Patient Label

UNIVERSITY of CALIFORNIA • IRVINE
HEALTHCARE

COMPREHENSIVE SPINE PROGRAM

NEW PATIENT FORM

101 The City Drive South Rt 54, Orange, CA 92868

NEW PATIENT HISTORY SECTION

Welcome and thank you for choosing the UC Irvine Comprehensive Spine Program for your care.
Please take the time to answer all questions that apply to your problems as completely as possible

Visit Date (mm/dd/yy): ____/____/____ Name (Last, First): _____

Date of birth (mm/dd/yy): ____/____/____ Age:_____ Sex: ☐ Male ☐ Female

Who referred you to this office?

☐ Referring Doctor: _____ Address: _____ Phone: _____

☐ Primary Physician: _____ Address: _____ Phone: _____

☐ Self Referral

A. Symptoms & Pain Assessment

1. Chief Complaint: _____
2. How long have you had these symptoms?: _____Days _____Weeks _____Months _____Years
3. Describe the quality of your pain (Please check ✓ in the box):
   ☐ Burning ☐ Sharp ☐ Shooting ☐ Tingling ☐ Numbness
   ☐ Pinprick ☐ Stabbing ☐ Deep-pressure ☐ Tightness ☐ Spasms
   ☐ Other (Please describe) _____
4. How often do you experience the pain?
   ☐ Constant ☐ Intermittent - ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _____
5. How did your pain start? ☐ Gradually ☐ Suddenly
   What day did your pain start? _____
6. Since the pain began, is it ☐ Worse ☐ Better ☐ Unchanged?
7. Does the pain radiate to.....an **arm**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
   or a **leg**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both

   Do you have weakness in.....an **arm**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
   or a **leg**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both

   Do you have numbness in.....an **arm**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
   or a **leg**? ☐ No ☐ Yes If Yes: ☐ Right ☐ Left ☐ Both
8. Any changes in bowel or bladder function?
   ☐ No ☐ Yes - ☐ Bowel incontinence ☐ Bladder incontinence ☐ Constipation ☐ Hesitancy ☐ Other: _____

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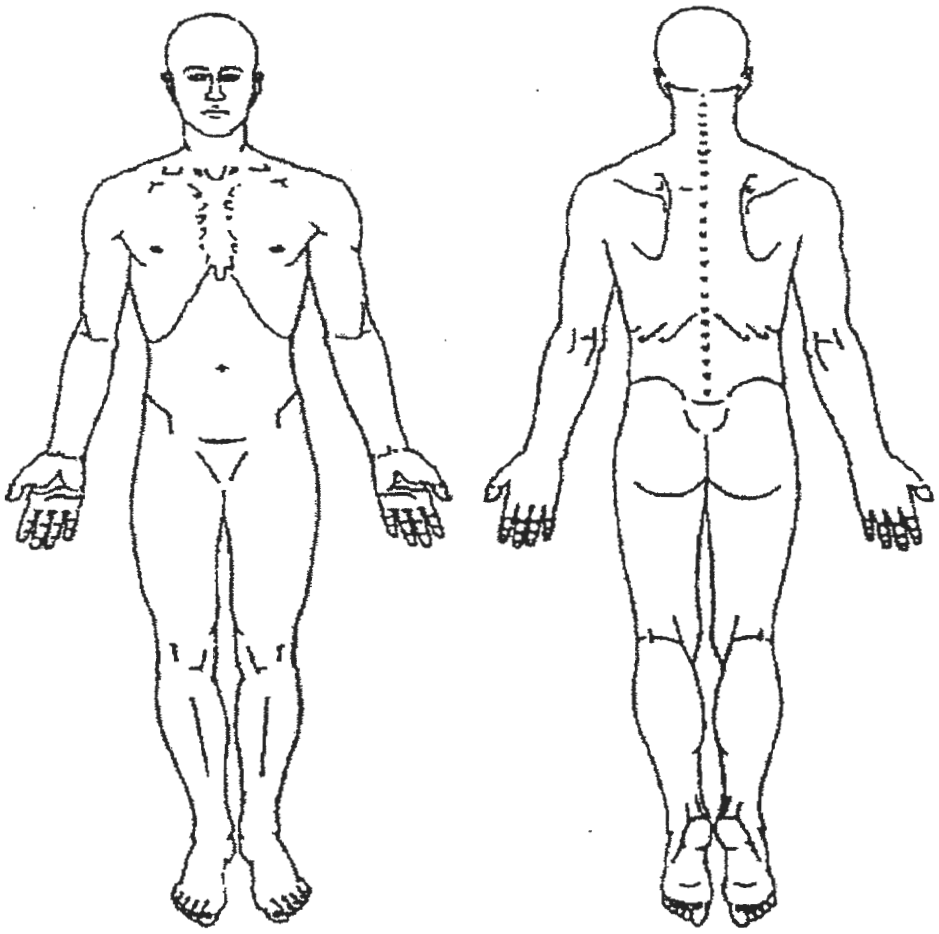
♦ Pain diagram

Using the symbols given below, mark the areas on your body where you feel the described sensation include all affected areas.

Numbness = = = **Pins&Needles ooo** **Burning xxx** **Stabbing ///** **Aching (((**



12. Do you have pain at night?
☐ No ☐ Yes - Does your pain wake you up from sleep? ☐ No ☐ Yes

13. What makes your pain better?
☐ Sitting ☐ Standing ☐ Bending ☐ Lying down ☐ Walking
☐ Epidural injections ☐ Nerve Blocks ☐ Physical therapy ☐ Acupuncture ☐ Massage
☐ Chiropractic ☐ Medications ☐ Other _____

14. What makes your pain worse?
☐ Sitting ☐ Standing ☐ Bending ☐ Lying down ☐ Walking ☐ Neck movement ☐ Coughing/Sneezing
☐ Other _____

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E. Social History (con't) (Please check ✓ in the box):

Do you drink alcohol? ☐ No ☐ Yes If Yes, how much? _____

Do you smoke? ☐ No ☐ Yes If Yes, how much? _____

Do you use recreational substances? ☐ No ☐ Yes If Yes, Type and Frequency: _____

Are you currently working?

☐ No

☐ Yes - Employer: _____ Job Title: _____

How long have you worked there? _____ Days _____ Weeks _____ Months _____ Years

Length of time on job: _____hours/day _____days/week

Movements required for your job (Please check ✓ in the box):

☐ twisting ☐ pushing ☐ pulling ☐ sitting ☐ standing ☐ stopping ☐ crawling

☐ bending ☐ crouching ☐ grasping ☐ balancing ☐ squatting ☐ kneeling ☐ climbing stairs

☐ climbing ladders ☐ lifting ___pounds ☐ reaching above shoulders ☐ repeated wrist/hand movements

Sitting time: _____hours/day Standing time: _____hours/day Machines used: _____

Are you able to perform your usual duties? ☐ No ☐ Yes

F. Review of Systems

(Please check ✓ in the box if you **currently** have any problems related to the following systems):

Skin
- ☐ Skin rash
- ☐ Easy bruising/bleeding
- ☐ Abnormal hair loss

Neurological
- ☐ Headache
- ☐ Migraine
- ☐ Seizure
- ☐ Paralysis

Eyes
- ☐ Visual loss
- ☐ Double vision
- ☐ Glaucoma
- ☐ Glasses/Contacts

Bone/Joint/Muscles
- ☐ Muscle wasting
- ☐ Muscle cramping
- ☐ Joint pain

Ears/Nose
- ☐ Deafness
- ☐ Hoarseness
- ☐ Vertigo/dizziness
- ☐ Sinusitis

Genitourinary
- ☐ Blood in urine
- ☐ Impotence
- ☐ Painful urination
- ☐ Kidney stones
- ☐ Incontinence

Mental Status
- ☐ Hallucination
- ☐ Nervous breakdown
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Suicidal thoughts

Respiratory
- ☐ Shortness of breath
- ☐ Asthma/Bronchitis
- ☐ Cough
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Emphysema / COPD

Gastrointestinal
- ☐ Appetite changes
- ☐ Jaundice
- ☐ Irritable bowels
- ☐ Nausea/Vomiting

Endocrine
- ☐ Goiter
- ☐ Heat/Cold intolerance
- ☐ Increased thirst
- ☐ Increased size of hands or feet

Cardiovascular
- ☐ Palpitations
- ☐ Chest pains
- ☐ Leg swelling
- ☐ Arrhythmia

Constitutional
- ☐ Fever/chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fatigue

Blood System
- ☐ Anemia
- ☐ Bleeding tendency
- ☐ Bruising

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SF-12 v. 2 HEALTH SURVEY

This Survey asks you for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b. Climbing several flights of stairs	☐	☐	☐

3. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Were limited in the kind of work or other activities	☐	☐	☐	☐	☐

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Accomplished less than you would like	☐	☐	☐	☐	☐
b. Did work or activities less carefully than usual	☐	☐	☐	☐	☐

MD Initial:_____ **Date:**_____ **Time:**_____

UNIVERSITY OF CALIFORNIA, IRVINE

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Professor in Residence

PERIPHERAL NERVE RESEARCH LAB
Ranjan Gupta, M.D., Chief, Professor

Dear Patient,

You are receiving this letter as notification of changes in our prescriptive practices for narcotic pain medications (i.e. Lortab, Norco, Oxycodone, Vicodin, OcyContin, Dilaudid).

The following changes have been put into effect in our practice to improve patient safety, quality of care, and abide by the updated rules set forth by the Drug Enforcement Administration (DEA):

1. All narcotic prescriptions must be written and signed on an official prescription form. These prescriptions cannot be called into a pharmacy and must be physically picked up from our office.

2. No refills of narcotic pain medications will be given between appointments or on weekends. Pain medications will be prescribed according to a scheduled following your doctor's discretion.

3. You should expect that narcotic pain medications will not be given longer than 6 weeks after your last surgery or for routine strains / sprains. We will continue to try and treat your pain with non-narcotic pain medication beyond 6 weeks. If you believe you will require narcotic medication beyond 6 weeks, it is advised that you establish care with a chronic pain or primary care physician as soon as possible and notify our clinic that another doctor will be assuming care of your pain.

4. If your prescription is lost or stolen, we will be unable to provide you with another prescription until your next appointment.

5. Pain medications cannot be given from multiple doctors. Any suspected abuse of narcotic pain medication prescriptions may result in discontinuation of care from our clinic and reporting to the relevant official agencies.

By signing below. I acknowledged that I have reviewed the above information and understand and agree to the rules regarding pain medication prescription in the Department of Orthopaedic Surgery at the University of California, Irvine.

Patient Signature _____ Date _____