SOUTHERN CALIFORNIA
Brain & Spine Surgery

Preparing for Your Appointment Checklist

We want to make sure you get the most out of your appointment. Having the following information at your appointment is important so that we have all the correct information to identify, understand and treat your spinal and/or brain condition.

Please read over the below checklist and bring each item with you to your appointment

- Drivers License or Other Form of Photo Identification
- Insurance Cards
- Completed Patient Registration Form
- All Radiology Studies Pertaining to your Case

Along with the report, please bring the CD or actual films

- MRI Scans
- CT Scans
- X-Rays

Prior Medical Reports

- Operative and Radiology Reports
- Injection Histories
- EMG and Nerve Conduction Results
- Consultations from Other and/or Referring Physicians

Information of ALL Physicians Involved in Your Care (Including your PCP)

- First and Last Name
- Contact Telephone Number
- Address

List of Questions and Concerns

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Health History Information

Patient Information			
Name (First, Middle, Last)	Birth Date	Age	Height

Chief Complaint
Pain
Decreased Strength
Numbness
Tingle

Please Explain Your Symptoms
Have you fallen in the past? The number of days of last fall?
When did your pain discomfort or numbness start?
On a scale of 1 to 10 (10 being the worst), rate your pain/discomfort, or numbness

Previous Surgeries (Include the year the surgery was complete)

Previous Medical / Illness (Check all that apply)						
Cancer ☐	Diabetes ☐	Heart Attack ☐	High Cholesterol ☐	History of Stroke ☐	High Blood Pressure ☐	Thyroid Problems ☐
Others:						

Diseases That Applies To Anyone In Your Blood Family				
Cancer ☐	Diabetes ☐	Heart Disease ☐	High Cholesterol ☐	History of Stroke ☐

Medications

Allergies

Health Questions
Do you smoke? Yes ☐ No ☐. If yes, how many cigarettes _____ per day_____ per week_____ per month
Do you drink alcohol? Yes ☐ No ☐. If yes, how many drinks _____ per day_____ per week_____ per month
Do you intravenous drugs? Yes ☐ No ☐.
Which hand is your dominant hand? Right ☐ Left ☐.
What is your occupation? _____ How long have you been doing this job?_____
Do you live alone? Yes ☐ No ☐ Who do you live with? _____

Symptoms That Best Describe Your Conditions(Check all that apply)									
General	No Problem ☐	Weight Gain ☐	Weight Loss ☐	Fatigue ☐	Weakness ☐	Fever ☐	Chills ☐	Night Sweat ☐	Other ☐
Head/ Neck	No Problem ☐	Headaches ☐	Loss Balance ☐	Dizzy: Room Spin ☐	Dizzy: You Spin ☐	Neck Pain ☐			
Eyes	No Problem ☐	Recent Visual Changes or Loss ☐	Wear Glasses or Contacts ☐	Prescription changed recently ☐					
Nose Sinuses	No Problem ☐	Runny Nose ☐	Stuffiness ☐	Sneezing Itching ☐	Sinus Headaches ☐	Other ☐			
Mouth/ Throat/ Neck	No Problem ☐	Bleeding Gums ☐	Mouth Sores ☐	Lump In Neck ☐	Horseness ☐	Sore Throat ☐	Swollen Neck ☐	Neck Stiffness ☐	Other ☐
Chest	No Problem ☐	Short Breath ☐	Wheezing ☐	Coughing ☐	Bronchitis ☐	Emphysema ☐	Pneumonia ☐	Asthma ☐	
Chest Continued	Tuberculosis - My Last X-Ray ☐	Blood In My Phlem/Sputum ☐	Have Suptum ☐	Other ☐					
Heart	No Problem ☐	High Blood Pressure ☐	Heart Murmur ☐	Chest Pain ☐	Palpitations ☐	Swollen Ankle ☐			
Heart Continued	Sleep On 2 Or More Pillows At Night ☐	Leg Cramp ☐	Last EKG Date:	Other ☐					
GI/GU	No Problem ☐	Vomiting ☐	Bloody Vomit ☐	Incontinent Stool ☐	Diarrhea ☐	Bloody Diarrhea ☐	Constipation ☐		
GI/GU Continued	Abdominal Pain ☐	Frequent Urination ☐	Urinary Urgency ☐	Need To Urinate More Than Twice a Night ☐					
GI/GU Continued	Incontinent of Urine ☐	Urinary Tract Infection Now ☐	Kidney Stone ☐	Hemorrhoids ☐					
Mental Status	No Problem ☐	Difficulty In Concentration ☐	Fainting ☐	Blackouts ☐	Seizures ☐	Numbness ☐	Tics ☐		
Psycho logical	No Problem ☐	Depressed ☐	Anxious ☐	Loss of Memory ☐	Insomnia ☐	Sleepy ☐			

Southern California Brain & Spine Surgery

Moksha Ranasinghe. M.D.

Patient Information Sheet / Datos del paciente

Please provide complete information so that we may bill your insurance. / Por favor provea información completa para poder enviar el cobro a la empresa de seguros.

First Name/Nombre	Last Name/Apellido	MI/Segundo Nombre	Today's Date/Fecha:

Street Address/Domicilio	Apt.# / # del Apartamento	City/Ciudad	State/Estado	Zip/Código Postal

Home Phone/Teléfono de la Casa:	Work Phone/Teléfono del Trabajo:	Cell Phone/ Telefono Celular	Age/Edad:

Social Security#/Núm de Seguro Social	Date Of Birth/Fecha de Nacimiento	Sex/Sexo: M F	Driver's Lic# / Licencia de manejar:

Who referred you to our office?/¿Quién le remitió a esta oficina?

First Name / Nombre: Last Name / Apellido: Phone / Teléfono:

Marital Status / Estado Civil (Circle one /Marque uno)	Employ Status / Clasificación laboral (Circle one /Marque uno)
Married Single Widowed Divorced Minor	Full Time Part Time Retired Not Employed Disabled/Incapacitado(a)
Casado(a) Soltero(a) Viudo(a) Divorciado(a) Menor de edad	Tiempo completo Tiempo parcial Jubilado(a) Desempleado(a)

Student Status/Horario de estudios (Circle one /Marque uno)	Employer's Name/Nombre del Empleador: Occupation/Ocupacion:
FullTime PartTime None	Employer's Phone/Teléfono del Empleador:
Tiempo completo Tiempo parcial No corresponde	

Emergency Contact Name:

Persona a contactar en caso de emergencia: (que no viva con usted) Phone Number/Núm de Teléfono

Reason for Visit:/Razón de la consulta:

Is your visit due to an accident? Yes No ¿Fue la consulta relacionada con un accidente? Si No	Date of Accident: Fecha del accidente:

Where was the accident? / ¿Dónde occurió el accidente? (circle one / trace un circulo alrededor del correspondiente)
Auto/automóvil Work/Trabajo Home/Casa Other / Otras razones:

If you would like to be contacted by E-mail, please enter your E-Mail address	Preferred Language

Primary Insurance / Seguro Primario			***Secondary Insurance / Seguro Secundario***		
Insurance Company Name / Nombre de la empresa de seguros			Insurance Company Name / Nombre de la empresa de seguros		
Address / Domicilio:			Address / Domicilio:		
City / Ciudad	State / Estado	Zip / Cód. Postal	City / Ciudad	State / Estado	Zip / Cód. Postal
Policy # / Núm. de la Póliza de Seguros	Group#/Núm. del Grupo		Policy # / Núm. de la Póliza de Seguros	Group#/Núm. del Grupo	
Subscriber's Name / Nombre del Subscriptor			Subscriber's Name / Nombre del Subscriptor		
Subscriber's Employer & Phone / Empleador y teléfono del subscriptor			Subscriber's Employer & Phone / Empleador y teléfono del subscriptor		
Subscriber's Date of Birth /Fecha de nacimiento del Subscriptor:	Subscriber's Sex / Sexo o género del Subscriptor: M F		Subscriber's Date of Birth /Fecha de nacimiento del Subscriptor:	Subscriber's Sex / Sexo o género del Subscriptor: M F	
Relationship to Subscriber? / Parentesco con el subscriptor(a)? Self / Personal Spouse / Cónyuge Child / Hijo(a)			Relationship to Subscriber? / Parentesco con el subscriptor(a)? Self / Personal Spouse / Cónyuge Child / Hijo(a)		

If you have an HMO, what hospital are you assigned to? / Si su seguro es un HMO, ¿cuál hospital se le asignó?

Please give all insurance cards and forms to the receptionist to be copied. / Le agradeceremos le entregue todos los formularios y tarjetas del seguro a la recepcionista, para que le saque copias.

I certify that the above information is true and accurate. / Certifico que toda la información provista es verdadera y correcta.

Signature / Firma Date/Fecha