐ Depression
☐ Memory loss
☐ Stress
:

Name of person completing form _____
Signature: _____
Relationship (if other than patient): _____

Health Questionnaire

English version for the US

By placing a checkmark in one box in each group below, please indicate which statements best describe your own health state today.

Mobility

I have no problems in walking about ❑

I have some problems in walking about ❑

I am confined to bed ❑

Self-Care

I have no problems with self-care ❑

I have some problems washing or dressing myself ❑

I am unable to wash or dress myself ❑

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

I have no problems with performing my usual activities ❑

I have some problems with performing my usual activities ❑

I am unable to perform my usual activities ❑

Pain/Discomfort

I have no pain or discomfort ❑

I have moderate pain or discomfort ❑

I have extreme pain or discomfort ❑

Anxiety/Depression

I am not anxious or depressed ❑

I am moderately anxious or depressed ❑

I am extremely anxious or depressed ❑

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today