CEDARS-SINAI®
SPINE CENTER

PHYSICIAN INFORMATION

PATIENT I.D.

Please provide your current Physician's information. Write down as much information you can provide (i.e., Name & City), so that we may keep them informed of your progress.

REFERRING PHYSICIAN

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

INTERNIST / PRIMARY CARE PHYSICIAN

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

WORKMANS COMPENSATION *(IF APPLIES)*

Name: _____
(Last, First)

Specialty: _____

Address: _____
(Street)

_____
(City, State, Zip Code)

Phone: (_____) _____ Fax: (_____) _____

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OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ______________ Fax: (_____) ______________

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ______________ Fax: (_____) ______________

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ______________ Fax: (_____) ______________

OTHER PHYSICIAN INVOLVED IN YOUR CARE

Name: ______________________________
(Last, First)

Specialty: ______________________________

Address: ______________________________
(Street)

____
(City, State, Zip Code)

Phone: (_____) ______________ Fax: (_____) ______________

CEDARS-SINAI
SPINE CENTER

Personal information

Last Name: _____ First Name: _____

Age: _____ Date of birth: _____ Occupation: _____ ❑ Not working

Social History

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Do you live alone: ❑ Yes ❑ No

How many children do you have? _____ ❑ None

Will you have a caregiver to assist you if surgery is needed? ❑ Yes ❑ No

Are you currently working? ❑ Yes ❑ No

Have you lost work due to your back problem? ❑ Yes ❑ No

Do you have stairs in your home? ❑ Yes ❑ No

Do you think you are at risk for a fall? ❑ Yes ❑ No

Date symptoms began: _____

Current Problems

Chief complaint or reason for visit: _____

_____

_____

_____

Cause of present problem *(e.g. work related injury, auto accident, slip-and-fall, etc.)*:

_____

What favorite activities does your pain prevent?: _____

_____

_____

Can you care for yourself *(i.e. dressing, eating, toileting, standing up, etc.)* _____

_____

Other difficult functions include: _____

Past History

Past or ongoing medical problems (e.g. high blood pressure, stroke, diabetes, heart condition, cancer, etc.):

(If more space is needed, please attach on a separate sheet.)

_____

_____

_____

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SPINE CENTER

Previous Surgeries

Name of operation: Date:

_____ _____

_____ _____

_____ _____

Other Information

Do you smoke? ❑ No ❑ Yes Number of cigarettes per day _____

Do you drink alcohol? ❑ No ❑ Yes Number of drinks per day _____

Have you had imaging in the last 3 months?

❑ No ❑ Yes ❑ MRI ❑ CT scan ❑ X-rays

Allergies

Please list all allergies and response such as rash, itching, difficulty breathing, or unknown:

Drug name	Reaction

Medications

Please list all current medications, over the counter drugs, vitamins and herbals.

Please give us the total number of "as needed" medication taken in a 24-hour period.

Name	Dosage / Amount	Time of day	Total taken in 24 hours.

Signature	Date	Time

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SPINE CENTER

PAIN DRAWING

PATIENT I.D.

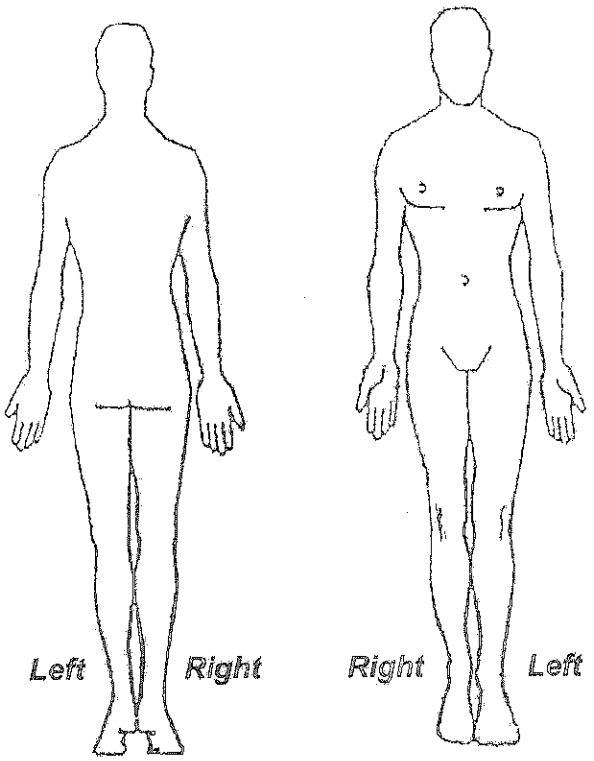
1. How much pain in general can you tolerate?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain Imaginable

2. Where is your pain now?

Mark the areas on your body using the appropriate symbols to describe your symptoms.



TYPE OF PAIN	SYMBOL
Ache	<<<<< <<<<<
Numbness	○○○○○ ○○○○○
Pins & Needles	■■■ ■■■
Burning	XXXXXX XXXXXX
Radiating Pain	/////////// ///////////

3. How bad is your pain?

Neck pain _____ %
Arm pain _____ %
Total 100%

Back pain _____ %
Leg pain _____ %
Total 100%

4. How bad is your pain now?

0 1 2 3 4 5 6 7 8 9 10

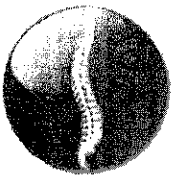
No Pain — Worst pain Imaginable

5. The duration of pain:

❑ Continuous ❑ Positional ❑ Intermittent (On/Off) ❑ Unable to Rate

6. Have you taken pain medication in the past 24 hours?

❑ YES ❑ NO



BEVERLY HILLS
SPINE SURGERY

EDWARD NOMOTO, MD
BRIAN PERRI, DO
ALEXANDRE RASOULI, MD
KHAWAR SIDDIQUE, MD
ALBERT WONG, MD

AUTHORIZATION TO COMMUNICATE VIA ELECTRONIC MEANS

Our office prefers the efficiency and convenience of electronic communication. We may send you office reminders, test results, and surgery instructions via the electronic method you prefer. If you agree to communicate with us electronically, please fill out your information below. We will never sell your information to any third party.

Per California law, certain test results such as HIV, cancer, pathology, and STD will not be sent via electronic means.

Fax number _____
EMAIL address_____
Phone number for messages_____

Name (Printed)_____

Signature_____

Date_____