BEVERLY HILLS SPINE SURGERY

Edward Nomoto, MD

ORTHOPEDIC SPINE SURGEON

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:	

PRIMARY CARE PHYSICIAN

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

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PERSONAL INFORMATION

PATIENT I.D.

Last Name: _____ First Name: _____ MI: _____

Age: _____ Occupation: _____ ❑ Right-handed ❑ Left-handed

Current Problem	
Symptoms:	Duration:

Past Medical History	
Previous Operations:	Dates:

Other Past and Current Medical Problems *(e.g., hypertension, stroke, diabetes, cancer, etc.)*

Family Medical History *(if deceased, list cause)*

Current Medications *(including over-the-counter medicines)*

Allergies *(medication and others)*

Allergies *(medication and others)*

Smoke / Day Alcohol Usage:

Recent X-Rays, CTs, MRIs *(including dates):*

Regarding MRIs, are you claustrophobic? ❑ Yes ❑ No

Do you have metal implants? ❑ Yes ❑ No

Patient / Guarantor Printed Name	Patient / Guarantor Signature	Date	Time
CSMC Representative Printed Name	CSMC Representative Signature	Date	Time

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HIPAA PRIVACY POLICY PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on Aprill4, 2003. Many of the policies have been our practice for years. This form is a "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3.The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

SIGNATURE: _____ DATE: _____

IF A MINOR, signature, name, and dare of parent/guardian:

Printed name:_____Date: _____ Signature: _____

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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 your 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.

Email Address_____

Secure Phone Number for Messagers_____

Name (Printed)_____

Signature_____

Date_____

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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 children:
_____

Patient / Guarantor Printed Name	Patient / Guarantor Signature	Date	Time
CSMC Representative Printed Name	CSMC Representative Signature	Date	Time

PI/Study ID:_____Visit Date:_____

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BEVERLY HILLS SPINE SURGERY

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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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	<u>Vigorous activities</u>, such as running, lifting heavy objects, participating in strenuous sports	☐ 1	☐ 2	☐ 3
b	<u>Moderate activities</u>, 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 <u>several</u> flights of stairs	☐ 1	☐ 2	☐ 3
e	Climbing <u>one</u> flight of stairs	☐ 1	☐ 2	☐ 3
f	Bending, kneeling, or stooping	☐ 1	☐ 2	☐ 3
g	Walking <u>more than a mile</u>	☐ 1	☐ 2	☐ 3
h	Walking <u>several hundred yards</u>	☐ 1	☐ 2	☐ 3
i	Walking <u>one hundred yards</u>	☐ 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

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6. During the <u>past 4 weeks</u>, 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 <u>bodily</u> pain have you had during the <u>past 4 weeks</u>?

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

8. During the <u>past 4 weeks</u>, how much did <u>pain</u> 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

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9. These questions are about how you feel and how things have been with you <u>during the past 4 weeks</u>. 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 <u>past 4 weeks</u>…

	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 <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting with 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

BEVERLY HILLS SPINE SURGERY

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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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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 ☐

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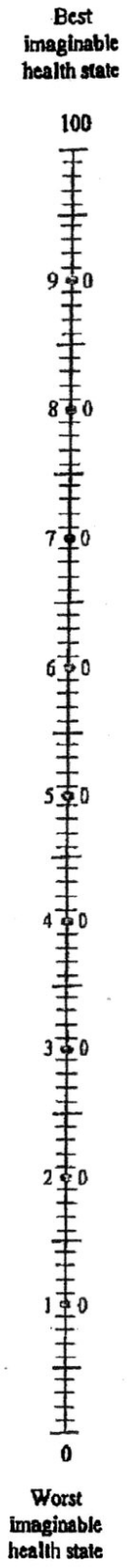
To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

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



PI/Study ID:_____Visit Date:_____

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BEVERLY HILLS SPINE SURGERY

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:_____

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Pain Assessment Tool (Patient)

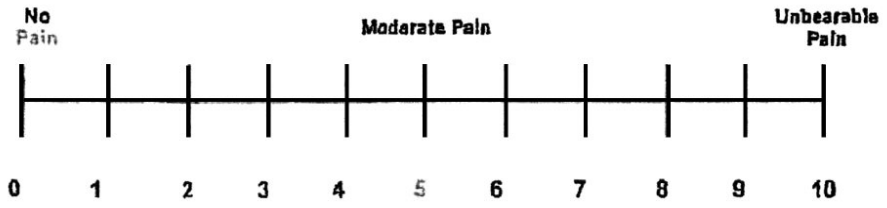
Please take a moment to review the scales shown below and mark appropriately.
Note: **The top scale relates to leg pain and the bottom scale relates to back pain.**

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

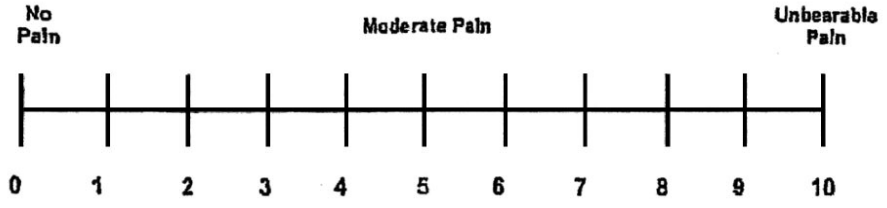
Please mark an "X" on the line below that best describes the level of pain you have experienced in the past month.



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☐