



Santa Monica UCLA Comprehensive Spine Center  
Langston T. Holly, MD  
1131 Wilshire Blvd, Suite 100  
Santa Monica, CA 90401  
(310) 319-DISK (clinical appt); (424) 259-6930 (fax)  
(310) 267-5580 (academic office); (310) 206-1857 (academic fax)

Dear Esteemed Patient:

Thank you for choosing to make an appointment at the Santa Monica UCLA Comprehensive Spine Center.

Your initial consultation will be with spinal neurosurgeon, Langston Holly, MD. He will obtain a medical history and perform a physical examination (with or without a Spine Fellow, Resident, Physician's Assistant, Nurse Practitioner student). The Santa Monica 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 and perform treatment based on a thorough evaluation, 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 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.

**Please be sure to bring the following to your appointment:**

- **Most current diagnostic images** that pertain to your current medical condition (i.e. MRI, CT, x-rays; SSEP or EMG report, etc.).
  - If your imaging was performed within the UCLA system, our office will have them available for your visit.
  - If your imaging was performed at an outside facility, please hand carry a CD of your imaging, along with the report.
- **Prior medical records and consultation reports** from your referring physician/other specialist you have seen that pertain to your current medical condition (i.e. Physical Therapy; Pain Medicine; Operative reports, etc.).
  - If your prior care was performed within the UCLA system, our office will have them available for your visit.
  - If your prior care was performed at an outside facility, please hand carry your reports.
- **Your medical insurance card(s)**
  - If you have HMO Insurance, please bring your "Letter of Authorization" and your co-payment. If you do not bring your authorization letter and we have no authorization on file, you will be financially responsible and you will be expected to pay the consultation fee on the day of your appointment.
- **New Patient Questionnaire**
  - Please hand carry the completed New Patient questionnaire (see attachment).

If you have any questions, please contact the UCLA Spine Center Appointment Scheduling desk at (310) 319-3475.  
PLEASE NOTIFY US OF ANY CANCELLATIONS AT LEAST 24 HOURS PRIOR TO YOUR APPOINTMENT.

Please find attached a New Patient questionnaire and a map with directions to our location.

We look forward to seeing you.

Sincerely,

Patient Care Coordinator  
Santa Monica UCLA Comprehensive Spine Center

**CSC Physicians**

Ulrich Batzdorf, MD; David Fish, MD; Langston Holly, MD; Jae Jung, MD;  
Daniel Lu, MD, PhD; Luke Macyszyn, MD; Duncan McBride, MD; Don Park, MD; Nick Shamie, MD

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:  
  
(Patient Label)

**Chief Complaint**

Reason for today's visit: \_\_\_\_\_

Duration : \_\_\_\_\_

**Allergies / Contraindications**

Have you ever had an allergic reaction to any medication? If yes, please list medication and reaction: \_\_\_\_\_

**Medications**

Please list any medications (prescription and over the counter) you are currently taking (including vitamins and aspirin):

Name	Dosage	Frequency Per Day

Preferred Pharmacy: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Preferred Laboratory:  UCLA     Outside: \_\_\_\_\_

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

**Medical History**

Have you ever been diagnosed with any of the following conditions?

Brain Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Memory Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Confusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Movement Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurocutaneous Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neuropathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Head Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Syncope	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Medical Problems: (Please list all medical conditions not listed above):

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**Diagnostic Imaging**

Please list all recent X-rays, CTs, MRIs, or other studies you have had related to these symptoms:

Type	Date	Location

Are you claustrophobic?  Yes  No      Have you required sedation in the past?  Yes  No

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

**Implants**

Please list any stimulators, medication pumps, metal (titanium or steel):

Type	Year	Location of implant

**Treatment**

Please list all previous treatments (i.e. physical therapy, injections, nerve block, acupuncture, chiropractic adjustments, etc.):

Type	When? For how long?	Did it help?

**Surgical History**

Please list all previous operations/hospitalizations:

Type of Operation	Year	Complications

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

**Family History**

For example: Cancer, Depression, Diabetes, Epilepsy, Heart Disease, Hypertension, Memory Loss, Multiple Sclerosis, Muscle Weakness, Psychosis, Seizures, Stroke, Thyroid Disease, etc...

Family Member	Age (or age at death)	Living		Medical Problems
		Yes	No	
Mother		<input type="checkbox"/>	<input type="checkbox"/>	
Father		<input type="checkbox"/>	<input type="checkbox"/>	
Sister		<input type="checkbox"/>	<input type="checkbox"/>	
Brother		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Aunt		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Uncle		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Aunt		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Uncle		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	
Maternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandmother		<input type="checkbox"/>	<input type="checkbox"/>	
Paternal Grandfather		<input type="checkbox"/>	<input type="checkbox"/>	
Child		<input type="checkbox"/>	<input type="checkbox"/>	
Child		<input type="checkbox"/>	<input type="checkbox"/>	
Child		<input type="checkbox"/>	<input type="checkbox"/>	

Other: \_\_\_\_\_

Adopted       Family History Unknown

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:  
  
(Patient Label)

**Social History**

Tobacco Use:  Yes  No      Stop Date: \_\_\_\_\_  
Packs/Day  ¼ Pack  ½ Pack  1 Pack  > 1 Pack  
Years:  < 1yr  1 – 5 yrs  > 5 yrs  years \_\_\_\_\_  
Smokeless Tobacco?  Yes  No      Stop Date: \_\_\_\_\_  
Ready to stop:  Yes  No      Stop Date: \_\_\_\_\_

Alcohol Use:  Yes  No

Drinks/Week:

Type	Frequency per Week
Glasses of Wine (5 oz.)	
Cans of Beer (12 oz.)	
Shots of Liquor (1.5)	
Drinks containing 1.5 oz. of alcohol	

Drug Use:  Yes  No

Type	Frequency per Week

Handedness:  Right  Left

Relationship Status:  Single  Married  Divorced  Widowed

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

**Mobility History**

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark only one box that applies to you. We realize you may consider that two of the statements in one section relate to you, but please mark only the box that most closely describes your problem.

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

**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)**

- 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 8 - Sex Life**

**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 ½ mile
- Pain prevents my walking more than ¼ 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 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

**Section 6 - Standing**

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

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

**Section 7 - Sleeping**

- Pain does not prevent me from sleeping well
- I can sleep well only by using medication
- 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

**Comments**

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**Section 9 - Social Life**

- Normal and gives me no extra pain
- Normal but increases the degree of pain
- Pain has no significant effect apart from limiting my more energetic interests
- 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 2 hours
- Pain restricts me to journeys of less than 1 hour
- Pain restricts me to short journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital



**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

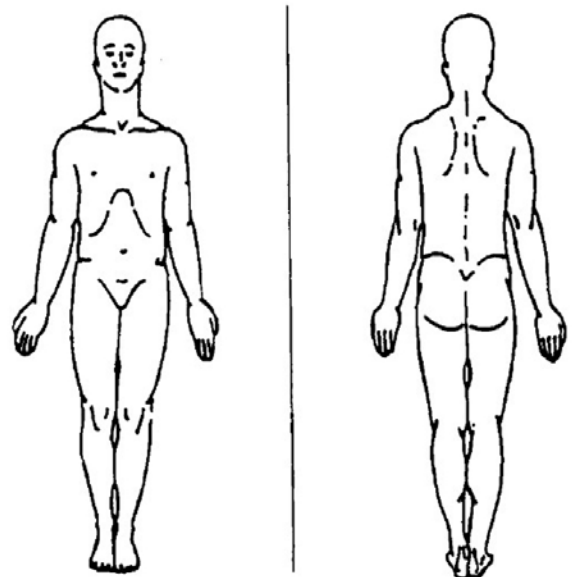
**Pain History**

1. Indicate the current intensity of your pain by marking an **X** anywhere on the line below:  
NO PAIN \_\_\_\_\_ MOST INTENSE PAIN IMAGINABLE
2. Indicate the intensity of your pain over the past month by marking an **X** anywhere on the line below:  
NO PAIN \_\_\_\_\_ MOST INTENSE PAIN IMAGINABLE
3. Indicate your mood over the past month by marking an **X** anywhere on the line below:  
GOOD MOOD \_\_\_\_\_ BAD MOOD
4. Indicate how often your pain has stopped you from doing what you wanted to do over the past month, by marking an **X** anywhere on the line below:  
DID NOT STOP ME \_\_\_\_\_ DID STOP ME
5. If you are taking pain medications, indicate the amount of relief you receive after taking medication, by marking an **X** anywhere on the line below:  
COMPLETE RELIEF \_\_\_\_\_ NO RELIEF
6. How many days per week have you had adequate relief of your pain, over the past month? \_\_\_\_\_
7. Overall, how satisfied are you with the results of your pain treatment (please circle)?

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

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

- |                                     |                                    |                                    |
|-------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Aching     | <input type="checkbox"/> Gnawing   | <input type="checkbox"/> Sickening |
| <input type="checkbox"/> Burning    | <input type="checkbox"/> Heavy     | <input type="checkbox"/> Splitting |
| <input type="checkbox"/> Cramping   | <input type="checkbox"/> Punishing | <input type="checkbox"/> Stabbing  |
| <input type="checkbox"/> Exhausting | <input type="checkbox"/> Sharp     | <input type="checkbox"/> Tender    |
| <input type="checkbox"/> Fearful    | <input type="checkbox"/> Shooting  | <input type="checkbox"/> Throbbing |



**Indicate the locations of your pain by shading in the painful areas on these figures >>**

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

**Review of Systems**

Have you experienced any of the following symptoms?

<b>System</b>	<b>Check Yes or No</b>	
<b>Allergies</b>		
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Skin eruptions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Cardiovascular</b>		
Chest pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irregular heart beat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High/low blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Poor circulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rapid heart beat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Constitutional</b>		
Chills/sweats/fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Forgetfulness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of sleep	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Ears, Nose, Mouth, Throat</b>		
Bleeding gums	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear ache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hoarseness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Persistent coughs	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ringing in ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Endocrine</b>		
Rapid weight loss/gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Intolerance to warm room	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple broken bones	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cessation of menstrual period	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive hunger/thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

<b>System</b>	<b>Check Yes or No</b>
<b>Endocrine (continued)</b>	
Loss of libido	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spontaneous nipple discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Eyes</b>	
Blurred vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision flashes or halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Gastrointestinal</b>	
Bloating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel changes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gas	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Poor appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Genitourinary</b>	
Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lack of bladder control	<input type="checkbox"/> Yes <input type="checkbox"/> No
Painful urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Hematologic/Lymphatic</b>	
Swollen lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Easy skin bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Integumentary Skin &amp; Breasts</b>	
Skin rashes or eruptions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Men</b>	
Breast lump	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lump in testicle	<input type="checkbox"/> Yes <input type="checkbox"/> No
Penis discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore on penis	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

<b>System</b>	<b>Check Yes or No</b>
<b>Musculoskeletal</b>	
Pain, weakness, numbness, swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hands, wrists, hips, knees, joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pain in arms and legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Neurological</b>	
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headache	<input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Numbness of arms and legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tingling of hands, arms, feet or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Psychiatric</b>	
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Panic attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Restlessness	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Respiratory</b>	
Blood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Women</b>	
Abnormal pap smear	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding between periods	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast lump	<input type="checkbox"/> Yes <input type="checkbox"/> No
Extreme menstrual pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hot flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nipple discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
Painful intercourse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last mammogram	_____
Last period	_____
Last pap smear	_____
Number of children and their ages	_____

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN:  
Patient Name:

(Patient Label)

**Referral Contact**

Were you by referred by another physician?

Please fill out address completely. This is important to ensure proper communication with your physician.

Referring MD: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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If you have a primary care physician other than your referring physician, please complete the information below.

Primary Care MD: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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Would you like the information from today's visit sent to a physician other than those listed above?

Name of MD: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**SANTA MONICA COMPREHENSIVE SPINE CENTER  
HISTORY AND PHYSICAL**

MRN: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
  
(Patient Label)

Current Occupation: \_\_\_\_\_

Employer \_\_\_\_\_ How long? \_\_\_\_\_

Are you presently:  Working  Disabled  Retired \_\_\_\_\_

Is the chief complaint a result of a specific injury or accident?  Yes  No

Date of accident \_\_\_\_\_ Type of accident \_\_\_\_\_

Are you involved in litigation regarding this condition?  Yes  No

**The above information is accurate to the best of my knowledge:**

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_

Interpreter Signature \_\_\_\_\_ ID # \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Physician Signature \_\_\_\_\_ ID # \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_



## **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



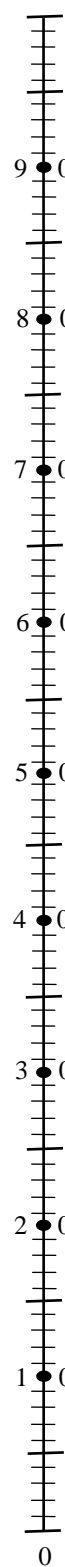
To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

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



Worst  
imaginable  
health state