UCSF Medical Center

UCSF Spine Center
400 Parnassus Avenue
San Francisco, CA 94143

PLACE PATIENT LABEL HERE

Patient Name: ________________

Dear Patient,

Welcome to the UCSF Spine Center. Our goal is to provide a comprehensive evaluation of your problem. During your visit, we will review your medical history, you will undergo a physical exam, and your x-rays will be reviewed. Our health care team consists of physician assistants (PAs), nurse practitioners (NPs), fellows (fully-trained surgeon spending an extra year training) and your surgeon. Depending on the complexity of your problem, may last less than an hour to over two to three hours.

To prepare for your visit, please obtain copies of all reports relevant to your surgical problem and bring them with you. Examples would be reports of any MRI, X-rays, CT, CT myelogram, or EMG/Nerve conduction tests. If you have had any of these tests, have your hospital put the images on a CD-ROM and bring it. We need to look at the images, not just the reports.

We strive to be detail-oriented and thorough. Your answers here will become part of the UCSF medical record and will be confidential.

Sometimes we will need to reach out to your primary care doctor and/or specialist for information. Providing this information to us will allow us to reach out to your physician as needed, and eliminate the need for you seeking doctor's notes or lab tests and/or the delay in your pre-surgical evaluation.

Can you tell us the names of the doctor who referred you here, your primary care doctor, and any specialist from whom you are receiving care?

Doctor who sent you to see us: __________________________ Contact Info: ________________

Primary care doctor: ____________________________________ Contact Info: ________________

Cardiologist: ____ Contact Info: ________________

Renal Specialist: _______________________________________ Contact Info: ________________

Pulmonologist: ____ Contact Info: ________________

Neurologist: ____ Contact Info: ________________

Endocrinologist: _______________________________________ Contact Info: ________________

Pain Management: _____________________________________ Contact Info: ________________

Other: ____ Contact Info: ________________

Emergency Contact: ____________________________________ Contact Info: ________________

Pharmacy: _________________________ City: ______________ Phone #:____________________

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Patient Name: ________________

What language are you most comfortable speaking? ____________________

Do you also speak English? ____________________

CURRENT MEDICATIONS

Please include all over-the-counter and herbal medications also.

Medication Name	Dosage	Route (by mouth, patch, injection, etc).	Frequency (per day, per week, or as needed?)

ALLERGIC REACTIONS TO MEDICATIONS

Have you ever had a reaction to any of the following? If so, please circle all reactions that apply:

YES NO **Latex** anaphylaxis/shock rash itching nausea/vomiting short-of-breath other

YES NO **Iodine** anaphylaxis/shock rash itching nausea/vomiting short-of-breath other

YES NO **Intravenous contrast agent (used in CTs or MRIs)** anaphylaxis/shock rash itching nausea/vomiting short-of-breath other

Are you allergic to any medications? If so, list the medication and the reaction that you had:

MEDICATION	REACTION (circle all that apply)
Example: Aspirin	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
	anaphylaxis/shock rash itching nausea/vomiting short-of-breath other:
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What is your **MAIN** symptom(s)?

PAST MEDICAL HISTORY

Please circle any illnesses you have now or in the past.

Type of Condition	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
Cardiac					
Hypertension					
Hyperlipidemia (high cholesterol)					
Arrhythmia (Irregular Heart Beat)					
Atrial Fibrillation				• EKG: past 2 years • Progress notes from cardiologist: past 5 years • Echocardiogram: past 5 years • Stress test: any • Catheterization reports: any • Hospitalization discharge summaries	
Chest Pain (Angina)					
If yes, symptoms within past 1 year					
Coronary stents					
Myocardial Infarction (Heart Attack)					
Heart Valve Disease					
Congestive Heart Failure					
Coronary Artery Disease					
Murmur					
Have you ever had a Stress Test, Echocardiogram or Cardiac Catheter?					
Pacemaker or Defibrillator (ICD)				• Interrogation reports: past 1 year • Implantation reports	
Exercise					
Breathlessness with exercise					
Fatigue or difficulty walking 1-2 blocks					
Fatigue or difficulty climbing 1 flight of stairs					
Respiratory					
Sleep apnea					
Do you use CPAP/Bipap?					

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Type of Condition	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
Asthma, COPD or Chronic Bronchitis					
If yes, symptoms within 6 months					
Other lung disease diagnosed or treated by a lung specialist					
Previous hospitalization for lung condition					
Do you use oxygen at home?					
Have you used steroids in prior 6 months for lung disease?					
Hematologic					
Anemia					
Do you take aspirin daily?					
Do you take any other medications to thin the blood (examples- Plavix, Brilinta, Coumadin, Pradaxa, Eliquis, Xarelto)?					
Clotting or Bleeding Disorder					
DVT (Deep Vein Thrombosis)					
Onset within past 6 months					
Pulmonary Embolism (Blood Clot in Lungs)					
Sickle Cell Anemia					
If yes, hospitalization within past 1 year					
Blood transfusion within the past 90 days					
Renal					
Renal insufficiency					
Kidney failure requiring dialysis				• Note from PMD or nephrologist: past 3 months if available • Any labs: past 3 months	
Neurological					
Brain Tumor					
Seizures					
Other Neurological Disorders					

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				Documentation	**Date Requested**
Stroke or TIA (transient ischemic attack)				H&P or progress note from: 1. Cardiologist 2. Primary doctor • Echocardiogram: if available • Carotid ultrasound: if available • Holter/event monitor: if available	
Seizures within past 6 months				• H&P or progress note from: 1. Neurologist 2. Primary doctor • Hospital discharge summary: if available	
Any of the following: • Myasthenia Gravis • Muscular dystrophy • Polio Myelitis • Multiple sclerosis • Spinal cord injury with weakness • Parkinson's Disease					
Autoimmune					
• Lupus • Rheumatoid arthritis • Scleroderma • Sjogren's • Other autoimmune disease- please specify					
Liver					
Cirrhosis or chronic hepatitis				• Any labs: past 1 year, if available • H&P or progress note: past 1 year 1. Liver specialist 2. Primary doctor	
Drink ≥ 3 drinks daily?					
Any other liver disease					

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				Documentation	Date Requested
Endocrine					
Diabetes					
If yes, insulin dependent					
If yes, non-insulin dependent					
Thyroid Disease					
Symptoms of overactive or underactive thyroid function in past 6 months				• H&P or progress note: past 6 months 1. Endocrinologist 2. PCP	
Cancer					
History of cancer- specify type					
Chemotherapy for cancer					
If yes, within past 6 months?					
Radiation Therapy					
If yes, within past 6 months?					
Other					
Anxiety					
Depression					
Obesity					
History of chronic steroid use					
Osteoporosis/osteopenia (specify)					
Osteomyelitis (bone infection)					
Ulcers					
GERD (heartburn/acid reflux)					
HIV/AIDS					
History of substance abuse					
Have you seen a pain management specialist within the past 1 year?					
Do you take any of the following: • Suboxone • Subutex • Butrans patch					
Prior complications after surgery: • Unexpected hospitalization • Unexpected ICU admission					
Hospitalization in prior 6 months					
Do you live > 2 hours away from SF, and a return to SF for more care would be a hardship?					

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Type of Condition	Yes	No	If yes, please describe (where, when and who treated you)	For UCSF Staff Only	
				Documentation	Date Requested
Difficulty accessing medical care in your local area					
Do you have any of the following: • Current respiratory infection • Recent onset shortness of breath • Recent onset chest pain or pressure • New or worsening swelling in your leg/s					

PAST SURGICAL HISTORY

Please circle any operations you have had.

	Type & Year performed
Spine surgery (Please list ALL - cervical, thoracic, lumbar, & sacral)	
Brain surgery	
Heart surgery (valve replacement, bypass, stent, etc)	
Cosmetic surgery	
Fracture surgery (broken bones)	
Joint replacement surgery	
Arthroscopic surgery (joint surgery)	
Lung surgery	
Kidney surgery	
Abdominal surgery	
Other:	

Have you ever been hospitalized for any other reason?

HABITS

Do you drink alcohol? YES NO

If yes, what is your average number of:

	glasses of wine per week
	cans of beer per week
	shots of liquor per week

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Do you use drugs recreationally now? YES NO If yes, circle the drugs you use:

amphetamines	amyl nitrate	anabolic steroid	barbituates	benzodiazepines
“crack” cocaine	cocaine	codeine	fentanyl	GHB
heroin	hydrocodone	hydromorphone	ketamine	LSD
marijuana	MDMA	methamphetamine	methaqualone	methylphenidate
morphine	nitrous oxide	opium	oxycontin	PCP
psilocybin	solvent inhalants	IV drugs	other:	other:

Are you a (circle one): current smoker former smoker never smoker

How many packs a day do you smoke, on average? __________ How many years have you smoked? _____

Do you take nicotine gum or nicotine patches?_____________________

Do you smoke medical marijuana? ____

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms in the **past 3 months**?

GENERAL	YES	NO	fevers
	YES	NO	chills
	YES	NO	weight loss
	YES	NO	malaise or fatigue
	YES	NO	sweating (excessive)
	YES	NO	weakness
SKIN	YES	NO	rash
	YES	NO	itching
HEAD	YES	NO	headaches
	YES	NO	hearing loss
	YES	NO	tinnitus
	YES	NO	ear pain
	YES	NO	ear discharge
	YES	NO	nosebleeds
	YES	NO	congestion
	YES	NO	stridor (groan when you breathe)
	YES	NO	sore throat
EYES	YES	NO	blurred vision
	YES	NO	double vision
	YES	NO	irritation with lights (photophobia)
	YES	NO	eye pain
	YES	NO	eye discharge
	YES	NO	eye redness
CARDIOVASC	YES	NO	chest pain
	YES	NO	palpitations (fluttering in the chest)
	YES	NO	orthopnea (difficulty breathing while lying flat in bed)
	YES	NO	claudication (pain in legs with exercise)
	YES	NO	leg / ankle swelling
	YES	NO	difficulty breathing during sleep
LUNGS	YES	NO	cough
	YES	NO	hemoptysis (coughing up blood)

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	YES	NO	sputum production (coughing up phlegm)
	YES	NO	shortness of breath
	YES	NO	wheezing
ABDOMEN	YES	NO	heartburn
	YES	NO	nausea
	YES	NO	vomiting
	YES	NO	abdominal pain
URINARY	YES	NO	dysuria (burning when you pee)
	YES	NO	urgency (need to pee quickly, can barely hold it)
	YES	NO	frequency (need to pee often)
	YES	NO	hematuria (blood in the urine)
	YES	NO	flank pain
MUSCLES	YES	NO	myalgias (crampy muscle pain)
	YES	NO	neck pain
	YES	NO	back pain
	YES	NO	joint pain
	YES	NO	falls
BLOOD	YES	NO	easy bruising or easy bleeding
	YES	NO	seasonal allergies
	YES	NO	polydipsia (always thirsty)
NEURO	YES	NO	dizziness
	YES	NO	tingling
	YES	NO	tremor
	YES	NO	sensory change
	YES	NO	speech change
	YES	NO	focal weakness
	YES	NO	seizures
	YES	NO	loss of consciousness
PSYCHIATRIC	YES	NO	depression
	YES	NO	suicidal ideas
	YES	NO	substance abuse
	YES	NO	hallucinations
	YES	NO	nervous / anxious
	YES	NO	insomnia
	YES	NO	memory loss

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Availability for PREPARE appointment

Based on your medical history, your pre-surgical interview may be able to be completed by a phone call which would be done about 2 weeks prior to your scheduled surgery date. To help us to provide excellent customer service, and align with your needs as much as possible, can you please tell us the day of week and time of day that would be best to reach you, and the best contact number.

Contact number:_________________________________

Day of Week	Time of Day		Contact Number (if different than above)
Monday	AM	PM	
Tuesday	AM	PM	
Wednesday	AM	PM	
Thursday	AM	PM	
Friday	AM	PM	

INFLUENZA VACCINATION

Please indicate date of most recent influenza vaccine: