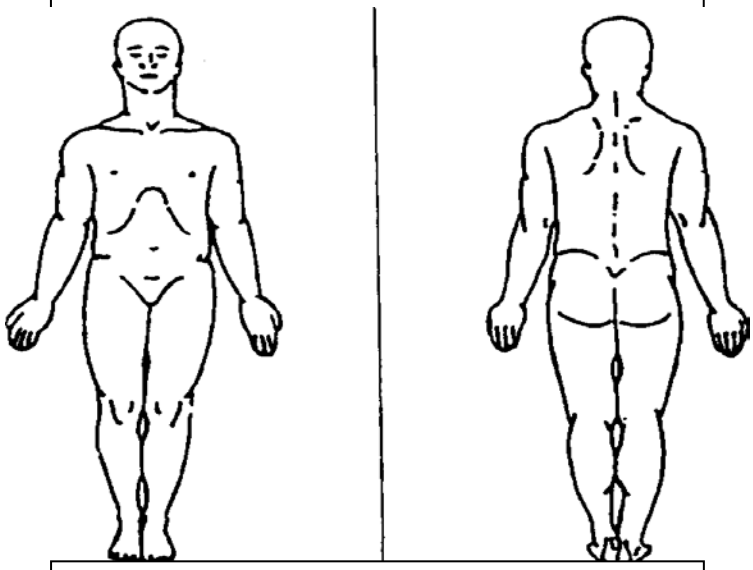
UCLA MEDICAL CENTER
Department of Orthopedic Surgery - Spine Service,
Kyle Yang, MD

Today's Date: _____

IMPORTANT! PLEASE MARK AREAS OF PAIN



IMPORTANT! PLEASE MARK AREAS OF PAIN

PATIENT INFORMATION

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

Work related?	□ Yes	□ No
Workers Compensation?	□ Yes	□ No
Are you working now?	□ Yes	□ No

Referring Physician:

Other Referral Source:

What problem/issue brings you here today?

HISTORY OF PRESENT ILLNESS

How long have you noticed pain?	____ Days	____ Weeks	____ Months	____ Years	
Was there any injury/event that caused your pain?					
Have you had surgery on your back/neck?					
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 Ever**				
Describe your pain (circle):	| Burning | Sharp-shooting | Tingling | Numbness | Pinprick | Stabbing | Deep-pressure | Tightness | Spasms | Other: _____				

TREATMENT & EVALUATIONS

What diagnostic tests have you had for this problem?	None	X-ray	MRI	CT	EMG	Orthopaedic Consult
Check treatment tried for pain and circle the best treatment to date:	□ Physical Therapy	□ Acupuncture	□ Massage □ Chiropractor	□ Medications □ Epidurals	□ Injections □ Surgery	□ Other _____
Have you done at least 6 weeks of physical therapy or other conservative care in the past 3 months?						
What makes pain worse?	| walking | sitting | standing | lying down | exercise | nothing | other: _____					
What makes pain better?	| walking | sitting | standing | lying down | exercise | nothing | other: _____					
How does the pain limit you?						

PAST SURGERY (LIST BELOW)	ALLERGIES □ No Known Drug Allergies
□	□ Allergic to the following:
□	□
□	□
□	□
Please list other MEDICAL problems:	**CURRENT MEDICATIONS & DOSAGES**
Medical History: Diabetes, Cancer, High Blood Pressure, Pacemaker, Arthritis, Other: _____ _____ _____	□ □ □ □

FAMILY HISTORY			SOCIAL HISTORY			
Arthritis:	□ Yes	□ No	How did/do you make a living?	_____		
Diabetes:	□ Yes	□ No	Can you dress yourself?	□ Yes	□ No	
Bone Disease:	□ Yes	□ No	Alcohol Use:	□ Yes	□ No	
Cancer:	□ Yes	□ No	Smoker:	□ Yes	□ No	#packs/day __
Heart Disease:	□ Yes	□ No	Recreational Substance:	□ Yes	□ No	
Mother:	Age _____	□ Healthy	□ Deceased due to:			
Father:	Age _____	□ 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/MUSCLE** □Normal	**RESPIRATORY** □Normal
□ deafness	□ blood in urine	□ dislocation	□ shortness of breath
□ 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	□ increased 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

Reviewing Physician Signature