David Geffen School of Medicine | UCLA Health System

Santa Monica UCLA Comprehensive Spine Center
Luke Macyszyn, 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, Luke Macyszyn, 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

UCLA Health

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 and 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: _____

UCLA Health

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

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

_____

_____

_____

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

UCLA Health

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

UCLA Health

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 Yes	Living No	Medical Problems
Mother		☐	☐	
Father		☐	☐	
Sister		☐	☐	
Brother		☐	☐	
Maternal Aunt		☐	☐	
Maternal Uncle		☐	☐	
Paternal Aunt		☐	☐	
Paternal Uncle		☐	☐	
Maternal Grandmother		☐	☐	
Maternal Grandfather		☐	☐	
Paternal Grandmother		☐	☐	
Paternal Grandfather		☐	☐	
Child		☐	☐	
Child		☐	☐	
Child		☐	☐	

Other: _____

☐ Adopted ☐ Family History Unknown

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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

UCLA Health

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

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

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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

_____

_____

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

UCLA Health

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? _____

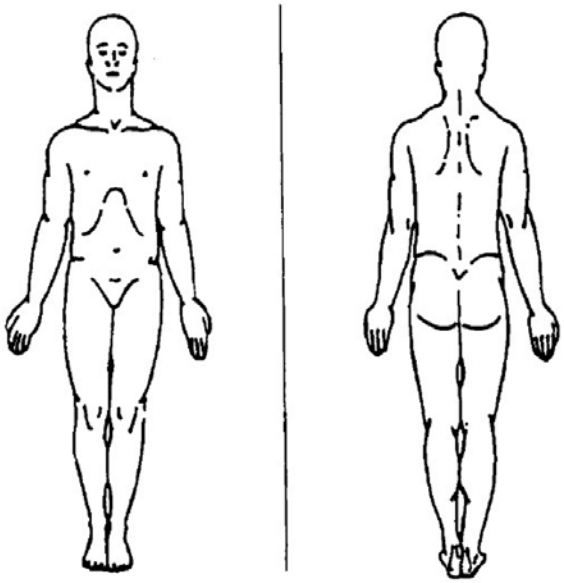
7. Overall, how satisfied are you with the results of your pain treatment (please circle)?

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

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

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

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



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SANTA MONICA COMPREHENSIVE SPINE CENTER HISTORY AND PHYSICAL

MRN:
Patient Name:

(Patient Label)

Review of Systems

Have you experienced any of the following symptoms?

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

UCLA Health

MRN:
Patient Name:

(Patient Label)

SANTA MONICA COMPREHENSIVE SPINE CENTER HISTORY AND PHYSICAL

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

UCLA Health

MRN:
Patient Name:

(Patient Label)

SANTA MONICA COMPREHENSIVE SPINE CENTER HISTORY AND PHYSICAL

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

UCLA Health

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: _____

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: _____

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: _____

UCLA Health

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