

CSC Physicians:

**Ulrich Batzdorf, MD; David E. Fish, MD; Langston Holly, MD; Jae Jung, MD;
Duncan Q. McBride, MD; Nick Shamie, MD; Daniel Lu, MD, PhD**



COMPREHENSIVE SPINE CENTER



Duncan McBride, MD

1131 Wilshire Blvd, Suite 100

Santa Monica, CA 90401

(310) 319-DISK (clinical appt); (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 YOUR APPOINTMENT

On your initial visit you will be seen by spinal neurosurgeon, **Duncan McBride, MD**, 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

Physician Name:
Specialty:
Phone Number:
Fax Number:
Address:

Physician Name:
Specialty:
Phone Number:
Fax Number:
Address:

Physician Name:
Specialty:
Phone Number:
Fax Number:
Address:

Duncan McBride, M.D.

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
<input type="text"/>	<input type="text"/>	<input type="text"/>

How long have you had leg/arm pain?

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

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

Duncan McBride, M.D.
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

Duncan McBride, MD

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

Last Name,		First Name,		Middle	
Name					
Birthdate (mo/day/year)					
Age		Sex (M/F)	Weight	Height	Right or Left Handed

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

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

Treatment	When / How Long	Did it help?

Please tell us about surgical procedures you have had before.

Previous operations

Dates

Any Problems (y/n?)

--	--	--

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

Medical Issue

How Long

Any Treatment? When?

--	--	--

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)

--

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?

--

Allergies to medications

Other allergies

--

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

--

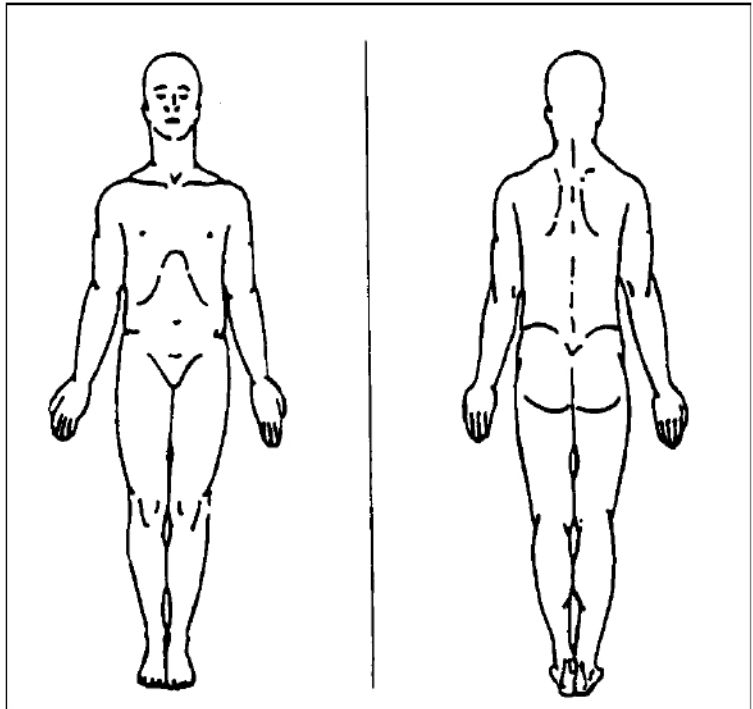
Are you claustrophobic? **Have you required sedation in the past?**

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

--

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 EXTREMELY BAD MOOD
GOOD MOOD

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

DID COMPLETELY STOPPED ME
NOT STOP 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