



Jeffrey D. Coe, MD
 Orthopaedic Spine Surgeon
Sherman N. Tran, MD
 Physical Medicine & Rehabilitation
Renee V. Wall, PA-C
 Physician's Assistant

Spinal Reconstructive Surgery
 Minimally Invasive Spinal Surgery
 Spinal Disc Arthroplasty Surgery
 Adult and Pediatric Spinal Deformity Surgery
 Cervical Spine Surgery
 Therapeutic and Diagnostic Spinal Injections
 Electrodiagnosis

221 East Hacienda Ave
 Suite A
 Campbell, CA 95008
 Tel: (408) 376 3300
 Fax: (408) 374 8830

PATIENT INFORMATION

Name of Patient _____ Date of Service _____

Address _____
Number Street City State Zip Code

Home Phone _____ Cell/Alternate Phone _____

Social Security Number _____ - _____ - _____ Date of Birth _____ Age _____

Single
 Married
 Divorced
 Widowed
 Sex: Female _____ Male _____

Date of Injury _____ Date Last Worked _____

Name of Employer at Time of Injury _____

Address of Employer at Time of Injury _____

Occupation at Time of Injury _____

Length Employed at Time of Injury _____

Name of Current Employer _____

Current Occupation _____

Referred by _____

Current and/or Most Recent Primary Treating Physician for this Injury _____

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES

Adjuster _____ Date of Injury _____

Name of Insurance Company _____

Address _____

Claim Number _____ Insurance Company Phone _____
 Fax _____

Name of Attorney _____ Phone _____
 Fax _____

Address _____

Nurse Case Manager _____ Phone _____
 Fax _____



Name: _____

Date: _____

PAIN DIAGRAM

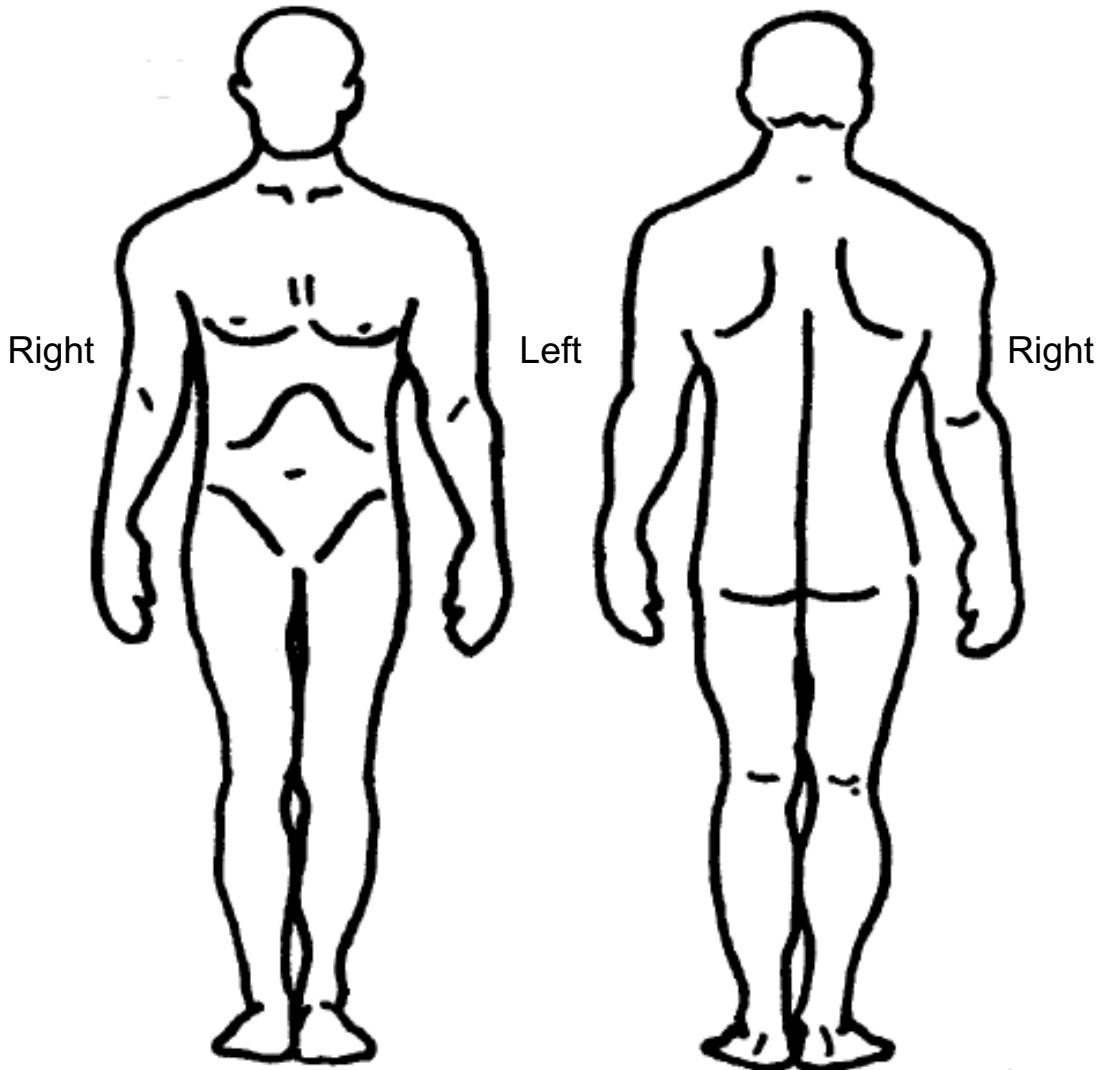
Using the symbols below, mark the areas on your body where you feel the described sensations. Include all affected areas. Just to complete the picture, draw in your face.

Major Pain – XXX
Secondary Pain – ///
Numbness – OOO

Tingling – YYY
Burning – ZZZ
Draw a line for radiating pain

Front

Back



Make any comments you feel are important:

HEALTH QUESTIONNAIRE

NAME: _____ DATE: _____

Age:	Height:	Weight:	Right handed: <input type="checkbox"/>	Left-handed: <input type="checkbox"/>	Ambidextrous: <input type="checkbox"/>
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PAST MEDICAL HISTORY: Have you ever had (circle No or Yes)

Diabetes.....	No	Yes	Myocardial Infarction(Heart Attack).....	No	Yes
Stroke.....	No	Yes	Rheumatic Fever.....	No	Yes
Cancer.....	No	Yes	Tuberculosis.....	No	Yes
High Blood Pressure.....	No	Yes	Hepatitis (A B C, please specify).....	No	Yes
Heart Problems.....	No	Yes	Anemia.....	No	Yes

Have you had, or do you have presently, any other serious illness or chronic medical condition that we should be aware of?.....No Yes

If yes, describe _____

Have you ever been hospitalized or been under medical care (other than surgery) for any period?

.....No Yes

If yes, for what reason? _____

Injuries:

Have you had any broken bones?.....No Yes If yes, briefly describe _____

Have you had any head concussions or injuries?.....No Yes If yes, briefly describe _____

Have you had any auto accidents?.....No Yes If yes, briefly describe _____

PAST PSYCHOLOGICAL HISTORY:

Have you ever had psychiatric care?.....No Yes describe _____

Have you ever been given a psychiatric diagnosis?.....No Yes describe _____

Have you ever been advised to undergo psychiatric care but not followed through? No Yes

If yes, briefly describe _____

PAST SURGICAL HISTORY: Have you had any surgery? No Yes

If yes, list all procedures and dates of surgeries

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____
6. _____ Date: _____
7. _____ Date: _____
8. _____ Date: _____
9. _____ Date: _____
10. _____ Date: _____

SOCIAL HISTORY:

Circle one: Single Married Divorced Widowed

Are you living with your husband/wife?.....No Yes

Do you have dependents at home?.....No Yes

Do you drink alcoholic beverages?.....No Yes

Amount and frequency: per day: _____ per week: _____ per month: _____

Do you smoke cigarettes?.....No Yes How many packs a day? _____ How long? _____

Have you ever smoked? _____ How many packs a day? _____ How long? _____ Last smoked _____

Is there any history of illegal drug abuse?.....No Yes

Is there any history of prescription drug abuse?.....No Yes

Are you currently working?.....No Yes

Full Time Part Time On disability Unemployed Retired Medically retired

FAMILY HISTORY:

If you are adopted and have no knowledge of your family history, please check this box and proceed to the Section #6.

BIOLOGICAL FAMILY HISTORY	IF LIVING		IF DECEASED	
	Age	Health	Age (at death)	Cause
Father				
Mother				
Brother				
Sister				
Son				
Daughter				

HAS ANY BLOOD RELATIVE HAD:			RELATIONSHIP
	NO	YES	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	
Gout	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Psych problems	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	

GENERAL MEDICATIONS:

Drugs recently taken, within the past six months, have you taken (circle No or Yes or Don't Know):

Cortisone.....No Yes Don't know
 Anticoagulants.....No Yes Don't know
 Tranquilizers.....No Yes Don't know
 Hypotensives (high blood pressure medications).....No Yes Don't know

List ALL GENERAL (i.e. NOT for your current spine condition) MEDICATIONS you are **currently** taking

1. _____ Dose (mg): _____ Frequency: _____
2. _____ Dose (mg): _____ Frequency: _____
3. _____ Dose (mg): _____ Frequency: _____
4. _____ Dose (mg): _____ Frequency: _____
5. _____ Dose (mg): _____ Frequency: _____
6. _____ Dose (mg): _____ Frequency: _____
7. _____ Dose (mg): _____ Frequency: _____
8. _____ Dose (mg): _____ Frequency: _____

MEDICATIONS FOR YOUR SPINAL CONDITION

List ALL PAIN/ANTI-INFLAMMATORIES, etc. you are **currently** taking for your spinal condition

1. _____ Dose (mg): _____ Frequency: _____
2. _____ Dose (mg): _____ Frequency: _____
3. _____ Dose (mg): _____ Frequency: _____
4. _____ Dose (mg): _____ Frequency: _____
5. _____ Dose (mg): _____ Frequency: _____
6. _____ Dose (mg): _____ Frequency: _____
7. _____ Dose (mg): _____ Frequency: _____
8. _____ Dose (mg): _____ Frequency: _____

ALLERGIES AND SENSITIVITIES:

Is there a history of any reaction or sickness following injection or oral administration of:

	No	Yes	Don't know	Describe Reaction & Specify Medication
Penicillin or other antibiotics:.....	No	Yes	Don't know	_____
Morphine, codeine, Demerol or other narcotics:.....	No	Yes	Don't know	_____
Novocain or other anesthetics:.....	No	Yes	Don't know	_____
Aspirin, Empirin or other pain remedies:.....	No	Yes	Don't know	_____
Sulfa drugs:.....	No	Yes	Don't know	_____
Tetanus antitoxin or other serums:.....	No	Yes	Don't know	_____
Any other drug or medication:.....	No	Yes	Don't know	_____
Any x-ray contrast material (dye, etc.):.....	No	Yes	Don't know	_____
Seasonal/environmental allergies:.....	No	Yes	Don't know	_____
Any foods, such as eggs, milk, or chocolate:.....	No	Yes	Don't know	_____

REVIEW OF SYSTEMS:

Do you have, or have you had, any of the following:

General:

Recent weight gain..... No Yes
 Have you been in good health.. No Yes

Skin:

Acne..... No Yes
 Dry skin/itching..... No Yes
 Eczema..... No Yes
 Rash..... No Yes

Head-Eyes-Ears-Nose-Throat:

Blurry vision/double vision... No Yes
 Cataracts..... No Yes
 Contact lenses/glasses..... No Yes
 Dizziness..... No Yes
 Ear problems..... No Yes
 Eye problems..... No Yes
 Hearing loss..... No Yes
 Loss of balance..... No Yes
 Neck stiffness..... No Yes

Breast:

Discharge..... No Yes
 Infection..... No Yes
 Mass/lump..... No Yes
 Surgery..... No Yes

Cardiac:

Angina..... No Yes
 Cardiac surgery..... No Yes
 Chest pain..... No Yes
 Murmur..... No Yes
 Palpitations..... No Yes
 Shortness of breath..... No Yes
 Swelling of extremities..... No Yes

Pulmonary:

Asthma..... No Yes
 Frequent cough..... No Yes
 Pain with breathing..... No Yes
 Wheezing..... No Yes

Urologic:

Dribbling..... No Yes
 Dysuria (pain with urination) No Yes
 Frequency..... No Yes
 Incontinence..... No Yes
 Hematuria (blood in urine) No Yes
 History of stones..... No Yes
 Infection..... No Yes
 Nocturia (night time urination) No Yes
 Stress incontinence..... No Yes
 Urgency..... No Yes

Gastrointestinal:

Abdominal pain..... No Yes
 Appetite change..... No Yes
 Blood in stool..... No Yes
 Change in bowel habits..... No Yes
 Constipation..... No Yes
 Diarrhea..... No Yes
 Gallbladder problems..... No Yes
 Indigestion/heartburn..... No Yes
 Hemorrhoids or piles..... No Yes
 Nausea/vomiting..... No Yes
 NSAID intolerance..... No Yes
 Rectal bleeding..... No Yes
 Ulcers..... No Yes

Ob-Gyn:

of pregnancies: _____
 # of miscarriages: _____
 Date of last Pap smear: _____
 Results (negative or positive): _____
 Frequency of periods, every _____ days
 Any pain with periods..... No Yes
 Menopausal..... No Yes
 (if yes, at what age _____)

Neurological:

Dizziness/fainting spells..... No Yes
 Headaches..... No Yes
 Loss of consciousness..... No Yes
 Memory loss..... No Yes
 Paralysis..... No Yes
 Seizures..... No Yes

Vascular:

Abnormal bleeding or bruising... No Yes
 Aneurysm..... No Yes
 Are you a Jehovah's Witness..... No Yes
 Phlebitis..... No Yes
 Varicose veins..... No Yes

Endocrine:

Blood transfusion..... No Yes
 Hormone therapy..... No Yes
 Thyroid problems..... No Yes
 Varicose veins..... No Yes

Immune System:

AIDS..... No Yes
 Diabetes..... No Yes
 History of infections..... No Yes
 Immunosuppressive disorders..... No Yes



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Silicon Valley Spine Institute Medication Refill Policy

- Refills will be made only during regular office hours.
- Allow 2-3 business days for all refill requests to be processed.
- Refills will not be made at night, on holidays or weekends.
- Refills will not be made if I "run out early."
- I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
- All refill requests must be faxed by your pharmacy by 10:00am Friday, anything faxed after that time will not be filled.
- Refills will not be made as an "emergency" on Friday afternoon.
- Prescriptions will not be filled by the on-call physician.

Please have your pharmacy fax a refill request to our office. Refills will be processed within 2-3 business days and faxed to your pharmacy.

Certain medications require a hand written scrip every time a refill is needed. In this case please call our office and let us know 2-3 business days before you run out so the physician will be able to write a new prescription for you.

Remember, your physician is in surgery 2-3 days a week and will not always be able to write the new prescription/refill your medication on the day it is requested.

I have been fully informed and will comply with the medication refill policy established by Silicon Valley Spine Institute.

Patient Name: _____

Patient Signature: _____ Date: _____



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**PATIENT DESIGNATION OF
PRIMARY TREATING PHYSICIAN**
(California Labor Code section 4601)

Date: _____

Patient Name: _____

Date of Birth: _____

I **DO** **DO NOT** know who my Primary Treating Physician is.
(Circle one)

My Primary Treating Physician's name is: _____

TO CHANGE YOUR PRIMARY TREATING PHYSICIAN PLEASE COMPLETE BELOW.

I hereby request the following physician of Silicon Valley Spine Institute as my
"Primary Treating Physician" pursuant to section 4601 of the California Labor Code.

____ Jeffrey D. Coe, MD

____ Sherman Tran, MD

PATIENT SIGNATURE: _____

OFFICE ONLY

- ____ ***I will accept*** this patient as their Primary Treating Physician.
- ____ ***I will not accept*** this patient as their Primary Treating Physician.
- ____ ***I will continue*** to treat this patient on a consulting basis **ONLY**.
- ____ ***I will no longer*** see or treat this patient.

Physician Signature: _____

Recommendations for new Primary Treating Physician (if applicable): _____

*The physician retains the right to assume medical care for the patient or refer the patient to another
Primary Treating Physician for continued treatment at any time.*