

**CSC Physicians:**

**Ulrich Batzdorf, MD; David E. Fish, MD; Langston Holly, MD; Jae Jung, MD;  
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**COMPREHENSIVE SPINE CENTER**



Daniel Lu, MD, PhD

1131 Wilshire Blvd, Suite 100

Santa Monica, CA 90401

(310) 319-DISK (clinical appt); (424) 825-7245 (fax)

(310) 267-2975 (academic office)

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 YOUR APPOINTMENT**

On your initial visit you will be seen by spinal neurosurgeon, **Daniel Lu, MD, PhD**, of the UCLA Comprehensive Spine Center, in Santa Monica. He 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

## Referring Physicians and Other Physicians involved in Medical Care

|                        |
|------------------------|
| <b>Physician Name:</b> |
| <b>Specialty:</b>      |
| <b>Phone Number:</b>   |
| <b>Fax Number:</b>     |
| <b>Address:</b>        |
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| <b>Physician Name:</b> |
| <b>Specialty:</b>      |
| <b>Phone Number:</b>   |
| <b>Fax Number:</b>     |
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| <b>Physician Name:</b> |
| <b>Specialty:</b>      |
| <b>Phone Number:</b>   |
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Daniel Lu, MD, PhD  
Functional Questionnaire  
UCLA Comprehensive Spine Center

\*You may be asked to complete this form on subsequent visits during your treatment

Name  UCLA number  Current Date

**Please read:**

This questionnaire has been designed to give the doctor any information as to how your back pain has affected your that ability to manage in every day life. Please answer every section and mark only the one box that applies to you.

We realize you may consider that two of the statements one section relate to you, but please mark only the box most closely describes your problem.

How long have you had back/neck pain?    Years    Months    Weeks  
       

How long have you had leg/arm pain?           

**Section 6 - Standing**

- Pain prevents me from standing more than 10 minutes
- Pain prevents me from standing at all

**Section 1 - Pain Intensity**

- I can tolerate the pain without having to use pain killers
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

**Section 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 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 and stay in bed

**Section 3 - Lifting**

- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned square 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 only very light weights
- I cannot lift or carry anything at all

**Section 4 - Walking**

- Pain does not prevent my walking any distance
- Pain prevents my walking more than 1 mile
- Pain prevents my walking more than 1/2 mile
- Pain prevents my walking more than 1/4 mile

**Section 5 - Sitting**

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than 1/2 hour
- Pain prevents me from sitting more than 10 min.
- Pain prevents me from sitting at all

**Section 7 - Sleeping**

- Pain does not prevent me from sleeping well
- I can sleep well only by using tablets
- Even if I take medication I have less than 6 hours sleep
- Even if I take medication I have less than 4 hours sleep
- Even if I take medication I have less than 2 hours sleep
- Pain prevents me from sleeping at all

**Section 8 - Sex Life**

- Normal and causes no extra pain
- Normal but increases the degree of pain
- Nearly normal but is very painful
- Nearly absent because of pain
- Pain prevents any sex life at all

**Section 9 - Social Life**

- Normal and give me no extra pain
- Normal but increases the degree of pain
- Pain has no significant effect apart from limiting my more energetic interests, e.g. dancing, etc.
- 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

**Section 10 - Traveling**

- I can travel anywhere without extra pain
- I can travel anywhere but it causes 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 journeys under 30 min
- Pain prevents me from traveling except to the doctor or hospital

Comments

Daniel Lu, MD, PhD  
General Medical Review of Systems  
UCLA Comprehensive Spine Center

**Allergies**

- Asthma
- Hay Fever
- Skin Eruptions

**Cardiovascular**

- Chest Pain
- Irregular Heart Beat
- High/Low blood pressure
- Poor circulation
- Rapid Heart Beat

**Constitutional**

- Chills/sweats/fever
- Fainting
- Forgetfulness
- Headache
- Loss of sleep
- Nervousness
- Weight Loss

**Ears, Nose, Mouth, Throat**

- Bleeding Gums
- Difficulty Swallowing
- Ear Ache
- Ear Discharge
- Hearing Loss
- Hoarseness
- Nosebleeds
- Persistent Coughs
- Ringing in Ears
- Sinus Problems

**Endocrine**

- Rapid Weight Loss/Gain
- Intolerance to warm room
- Multiple Broken Bones
- Cessation of Menstrual period
- Excessive hunger/thirst
- Loss of libido
- Spontaneous Nipple Discharge

**Eyes**

- Blurred Vision
- Crossed Eyes
- Double Vision
- Vision Flashes or Halos

**Genitourinary**

- Blood in Urine
- Lack of bladder control
- Painful urination

**Gastrointestinal**

- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Rectal bleeding
- Stomach Pain

**Hematologic/Lymphatic**

- Swollen Lymph Nodes
- Easy Skin Bruising
- Prolonged Bleeding

**Integumentary**

- Skin Rashes or Eruption
- Chronic Bleeding

**Men**

- Breast Lump
- Lump in testicle
- Penis discharge
- Sore on penis

**Neurological**

- Fainting
- Headache
- Seizures
- Numbness of arms and legs
- Tingling of hands, feet arms, or legs

**Musculoskeletal**

- Pain, Weakness, Numbness, Swelling
- Hands, Wrists, Hips, Knees, Joints
- Pain in arms and legs

**Psychiatric**

- Anxiety
- Depression
- Panic attacks
- Restlessness

**Respiratory**

- Blood
- Cough
- Dizziness
- Shortness of Breath

**Women**

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump
- Extreme Menstrual Pain
- Hot flashes
- Nipple Discharge
- Painful Intercourse
- Are you Pregnant?

Last Mammogram

Last Period

Last Pap Smear

# of Children and Ages



# Comprehensive Spine Center

Medical Information Sheet

*Daniel Lu, MD, PhD*

*"Please take some time to carefully fill out these sheets so that we can provide you with the very best care."*

| Name                 | Last Name, | First Name, | Middle | Birthdate (mo/day/year) | Age | Sex (M/F) | Weight | Height | Right or Left Handed |
|----------------------|------------|-------------|--------|-------------------------|-----|-----------|--------|--------|----------------------|
| <input type="text"/> |            |             |        |                         |     |           |        |        |                      |
| <input type="text"/> |            |             |        |                         |     |           |        |        |                      |
| <input type="text"/> |            |             |        |                         |     |           |        |        |                      |
| <input type="text"/> |            |             |        |                         |     |           |        |        |                      |
| <input type="text"/> |            |             |        |                         |     |           |        |        |                      |
| <input type="text"/> |            |             |        |                         |     |           |        |        |                      |

Your Occupation(s):

Are you presently (working/disabled/retired)?

Are you:  Married  Single  Divorced  Separated  Widowed

*In your words, please describe your problem and reason for visiting us today.*

| Symptoms             | Duration             |
|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> |

*Please tell us what treatments you have had up to now for the problems you described above.*

| Treatment            | When / How Long      | Did it help?         |
|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

*Please tell us about surgical procedures you have had before.*

**Previous operations**

**Dates**

**Any Problems (y/n?)**

|  |  |  |
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*Please tell us about any other medical problems you may have (examples: hypertension, diabetes, stroke, cancer, etc.)*

**Medical Issue**

**How Long**

**Any Treatment? When?**

|  |  |  |
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Check box if answer is yes

**Do you smoke?**  **How many packs per day?**  **For how many years?**

**Do you drink?**  **What do you drink?**  **How often?**

**Osteoporosis**  **Rheumatoid Arthritis**  **Cancer**

**Recent Infections**  **HIV/AIDS**  **Hepatitis**

**Heart Attacks**  **Chest Pain**  **Lung Problems**

*Family History: Parents, Grandparents, Siblings (alive or deceased; list age at date of death and cause)*

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*Please tell us ALL medications, pain pills, aspirins, or supplements you are taking or have recently taken.*

**Medication**

**Strength/Amount**

**How many pills and times per day?**

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**Allergies to medications**

**Other allergies**

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*Please list all recent X-rays, CTs, MRIs, or other studies you have had for your problem. (dates/where)*

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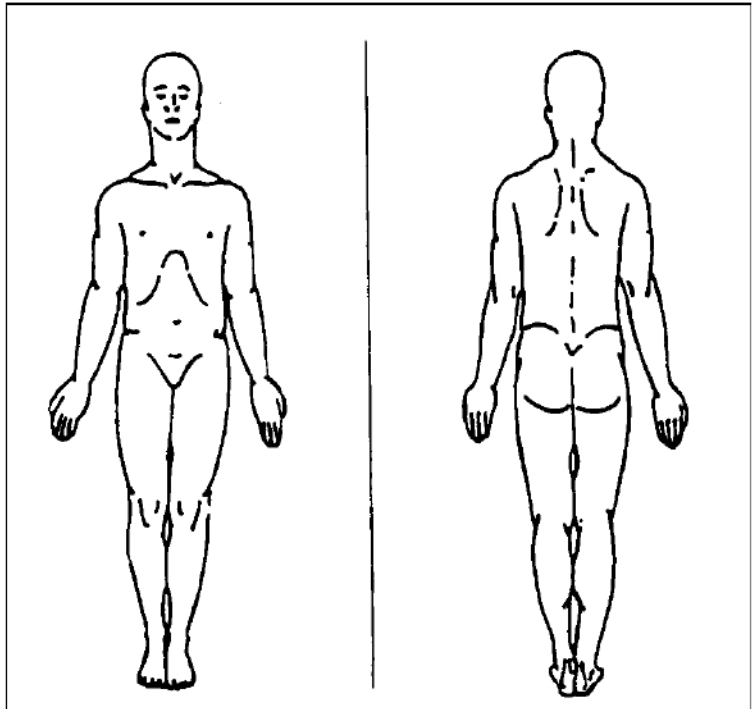
**Are you claustrophobic?**  **Have you required sedation in the past?**

*Implants (i.e. stimulators, medication pumps, metal (titanium or steel), include location of implant)*

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Please help us better understand the pain that you are experiencing.

Indicate the locations of your pain by shading in the painful areas on these figures >> (After printing out the form)



1. Please indicate the **current** intensity of your pain by making an X anywhere on the line below:

NO PAIN  THE MOST INTENSE PAIN IMAGINABLE

2. Please indicate the **worst** intensity of your pain over **the past month** by making an X anywhere on the line below:

NO PAIN  THE MOST INTENSE PAIN IMAGINABLE

3. Please indicate your **mood** over **the past month** by making an X anywhere on the line below:

EXTREMELY GOOD MOOD  EXTREMELY BAD MOOD

4. Please rate how **often** your pain problem **stopped you** from doing what you wanted to do over **the past month**:

DID NOT STOP ME  COMPLETELY STOPPED ME

5. Please indicate how many **days per week** you have had **adequate** relief of your pain over **the past month** (by indicating a number):

6. If your are taking pain medications, please indicate the **amount of relief** you receive after taking your medication by making an X anywhere on the line below:

NO RELIEF  COMPLETE RELIEF

7. Overall, how satisfied are you with the results of your pain treatment?

extremely dissatisfied  very dissatisfied  somewhat dissatisfied  mixed  somewhat satisfied  very satisfied  extremely satisfied

8. Check all the words that describe your pain this month:

Aching  Throbbing  Shooting  Stabbing  Gnawing  Fearful  Sharp  
 Tender  Heavy  Burning  Exhausting  Splitting  Punishing  
 Sickening  Cramping



## **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**

Best  
imaginable  
health state

100

90

80

70

60

50

40

30

20

10

0

Worst  
imaginable  
health state