CEDARS-SINAI®
SPINE CENTER

# PATIENT INFORMATION SHEET

☐ **Dr. Edward Nomoto**

## PATIENT INFORMATION

| | | |
|---|---|---|
| Last Name: | First Name: | |
| Date of Birth: | Last 4 Digits of Social Security Number: XXX - XX - _____ | Gender: ☐ Female ☐ Male |
| Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell: | Work Phone: |

## PHYSICIAN INFORMATION

REFERRING PHYSICIAN

| | | |
|---|---|---|
| Last Name: | First Name: | |
| Specialty: | | |
| Address: | | |
| City: | State: | Zip: |
| Office Phone: | Fax: | |

## INTERNIST / PRIMARY CARE PHYSICIAN

| | | |
|---|---|---|
| Last Name: | First Name: | |
| Address: | | |
| City: | State: | Zip: |
| Office Phone: | Fax: | |

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# PAIN DRAWING

PATIENT I.D.

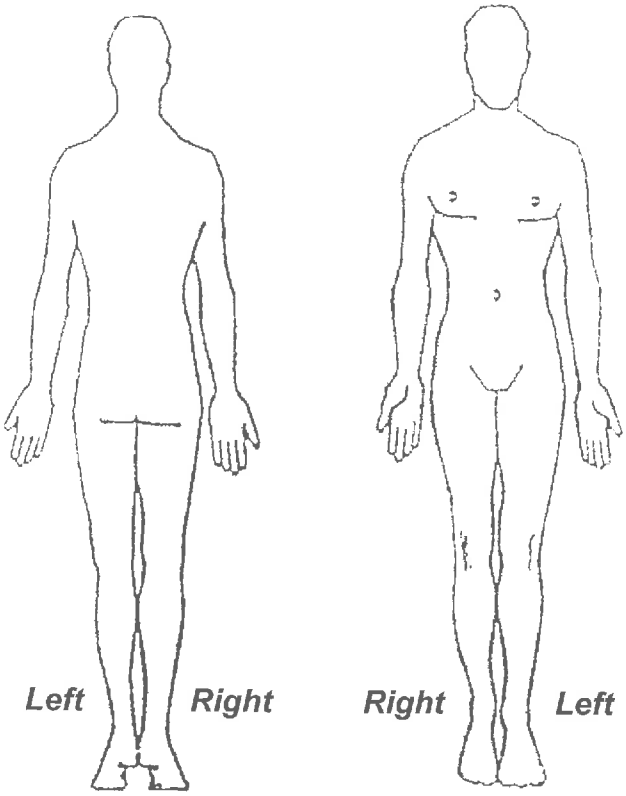
1. **How much pain in general can you tolerate?**

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

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# GENERAL REVIEW OF THE SYSTEMS

PATIENT I.D.

*Please mark any medical condition that applies to you*

**Allergies**
- ❑ Asthma
- ❑ Hay fever
- ❑ Skin eruptions

**Cardiocascular**
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ High / low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart rate
- ❑ Swelling of ankles
- ❑ Varicose veins
- ❑ Heart attack

**Constitutional**
- ❑ Chills / sweats / fever
- ❑ Fainting
- ❑ Forgetfulness
- ❑ Loss of sleep
- ❑ Nervousness
- ❑ Weight loss

**Ears / Nose / Throat**
- ❑ Bleeding gums
- ❑ Difficulty swallowing
- ❑ Earache
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Hoarseness
- ❑ Nosebleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems

**Endocrine**
- ❑ Rapid weight loss / gain
- ❑ Intolerance to warm room
- ❑ Multiple broken bones
- ❑ Cessation of menstrual periods
- ❑ Excessive hunger / thirst
- ❑ Loss of libido
- ❑ Spontaneous nipple discharge

**Eyes**
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Vision flashes or halos

**Genitourinary**
- ❑ Blood in urine
- ❑ Lack of bladder control
- ❑ Painful urination
- ❑ Frequent urination

**Gastrointestinal**
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas
- ❑ Hemorroids
- ❑ Indigestion
- ❑ Nausea
- ❑ Poor appetite
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Ulcers
- ❑ liver problems

**Hemotologic / Lympathic**
- ❑ Swollen lymph nodes
- ❑ Easy skin bruising
- ❑ Prolonged bleeding cuts tooth extractions
- ❑ Low blood count
- ❑ Frequent infections

**Integumentary**
- ❑ Skin rashes or eruptions
- ❑ Chronic skin itching

**Men**
- ❑ Breast lump
- ❑ Lump in testicle
- ❑ Penis discharge
- ❑ Sore on penis

**Musculoskeletal**
- ❑ Pain, weakness, numbness, or swelling in hands, wrist, hips. knees or joints
- ❑ Pain in arms or legs

**Neurological**
- ❑ Fainting
- ❑ Headaches
- ❑ Numbness of arm or leg
- ❑ Seizures
- ❑ Tingling in hands or feet

**Psychiatric**
- ❑ Anxiety
- ❑ Depression
- ❑ Panic attacks
- ❑ Restlessness

**Respiratory**
- ❑ Blood
- ❑ Cough
- ❑ Dizziness
- ❑ Shortness of breath

**Women**
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ nipple discharge
- ❑ Painful intercourse

Date of last period: _____
Date of last pap smear: _____
Date of mammogram: _____

Are you pregnant?
❑ Yes ❑ No

Number of childrens:

_____

IRB No: Pro00015483
Approval Date: 8/1/2017 Expiration Date: 7/31/2018

CEDARS-SINAI

# SPINAL SURGICAL OUTCOMES DATA REGISTRYCONSENT& AUTHORIZATION FORM

**Principal Investigator:** Neel Anand, MD Phone: (310) 423-9779

**Co- investigator:** Edward Nomoto, MD Phone: (310) 423-9780

## PURPOSE

Data collection and analysis related to medical records plays a key role in research. The purpose of this Spinal Surgical Outcomes data registry is to collect the medical information of as many patients as possible in order to study how different factors, such as medical history and surgical technique, affect short-term and long-term outcomes in spine surgery.

## PROCEDURES

We ask for your voluntary consent and authorization to allow Dr. Anand or Dr. Nomoto and their team to review your medical record maintained by Cedars-Sinai Medical Center and copy information from your medical record into the Spinal Surgical Outcomes Registry database for research. We will collect information from your medical records to learn about factors affecting surgical outcomes. Private health information to be reviewed and abstracted from your medical record will include: Operation reports, progress notes, lab reports, questionnaire responses, x-rays and other radiology exams, medications taken, and demographics, If you sign this consent/authorization form, you are giving Dr. Anand or Dr. Nomoto and their team permission to continue to collect information from your spinal surgical medical records at Cedars-Sinai Medical Center.

## CONFIDENTIALITY OF INFORMATION COLLECTED

The Spinal Surgical Outcomes data registry has a system in place to maximize the protection of your medical information. In the registry, your medical history information will be identified by a randomly assigned study number, not by your name or other personal information that identifies you. A list that contains both the assigned study number and your name and medical record number (the linking list) will be maintained separately and is only accessible to limited individuals who are approved to conduct, monitor and/or oversee this research.

The data and information gathered during this study may be used by the investigator and published and/or disclosed outside of Cedars-Sinai Medical Center in publications or other dissemination of the research data. Your identity will not be disclosed in any publication of our research findings. When we share your information for future research or with researchers at other academic institutions, we will keep your identity confidential and the information released will be identified only by a randomly assigned study number.

Information collected about you during the course of this research may be subject to inspection by CSMC departments and committees responsible for research oversight, accrediting agencies, government and regulatory groups.

By agreeing to participate in this data registry, you authorize the use and sharing of your private information indefinitely.

## RISKS

Accidental breach of your confidential health information is a potential risk associated with your participation in this research registry. As noted above, Dr. Anand and his research team will take every precaution to prevent a breach from occurring. Additionally, if your confidential health information is shared with a recipient outside of Cedars-Sinai Medical Center under this Authorization, it could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA). However, in California, the law prohibits such further disclosure of confidential health information without another signed authorization from you (unless the law specifically permits or requires the particular disclosure, such as to report suspected child abuse).

## BENEFITS

Taking part in the Spinal Surgical Outcomes data registry is not intended to help you directly. However, we hope the information learned will benefit others considering spine surgery in the future by helping us to improve treatments and surgical techniques.

## COMPENSATION AND COSTS

You will not be paid for your participation in the registry. There are no charges to you for collection of your data by the registry team.

## PARTICIPATION

You have the right not to participate or to withdraw from this registry at any time without any penalty or loss of benefits to which you would be entitled outside of the study. You may refuse to sign this consent and authorization form. If you refuse to sign this consent and authorization form, your refusal will not affect your ability to obtain treatment at Cedars-Sinai Medical Center (CSMC).

You have the right to revoke your authorization for us to use or share your health information for this research at any time. You must contact Dr. Anand or Dr. Nomoto in **writing** to revoke your authorization. However, if you revoke this authorization, the revocation will not have any effect on any actions taken prior to receiving the revocation. Any information already obtained at the time you revoke your authorization may continue to be used as necessary to ensure study integrity.

If you have questions about this consent/authorization, or about the study, or wish to withdraw and revoke your authorization from the Spinal Surgical Outcomes data registry, please contact: Dr. Neel Anand, 444 S. San Vicente Blvd., Suite 900 Los Angeles, CA 90048, Email: anandn@cshs.org, Office: (310) 423-9779 or Dr. Edward Nomoto, 444 S. San Vicente Blvd., Suite 800 Los Angeles, CA 90048, Email: Edward.nomoto@cshs.org, Office: (310) 423-9780

If you have any questions regarding your rights, concerns, or complaints about taking part in this registry, please contact: CSMC Institutional Review Board (IRB); Phone: (310) 423-3783; Email: ResearchConcerns@cshs.org.

## SIGNATURE BY THE SUBJECT:

- I have received the information concerning the Spinal Surgical Outcomes data registry and understand the risks and benefits of participation.
- I agree (consent) to enroll in the Spinal Surgical Outcomes data registry.
- I permit (authorize) the use and sharing of my data as described in this document.
- I have been given a copy of this consent/authorization form.

| Name of Subject | Signature of Subject | Date of Signature |
|---|---|---|

**SIGNATURE BY THE INVESTIGATOR:**
I attest that all the elements of informed consent described in this form have been discussed fully in non-technical terms with the subject. I further attest that all questions asked by the subject were answered to the best of my knowledge.

_____ _____
Signature of the Investigator Who Obtained Consent/Authorization Date of Signature

PI/Study ID:_____ Visit Date:_____

# CLINICAL EXAMINATION (PATIENT)

| Patient Name: | DOB: | Gender: | Race: |
|---|---|---|---|

*Patient History*

| | | |
|---|---|---|
| Bowel incontinence Yes ☐ No ☐ | Numbness/tingling in legs Yes ☐ No ☐ | Leg weakness Yes ☐ No ☐ |
| Bladder incontinence Yes ☐ No ☐ | Loss of balance Yes ☐ No ☐ | |

| Method of treatment to date? *(Check all that apply)* | Rate of relief associated with treatment? | Duration of relief (0-3mos, 3-6mos, 6-12mos, >1yr) |
|---|---|---|
| None☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| Bracing☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| Chiropractor☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| Injection – spine☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| NSAIDS☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| Narcotics☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| Pain program☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| Physical therapy☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |
| Other☐ | 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ | 0-3mos ☐/ 3-6mos ☐/ 6-12mos ☐/ >1yr ☐ |

Past Medical History *(check all that apply)*

None☐ / Alcohol/drug abuse☐ / Anemia☐ / Arthritis☐ / Blood clots☐ / Cancer☐ / Depression☐ / Diabetes☐ / Heart disease ☐ / Hypertension☐ / Kidney disease☐ / Liver disease☐ / Lung disease☐ / Nervous system disorders☐ / Osteoporosis☐ / Peripheral vascular disease☐ / Psychiatric disorders☐ / Ulcers and/or stomach disease☐ / Other☐ please list:_____

| Work status (*check one*) | Level of physical labor in your job (*check one*) |
|---|---|
| Employed☐ /Disabled ☐ /Retired due to back pain ☐ /Retired☐ / Unemployed ☐ | Heavy☐ /Moderate☐ /Minimal☐ /No physical labor ☐ |

| Do you smoke? | If yes, how much do you smoke? *(check one)* | If quit, how long? *(check one)* |
|---|---|---|
| Yes ☐ / No ☐ | Less than 1pk/day☐ /1pk/day☐ / 2pk/day☐ /3pk or more/day☐ | 0-6 months☐ /6-12 months☐ / 1yr or greater ☐ / 2yrs or greater☐ |

PI/Study ID:_____ Visit Date:_____

# PAIN ASSESSMENT TOOL (PATIENT)

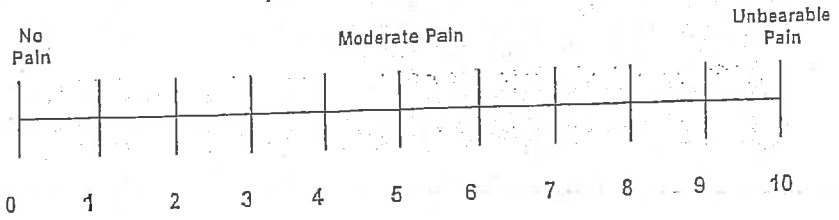
Please take a moment to review the scales shown below and mark appropriately.
*Note:* The top scale relates to leg pain and the bottom scale relates to back pain.

*Please check one:*

- ☐ Back pain: 0% Leg pain: 100%
- ☐ Back pain: 10% Leg pain: 90%
- ☐ Back pain: 25% Leg pain: 75%
- ☐ Back pain: 50% Leg pain: 50%
- ☐ Back pain: 75% Leg pain: 25%
- ☐ Back pain: 90% Leg pain: 10%
- ☐ Back pain: 100% Leg pain: 0%

*Numeric Rating Scale (NRS)*
**Leg Pain**

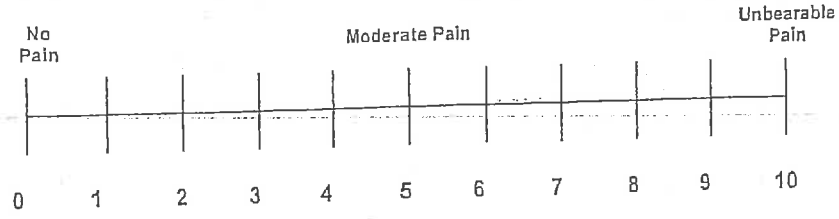
Please mark an "X" on the line below that best describes the level of pain you have experienced in the past month.




If pain, how long has Leg Pain been present?
1yr☐ / 5yrs☐ / 10yrs☐ / 15yrs☐ / 20yrs or greater☐

*Numeric Rating Scale (NRS)*
**Back Pain**

Please mark an "X" on the line below that best describes the level of pain you have experienced in the past month.




If pain, how long has Back Pain been present?
1yr☐ / 5yrs☐ / 10yrs☐ / 15yrs☐ / 20yrs or greater☐

Pt/Study ID:_____ Visit Date:_____

# Your Health and Well-Being

**This survey asks 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.** ***Thank you for completing this survey!***

**For each of the following questions, please mark an ☒ in the one box that best describes your answer.**

1. **In general, would you say your health is:**

| Excellent | Very good | Good | Fair | Poor |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

2. **<u>Compared to one year ago</u>, how would you rate your health in general <u>now</u>?**

| Much better now than one year ago | Somewhat better now than one year ago | About the same as one year ago | Somewhat worse now than one year ago | Much worse now than one year ago |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |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(SF-36v2 Standard, US Version 2.0)

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**3. The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?**

| | Yes, limited a lot | Yes, limited a little | No, not limited at all |
|---|---|---|---|
| a Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports | ☐1 | ☐2 | ☐3 |
| b Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | ☐1 | ☐2 | ☐3 |
| c Lifting or carrying groceries | ☐1 | ☐2 | ☐3 |
| d Climbing several flights of stairs | ☐1 | ☐2 | ☐3 |
| e Climbing one flight of stairs | ☐1 | ☐2 | ☐3 |
| f Bending, kneeling, or stooping | ☐1 | ☐2 | ☐3 |
| g Walking more than a mile | ☐1 | ☐2 | ☐3 |
| h Walking several hundred yards | ☐1 | ☐2 | ☐3 |
| i Walking one hundred yards | ☐1 | ☐2 | ☐3 |
| j Bathing or dressing yourself | ☐1 | ☐2 | ☐3 |




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

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|---|
| a. Cut down on the <u>amount of time</u> you spent on work or other activities | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| b. <u>Accomplished less</u> than you would like | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| c. Were limited in the <u>kind</u> of work or other activities | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| d. Had <u>difficulty</u> performing the work or other activities (for example, it took extra effort) | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

5. **During the <u>past 4 weeks</u>, how much of the time have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (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. Cut down on the <u>amount of time</u> you spent on work or other activities | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| b. <u>Accomplished less</u> than you would like | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| c. Did work or other activities <u>less carefully than usual</u> | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

PI/Study ID:_____ Visit Date:_____

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

| Not at all | Slightly | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

7. How much bodily pain have you had during the past 4 weeks?

| None | Very mild | Mild | Moderate | Severe | Very Severe |
|---|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 | ☐6 |

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

| Not at all | A little bit | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

PI/Study ID:_____ Visit Date:_____

9. **These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...**

| | All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|---|
| a Did you feel full of life? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| b Have you been very nervous? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| c Have you felt so down in the dumps that nothing could cheer you up? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| d Have you felt calm and peaceful? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| e Did you have a lot of energy? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| f Have you felt downhearted and depressed? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| g Did you feel worn out? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| h Have you been happy? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| i Did you feel tired? | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

10. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |


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**11. How TRUE or FALSE is <u>each</u> of the following statements for you?**

| | Definitely true | Mostly true | Don't know | Mostly false | Definitely false |
|---|---|---|---|---|---|
| a I seem to get sick a little easier than other people | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| b I am as healthy as anybody I know | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| c I expect my health to get worse | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |
| d My health is excellent | ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

***THANK YOU FOR COMPLETING THESE QUESTIONS!***


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Pt/Study ID:_____ Visit Date:_____

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 ❑

Pt/Study ID:_____ Visit Date:_____

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**