Print Form

UCLA MEDICAL CENTER

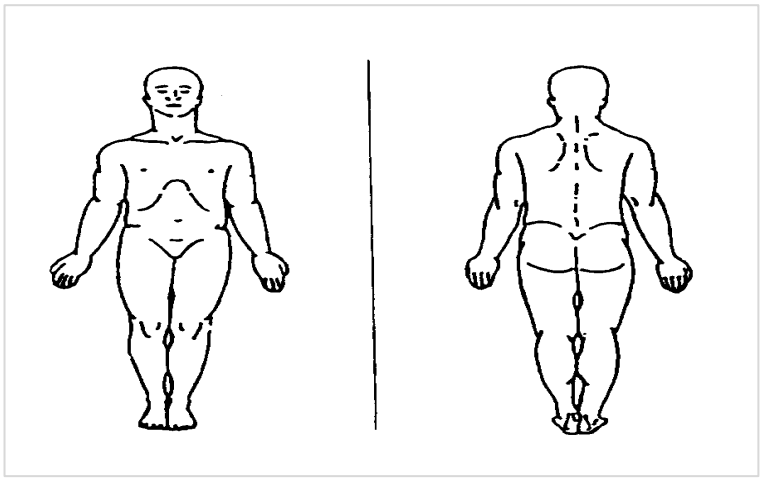
Department of Orthopedic Surgery - Spine Service,

David E Fish, MD,MPH

Today's Date: _____

PATIENT INFORMATION

WHERE IS THE PAIN? Draw the location of your pain
By shading on the diagram to the right: >>>>>>>>>>>>>>



Work related?	☐ Yes	☐ No
LEGAL Actions pending?	☐ Yes	☐ No
Workers Compensation?	☐ Yes	☐ No
Are you working now?	☐ Yes	☐ No

REFERRAL: doctor that sent you to clinic with address:
_____
_____
_____ (**Please add names of who should have copy of report)**

CHIEF COMPLAINT (Circle):	Upper / Mid / Low Back	Legs / Buttock / Hip	shoulder / elbow
	Right / Left / Both Neck	Arms / wrist / hands	Foot / ankle

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other _____

HISTORY OF PRESENT ILLNESS:

How long have you noticed pain?	_____Days	_____Weeks	_____ Months	_____Years
Was there any injury/event that caused your pain? ☐ No ☐ Yes (please describe):	_____			
Have you had surgery on your back / neck? ☐ No ☐ Yes (What Type?):	_____			

The pain is described as:	☐ Constant	☐ Intermittent	☐ Unchanged	☐ Worse	☐ Better

RATE YOUR USUAL PAIN (Circle): No Pain 0 1 2 3 4 5 6 7 8 9 10 The Worst Pain Imaginable

Describe your pain: Burning Sharp-shooting tingling numbness pinprick stabbing deep-pressure Tightness spasms

Others: _____

TREATMENT & EVALUATIONS:	☐ MRI	☐ X-Ray	☐ CT	☐ Bone Scan	☐ Blood/Laboratory	☐ Epidurals
Check treatment tried for pain and circle the best treatment to date:	☐ Physical Therapy	☐ TENS	☐ heating pad	☐ Ice	☐ Injections	☐ Exercise
	☐ Epidural steroids	☐ Surgery	☐ Massage	☐ Medications	☐ Acupuncture	☐ Chiropractor

What makes pain worse?	_____
What makes pain better?	_____
How does the pain limit you?	_____

PAST SURGERY (List it below**):**	**ALLERGIES** ☐ allergic to following:	☐ no drug allergies:
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Please list other MEDICAL Problems :		**Current Medications and Dosages**
☐ Diabetes	☐ Low Back Pain	☐
☐ Arthritis	☐ High Cholesterol	☐
☐ Osteoporosis	☐ Bleeding Disorder	☐
☐ Heart Disease	☐ Neck Pain	☐
☐ Depression	☐	☐
☐ High Blood Pressure	☐	☐
☐ Cancer:		☐

FAMILY HISTORY?			**SOCIAL HISTORY?**			
Arthritis	☐ Yes	☐ No	How did/do you make a living?	_____		
Diabetes	☐ Yes	☐ No	Can you dress yourself	☐ No	☐ Yes	
Bone disease	☐ Yes	☐ No	Alcohol Use	☐ No	☐ Yes	
Cancer	☐ Yes	☐ No	Smoker	☐ No	☐ Yes	# packs / day = ____
Heart Disease	☐ Yes	☐ No	Recreational Substance	☐ No	☐ Yes	

Mother:	Age _____ Years	☐ Healthy	☐ Deceased due to: _____
Father:	Age _____ Years	☐ Healthy	☐ Deceased due to: _____

REVIEW OF SYSTEMS: Please fill out CURRENT symptoms only. Check if None or Normal ☐

SKIN ☐ Normal	**Neurological** ☐ Normal	**Eyes** ☐ Normal	**Lymph Nodes** ☐ Normal
☐ skin rash	☐ Headaches	☐ visual loss	☐ enlargement
☐ easy bruising/bleeding	☐ Incontinence	☐ color blindness	☐ pain
☐ abnormal hair loss	☐ seizures	☐ glaucoma	
☐ nail ridging, pitting	☐ paralysis	☐ glasses / contacts	
Ears/Nose ☐ Normal	**Genitourinary** ☐ Normal	**Bone/ joint/ muscles** ☐ Normal	**Respiratory system** ☐ Normal
☐ deafness	☐ blood in urine	☐ dislocation	☐ breath shortness
☐ vertigo/dizziness	☐ impotence	☐ fracture	☐ cough
☐ hoarseness	☐ painful urination	☐ muscle wasting	☐ asthma/bronchitis
☐ sinusitis	☐ kidney stones	☐ muscle pain	☐ tuberculosis
☐ post nasal drip	☐ venereal disease	☐ muscle weakness	☐ pneumonia
Mental Status ☐ Normal	**Blood System** ☐ Normal	**Endocrine** ☐ Normal	**Cardiovascular** ☐ Normal
☐ Hallucinations	☐ anemia	☐ abnormal growth	☐ palpitations
☐ nervous breakdown	☐ bleeding	☐ goiter	☐ chest pains
☐ depression	☐ bruising	☐ heat/cold intolerance	☐ leg swelling
☐ sleep disturbances	☐ blood thinners	☐ increase thirst	☐ arrhythmia
Constitutional ☐ Normal	**Allergies** ☐ Normal	**Gastrointestinal** ☐ Normal	**General** ☐ Normal
☐ fever / chills	☐ dermatitis	☐ appetite changes	☐ poor sleep
☐ weight loss	☐ hay fever	☐ jaundice	☐ poor energy
☐ nausea	☐ migraine	☐ hemorrhoids	☐ eat too much / little
☐ vomiting	☐ sensitivity to pollen	☐ irritable bowels	☐ unhappy

PHYSICAL EXAMINATION	
Temp:	
BP:	
Pulse:	
Respirations:	
Pain VAS:	/10

_____

Reviewing Physician Signature