



DANIEL S. YANNI, MD
NEUROSURGEON &
SPINE SURGEON

Disc Comfort, Inc.
1501 Superior Avenue Ste. 214 Newport Beach, CA 92663
P: 949-515-0051 F: 949-515-0052
www.yannimd.com

Patient Information

Thank you for taking the time to fill out this confidential patient information form.

Name: _____ Sex: Male Female

Date of birth: ____/____/____ Age: _____ SS#: _____

Address: _____

City, State, Zip: _____

Phone: _____ Marital Status: _____

Who is referring you to our practice? _____

Who is your Primary care physician? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Alternate Phone: _____

Is the guarantor same as the patient? Yes No

If not, please fill out the guarantor information:

Name: _____ Date of birth: ____/____/____

Address: _____

SS#: _____ Employer: _____

Phone: _____ Alternate Phone: _____

I hereby authorize and consent to examination and treatment as deemed necessary by physicians and allied medical practitioner of Disc Comfort, Inc.

I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any cost incurred by Disc Comfort, Inc. in the collection of amounts due including, but not limited to, reasonable attorney's fee. I hereby assign all medical and/or surgical benefits including major medical benefits to which I am entitled, include Medicare, private insurance, and other health plans to Disc Comfort, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Signature: _____ Date: ____/____/____



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Medical records release authorization

Patient Name: _____

Date of birth: _____

I hereby authorize Disc Comfort Inc, Daniel Yannini, MD and medical staff to release any and all of my medical records, or to discuss my health care treatment with:

Please list the name and relationship to the patient

1. _____
2. _____
3. _____
4. _____
5. _____

Patient's signature: _____ Date: _____

Legal guardian's signature: _____ Date: _____



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Office Policies

- I, the undersigned, understand that payment for all care received is my responsibility.
- For clinical appointments, I understand that a 24-hour cancellation notice is necessary to avoid charges.
- A \$75 fee is charged for cancellations made with less than 24 hours' notice and for missed appointments.
- For any paperwork, I understand that a \$50 fee is charged for any forms that need to be filled out, including disability forms after surgery.
- For surgical scheduling, I understand that there will be a \$500 fee to change dates of surgery with **less than two-weeks'** notice from the tentatively agreed upon surgical date.
- I understand that there will be a \$750 fee for cancelation of surgery within **two weeks** of the tentatively agreed upon surgical date.
- I understand that there will be a \$1,250 fee for cancelation of surgery within **one week** of the tentatively agreed upon surgical date.
- I understand that there will be a \$1, 500 fee for cancelation of surgery within **48 hours** of the tentatively agreed upon surgical date.
- Payment is due immediately upon cancellation. Late fees will apply.
- I also understand that my tentatively agreed upon surgical date may be moved or cancelled by the office at any time, in which circumstance, I would not incur a rescheduling or cancellation fee.

Today's date: ____ / ____ / ____

Patient's or guardian's signature: _____

Patient's or guardians name (please print): _____



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Financial Policy

Thank you for choosing us as your health care provider. Our goal is to provide excellent patient care and we are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

We accept cash and most major credit cards.

Regarding insurance billing:

We will bill your insurance company as a courtesy. Your insurance policy is a contract between you and your insurance company. It is your responsibility to know your benefits and how they will apply to your treatment by the doctor. We are not a party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will be transferred to you and/or the guarantor listed on the patient's information form.

- PPO plans (with which we are contracted): we have agreed to take a discount from your insurance company. Your coinsurance is your responsibility and is due at the time of treatment. In the event your insurance coverage changes to a plan where we are not a participating provider you will be responsible for any out of network deductible or coinsurance amounts.
- Medicare: we accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for the balance of which Medicare or your secondary does not pay.

Usual and customary rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.



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Financial Policy continued

Cash patient:

All services must be paid in full at the time of treatment.

Administrative fee:

All co-payments will be collected at the time of service. If a patient does not submit payment at the time of service, the patient will be billed for the Co-payment and a \$15 administrative fee will be added. In addition, any patient invoices that are not paid within thirty days of the invoice date, a \$75 fee will be added to the current bill.

Benefit reassignment agreement

Below please find the benefit reassignment agreement policy of Disc Comfort, Inc. regarding payments for services.

I, _____, hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering services. I understand that I am financially responsible for the charges not covered by my medical insurance policy. I understand that it is my responsibility as the patient to become familiar and understand coverage of services and benefits under my insurance plan. I hereby authorize the doctor providing medical service to release any information required by the insurance carrier. All services rendered by Disc Comfort, Inc. are the sole property of Disc Comfort, Inc. I agree not to cash those payments and to submit them directly to Disc Comfort, Inc. within one week of receiving such payments.

Please do not hesitate to contact our staff with any questions or comments regarding the document.

By signing this document, I understand both the financial policy and the benefit reassignment agreement with Disc Comfort, Inc.

Name (please print): _____

Signature: _____ Date: _____



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Credit Card on File Policy and Pre-Authorization

Thank you for choosing Disc Comfort Inc. for your Neurosurgical needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible by streamlining our billing and payment system and providing a seamless, convenient way for patients to pay their bills.

It is our office policy to collect credit card information from all patients or their responsible parties and to maintain this information on file in a HIPAA compliant and confidential manner. We maintain this information for three purposes:

1. We require that insurance co-payments /fees be paid at the time of your visit. If a patient is not able to pay their co-payment or fees at the time of the visit with cash or check, we will have their credit card information on file and will process the payment for them. It is too costly for our practice to bill a patient for their co-payment/fees.
2. If an appointment is cancelled in less than 24 business hours or a patient does not show for an appointment, the full fee is due and will be charged to the card on file. No-shows and late cancellations cannot be billed to the insurance.
3. If a patient becomes 60+ days overdue, with any balance, we will process the payment using the credit card information or they may set up a monthly installment plan as agreed on by the office administration.

If the credit card we have on file for you changes, please notify our office IMMEDIATELY. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you documented on this original pre-authorized form. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional \$35 declined card fee if we are not able to run a new credit card within 7 days. Disc comfort Inc. does not accept patients without a credit card on file.

I, _____, am authorizing Disc Comfort Inc. to charge my credit card for the reasons stated above. Furthermore, for outstanding payments equal to or greater than 60 days, I authorize Disc Comfort Inc. to charge my credit card for the full amount due. I am aware that my card will be manually entered and thus no signature obtained, but I am consenting to this per the above parameters. I will not dispute charges for services I have received or that I have cancelled less than 24 business hours in advance. If I chose to dispute a charge to my credit card company, a copy of this credit card authorization will be provided.

Card Type (circle one): **Visa** **MasterCard** **American Express** **Discover**

Name on Card: _____

Card Number: _____

Expiration Date: _____ **CCV#** _____

Billing Address (If different than primary): _____

Signature of cardholder (if different than patient): _____

Date: _____

Signature of Patient/Guardian: _____

Date: _____



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Patient Privacy Policy Notice

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards, and our internal policies and procedures.

On file and displayed in our office(s) is our Notice of Privacy Practices. This notice explains your rights, our legal duties, and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice.

- Our pledge
- Your personal information
- Our privacy practices
- How we may use or share your information for:
 - Treatment
 - Payment
 - Health Care options
 - Notifications
- Marketing
- Research
- Special circumstances and the law
- Your written permission
- Other restrictions
- Your rights
- Changes
- Questions or complaints

Please understand that this summary is not our notice of privacy practices, nor is it a substitute for the notice. The actual notice should be available to you, as required by law. If you wish to keep a copy of our Notice of Privacy Practices, please let the receptionist know when you check in to see the Doctor.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have presented for your review a paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements. If, after reviewing the notice, you decided that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipts of the Notice of Privacy Practices:

Name (please print): _____

Signature: _____ Date: _____



Controlled substance agreement

I understand that my provider is prescribing controlled medications (opioids, barbiturates, benzodiazepines) to assist me in managing my post-operative pain. These medicines are intended to decrease pain in order to improve function and allow progress in rehabilitation. As the user of the medications, I understand that I have important responsibilities regarding the care and use of these medications. The risks, benefits, and side effects of these medications have been explained to me and I agreed to the following conditions for this type of treatment.

1. I understand that I should be received pain medication from only one doctor or practice at any one time. I understand that I will be only getting prescriptions for pain medicine from Dr. Yanni or from a physician outside of the practice, but NOT BOTH. If I develop another condition that requires a prescription of a controlled medication, I will inform the clinic within one business day of receiving any new controlled medications.
2. I understand that Dr. Yanni may only be prescribing my pain medication up to 90 days past the date of surgery. At that point, if they are still necessary, I will receive them from my PCP or a dedicated pain management physician.
3. I will designate only one pharmacy where all of my narcotic prescriptions will be filled.
4. I will take my medications exactly as prescribed and will not change the medication dosage or schedule without my provider's approval. Refills may not be given if I "ran out early."
5. I understand that I am responsible for the care of my medication once I leave the office/hospital with my prescription. I understand that my narcotic medications may not be replaced if they are lost, stolen, or destroyed. Controlled medication should be locked up and secured.
6. Refills of controlled medications will be made only during regular office hours.
7. I understand that the medications prescribed are for the sole purpose of pain control and agree not to use it for any other purpose.
8. I will not share or divert my narcotic medications with any other person.
9. I understand that the controlled medications can affect my thinking and judgement and my interfere with my ability to drive. I will not drive if I have this concern.



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Controlled substance agreement continued

10. I understand that my physician may use a prescription monitoring program to keep track of my medications.

I understand these rules and that noncompliance may lead to the discontinuation of my medication and/or discharge from Dr. Yanni's care. I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency. Including this states' Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication.

I authorize my doctor to provide a copy of this agreement to my pharmacy.

I agree to waive any application or right of privacy or confidentiality with respect to these authorizations.

I have read the contract and it has been explained to me. I fully understand the consequences of a violated agreement.

Name (please print): _____

Signature: _____ Date: _____



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HIPAA email consent

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers are encrypted
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- **When we send you an email or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people do o in their latest modification to the HIPAA act; the federal government provided guidance on email and HIPAA.
- The guidelines state that if a patient has been made aware of the risk of unencrypted email, and if that same patient provides consent to receive health information via email; then a health entity may send that patient personal medical information via unencrypted email.
- Since email can be used to spread viruses, please do not send attachments in the emails. For example, some viruses can cause email messages to be sent to people who you do not intent to send an email to; therefore, you should install and maintain virus protection software on your PC.

By consenting to the use of email with Disc Comfort, Inc., you agree that:

- Disc Comfort, Inc. may forward emails as appropriate for diagnosis, treatment, reimbursement, and other related reasons. As such, Disc Comfort, Inc. employees, medical staff, and other than the recipient, may have access to emails that you send. Such access will only be to people who have a right to access your email to provide independent this parties without your prior written consent, unless as authorized or required by law.



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HIPAA email consent continued

- Although Disc Comfort, Inc. will try to read and respond promptly to your emails; Disc Comfort, Inc. staff may not read your email immediately. Therefore, you should not use email to communicate with Disc Comfort, Inc. if there is an emergency or where you require an answer in a short period of time.
- If your email requires or asks for a response and you have not received a response within a reasonable time period, it is your responsibility to follow up directly with Disc Comfort, Inc.
- You should carefully consider the use of email for the communication of sensitive medical information such as but not limited to; information regarding sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse.

Acknowledgement and agreement

Disc Comfort, Inc. will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, Disc Comfort, Inc. cannot guarantee that email will be confidential. Additionally, Disc Comfort, Inc. will not be liable in the event that you or anyone else inappropriately uses or accesses your email. Disc Comfort, Inc. will not be liable for improper disclosure of your health information that is not caused by Disc Comfort, Inc. intentional misconduct.

By signing this form, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of email between Disc Comfort, Inc. and me, and consent to the conditions outlined herein, as well as any other instructions that Disc Comfort, Inc. may impose to communicate with me by email. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.



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HIPAA email consent continued

Please select an option below.

Option 1. – **Allow** unencrypted email

I understand the risks of unencrypted email and do hereby give permission to (Disc Comfort, Inc.) to send me personal health information via unencrypted email regarding patient _____ (Patient’s name)

Signature: _____ Date: _____

Please print clearly ONE email: _____

Printed name (parent of guardian if patient is a minor): _____

Option 2. – **DO NOT** Allow unencrypted email

I do not wish to receive personal health information vis email for patient _____ (Patient’s name)

Signature: _____ Date: _____

Please print clearly ONE email: _____

Printed name (parent of guardian if patient is a minor): _____

Option 3. – **Revoke** unencrypted email

I wish to revoke unencrypted email communication regarding personal health information via email for patient _____ (Patient’s name)

Signature: _____ Date: _____

Please print clearly ONE email: _____

Printed name (parent of guardian if patient is a minor): _____

Also, Disc Comfort, Inc. has the right to revoke unencrypted email communication regarding personal health information via email.

Revoke date: _____ Reason: _____

Please fax completed form to 949-515-0052 or bring completed form into the office.



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New Patient History

Name: _____ Sex: Male Female
Date of birth: ____/____/____ Age: _____ Visit date: _____

- Referring doctor: _____ Phone: _____
- Primary Physician: _____ Phone: _____
- Self-Referral

A. Symptoms and Pain assessment

1. Chief Complaint: _____

2. How long have you had these symptoms?
_____ days _____ weeks _____ months _____ years

3. Describe the quality of your pain (please check the box)
 Burning Sharp Shooting Tingling Numbness Stabbing
 Deep-pressure Tightness Spasms Pinprick

Other (please describe): _____

4. How often do you experience the pain? Constant Intermittent – Daily
 Weekly Monthly

Other: _____

5. How did your pain start? gradually suddenly

What day did your pain start? _____

6. Since the pain began, is it: better worse unchanged



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7. Does the pain radiate to?

An arm	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
Or a leg	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

Do you have weakness in?

An arm	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
Or a leg	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

Do you have numbness in:

An arm	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both
Or a leg	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Both

8. Any changes in bowel or bladder function?

- No
- Yes
- Bowel Incontinence
- Other: _____
- Bladder Incontinence
- Constipation
- Hesitancy

9. Was there any injury/event that caused your pain?

No Yes, if yes: Date of injury (mm/dd/yyyy) ____/____/____

Please describe how you were injured: _____

A. Legal action pending? No Yes

B. Work related? No Yes

Employer at the time of injury: _____

Job Title: _____

Worker's Compensation? No Yes

Name of your attorney: _____

10. Any prior back or neck injury/pain before the event? No Yes- if yes:
what type? (Please describe) _____



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How severe is your pain today?

(Please circle the number to indicate how bad you feel your pain is today)

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

11. Pain rating

Please rate your **average** level of pain on the following scale (circle one)

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

Please rate your **worst** level of pain on the following scale (circle one)

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

Please rate your **best** level of pain on the following scale (circle one)

No pain _____ Worst pain
0 1 2 3 4 5 6 7 8 9 10

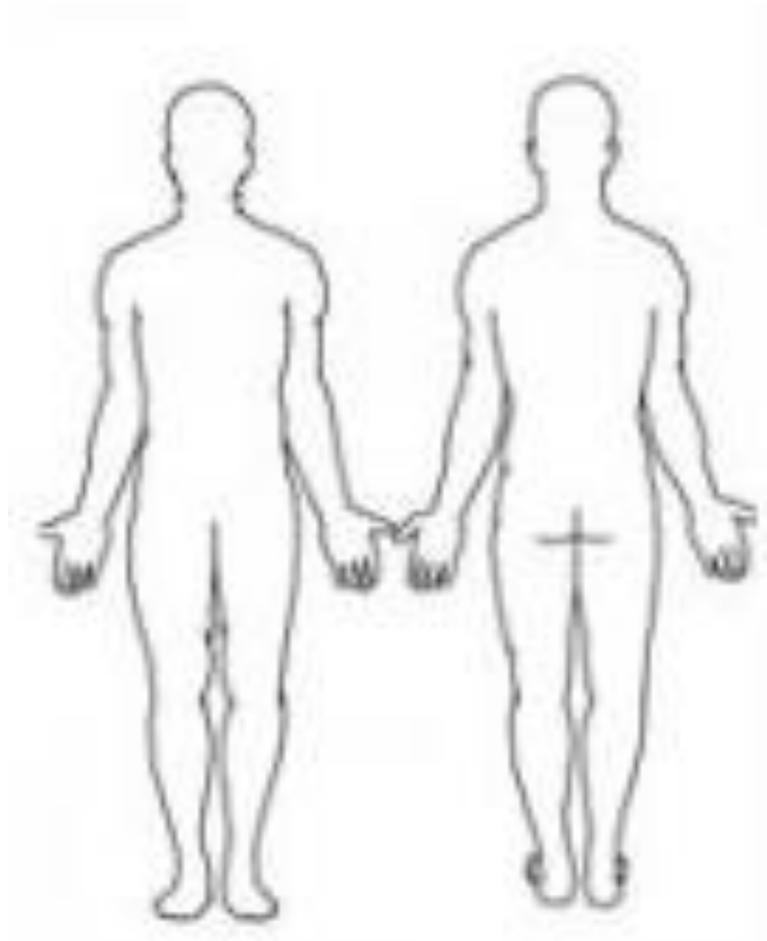


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Using the symbols below, mark the area on your body where you feel the described sensation include all affected areas.

Numbness = = = Pins and Needles 0 0 0 Burning X X X Stabbing / / / Aching (((



12. Do you have pain at night? No Yes
If yes, does it wake you from your sleep? No Yes



13. What makes your pain better?

- Sitting
- Standing
- Bending
- Laying down
- Walking
- Other: _____
- Epidural injection
- Nerve blocks
- Physical therapy
- Acupuncture
- Message
- Chiropractic
- Medication

14. What makes your pain worse?

- Sitting
- Standing
- Bending
- Other: _____
- Lying down
- Walking
- Neck movement
- Coughing/sneezing

B. Previous Treatment and Evaluation

1. What Diagnostic tests have you had for this problem?

- X-ray
- MRI
- CT
- EMG
- Bone scan
- Myelogram
- Blood/Laboratory

2. Please check any of the following if you have tried for your pain or discomfort:

- Surgery
- TENS
- Epidural Injections
- Nerve Blocks
- Physical Therapy
- Acupuncture
- Massage
- Anti-inflammation medications
- Chiropractic
- Other: _____

a. Which treatment have you tried is the best treatment for your pain or discomfort? _____

C. Medical/ Surgical History

1. Please list other medical problems (please check the box)

- High blood pressure
- Arthritis
- Diabetes
- Heart disease- Type: _____
- Stroke
- Osteoporosis
- High Cholesterol
- Cancer- Type: _____
- Thyroid
- Asthma
- Stomach Ulcer
- Kidney Stones
- Blood clots in legs
- Depression
- AIDS/HIV
- Other: _____



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2. Have you ever had **spine surgery** in the past? No Yes

Type of spine surgery: _____ Date: _____
_____ Date: _____
_____ Date: _____

3. Please list other non-spinal surgery:

Type of non-spinal surgery: _____ Date: _____
_____ Date: _____
_____ Date: _____

D. Family Medical History

Arthritis Bone disease Heart disease Diabetes Cancer

Mother Age: _____ Healthy Deceased due to: _____
Father Age: _____ Healthy Deceased due to: _____
Brother Age: _____ Healthy Deceased due to: _____
Sister Age: _____ Healthy Deceased due to: _____

E. Social History

Marital Status: Single Married Divorced Separated Widowed

Number of Children: _____

Do you drink alcohol? No Yes if yes, how much? _____

Do you smoke? No Yes if yes, how much? _____

Do you use recreational substances? No Yes

if yes, what type and frequency: _____

Are you currently working? No Yes

If yes, Employer: _____ Job title: _____

How long have you working there? _____

Movements required for your job:

twisting pulling pushing sitting standing stopping crawling lifting
_____ pounds reaching bending crouching grasping balancing

squatting kneeling climbing stairs climbing ladder

Sitting time: _____ hours/day Standing time: _____ hours/day

Are you able to perform your usual duties No Yes



F. Review of systems:

Skin

- Skin rash
- Easy bruising
- Abnormal hair loss

Ear and nose

- Deafness
- Hoarseness
- Vertigo/dizziness
- Sinusitis

Gastrointestinal

- Appetite change
- Jaundice
- Irritable bowels
- Nausea/Vomiting

Blood System

- Anemia
- Bleeding tendency
- Bruising

Neurological

- Headache
- Migraine
- Seizure
- Paralysis

Genitourinary

- Blood in urine
- Impotence
- Painful urination
- Kidney stones
- Incontinence

Endocrine

- Goiter
- Heat/cold intolerance
- Increased thirst
- Increase size of hand or feet

Eyes

- Visual loss
- Double Vision
- Glaucoma
- Glasses/contact lenses

Mental Status

- Hallucinations
- Nervous breakdown
- Depression
- Sleep disturbance
- Suicidal thoughts

Cardiovascular

- Palpitations
- Chest pains
- Leg swelling
- Arrhythmia
-

Bone/Joint Muscles

- Muscle wasting
- Muscle cramping
- Joint pain

Respiratory

- Shortness of breath
- Asthma/bronchitis
- Cough
- Tuberculosis
- Pneumonia
- Emphysema/CO PD

Constitutional

- Fever/chills
- Weight loss
- Weight gain
- Fatigue

Medication



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1. Do you have any allergies to medication, food or latex?

- No known allergies
- Yes – Allergies: _____ Reaction: _____
- Allergies: _____ Reaction: _____

2. Current Medications

- none Yes, list below

Medications	Dose	Route	Frequency	Time and Date last taken
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				



This survey asks you for your view about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by selecting the answer as indicated. If you are unsure how to answer a question, please give the best answer you can.

1. in general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

2. The following questions are about activities you might do during a typical day.

Does **your health now limit you** in these activities? If so, how much?

- | | |
|--|---|
| <p>a. <u>Moderate activity</u>, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf-</p> <ul style="list-style-type: none"><input type="checkbox"/>Yes, limited a lot<input type="checkbox"/>Yes, limited a little<input type="checkbox"/>Not limited at all | <p>b. Climbing <u>several flights</u> of stairs-</p> <ul style="list-style-type: none"><input type="checkbox"/>Yes, limited a lot<input type="checkbox"/>Yes, limited a little<input type="checkbox"/>Not limited at all |
|--|---|

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

- | | |
|--|--|
| <p>a. <u>Accomplished less</u> than you would like-</p> <ul style="list-style-type: none"><input type="checkbox"/>All of the time<input type="checkbox"/>Most of the time<input type="checkbox"/>Some of the time<input type="checkbox"/>A little of the time<input type="checkbox"/>None of the time | <p>b. Were limited in the <u>kind</u> of work or activities</p> <ul style="list-style-type: none"><input type="checkbox"/>All of the time<input type="checkbox"/>Most of the time<input type="checkbox"/>Some of the time<input type="checkbox"/>A little of the time<input type="checkbox"/>None of the time |
|--|--|

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- | | |
|---|--|
| <p>a. <u>Accomplished less</u> than you would like-</p> <p>All of the time</p> <ul style="list-style-type: none"><input type="checkbox"/>Most of the time<input type="checkbox"/>Some of the time<input type="checkbox"/>A little of the time<input type="checkbox"/>None of the time | <p>b. Did work or activities less carefully than usual</p> <ul style="list-style-type: none"><input type="checkbox"/>All of the time<input type="checkbox"/>Most of the time<input type="checkbox"/>Some of the time<input type="checkbox"/>A little of the time<input type="checkbox"/>None of the time |
|---|--|

SF-12 v.2 Health Survey Continued



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

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

6. These questions are about how you feel and how things have been during the past 4 weeks. For each question, please give one answer that comes closest to the way you have been feeling.

How much of the time in the past 4 weeks:

a. Have you felt calm and peaceful?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

b. Did you have a lot of energy?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

c. Have you felt downhearted and depressed?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

7. 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



Oswestry Questionnaire This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which most clearly describes your problem.

How long have you had back pain? ____ Years ____ Months ____ Weeks ____ Days

How long have you had leg pain? ____ Years ____ Months ____ Weeks ____ Days

Section 1- Pain intensity

- I can tolerate the pain I have without pain killers
- The pain is bad but I manage without pain killers
- Pain killers give complete relief from pain
- Pain killers give moderate relief from pain
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain

Section 2- Personal Care (washing, dressing)

- I can look after myself normally without causing pain
- I can look after myself normal but cause more pain
- It is painful to look after myself and I am slow
- I need some help but manage most of my personal
- I need help every day in most aspects of self-care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3- Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- pain prevents me from lifting heavy weights off the floor, but I can manage if they are coincidentally positioned on a table.
- pain prevents me from lifting heavy weights but I can manage light weights
- I can lift only very light weights
- I cannot lift or carry anything at all

Section 4- Walking

- Pain doesn't keep me from walking
- pain prevents me from walking more than 1 mile
- pain prevents me from walking more than 1/2 mile
- pain prevents me from walking more than 1/4 mile
- I can only walk using a stick or crutches
- I am in bed most of the time and crawl to the toilet

Section 5- Sitting

- I can sit in any chair as long as I like
- I can only sit in my favorite chair(s) as long as I like
- Pain prevents me from sitting more than 1 hour
- Pain prevents me from sitting more than 1/2 hour
- Pain prevents me from sitting more than 10 min
- Pain prevents me from sitting at all

Section 6- Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me pain
- Pain prevents me from standing more than 1 hour
- Pain prevents me from standing more than 30 min
- Pain prevents me from standing more than 10 min
- Pain prevents me from standing at all

Section 7- Sleeping

- Pain does not prevent me from sleeping well
- I can sleep well only by using tablets
- Even when I take tablets I have less than 5 hours of sleep
- Even when I take tablets I have less than 4 hours of sleep
- Even when I take tablets I have less than 2 hours of sleep
- Pain prevents me from sleeping at all

Section 8- Sex Life

- My sex life is normal and causes no extra pain
- My sex life is normal but causes extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9- Social Life

- My social life is normal and gives me no pain
- My social life is normal but increased the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests
- Pain has restricted my social life and I do not go out often
- Pain has restricted my social life to stay home
- I have no social life because of pain

Section 10- Traveling

- I can travel anywhere without extra pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys less than one hour
- Pain restricts me to short necessary journeys under 30 min
- Pain prevents me from traveling except to the doctor or hospital



Neck Pain Disability Questionnaire (Vernon-Mior)

Section 1- Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2- Personal care (washing, dressing)

- I can look after myself normally without causing pain
- I can look after myself normal but cause more pain
- It is painful to look after myself and I am slow
- I need some help but manage most of my self-care
- I need help every day in most aspects of self-care
- I do not get dressed, I wash with difficulty and stay in bed

Section 3- Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives extra pain
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are coincidentally positioned on a table.
- Pain prevents me from lifting heavy weights but I can manage light weights
- I can lift only very light weights
- I cannot lift or carry anything at all

Section 4- Reading

- I can read as much as I want with no neck pain
- I can read as much as I want with slight neck pain
- I can read as much as I want with moderate neck pain
- I can't read as much as I want because of pain
- I can hardly read at all because of severe pain
- I cannot read at all

Section 5- Headaches

- I have no headaches at all
- I have slight headaches that come infrequently
- I have moderate headaches that come infrequently
- I have moderate headaches that come frequently
- I have severe headaches that come frequently
- I have headaches almost all of the time

Section 6- Concentration

- I can concentrate fully with no difficulty
- I can concentrate fully with slight difficulty
- I have a fair degree of difficulty concentrating
- I have a lot of difficulty in concentrating to
- I have a great deal of difficulty concentrating
- I cannot concentrate at all

Section 7- Work

- I can do as much as I want
- I can do my usual work but no more
- I can do most of my usual work but no more
- I cannot do my usual work
- I can hardly do any work at all
- I can't do any work at all

Section 8- Driving

- I can drive my car without any neck pain
- I can drive my car as long as I want with slight neck pain
- I can drive my car as long as I want with moderate neck pain
- I can't drive my car as long as I want because of moderate neck pain
- I can hardly drive at all because of severe neck pain
- I cannot drive my car at all

Section 9- Sleeping

- I have no trouble sleeping
- My sleep is slightly disturbed (less than 1 hr. sleepless)
- My sleep is mildly disturbed (1-2 hours sleepless)
- My sleep is moderately disturbed (2-3 hours sleepless)
- My sleep is greatly disturbed (3-5 hours sleepless)
- My sleep is completely disturbed (5-7 hours sleepless)

Section 10- Recreation

- I am able to engage in all my recreation activities with no pain
- I am able to engage in all my recreation activities with some pain
- I am able to engage in most but not all of my usual recreation activities because of neck pain
- I am able to engage in a few of my usual recreation activities because of neck pain
- I hardly do any recreation activities because of pain
- I cannot do recreation activities at all