



# ALEXANDER TAGHVA, MD

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## NEUROSURGERY

26732 Crown Valley Pkwy  
Suite 541  
Mission Viejo, CA 92691  
Phone (949) 388-7190  
Fax (949) 388-7150

### NEW PATIENT QUESTIONNAIRE

#### PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address (State, City, Zip): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had any recent imaging done?  Yes  No

If yes, what imaging study was done? \_\_\_\_\_ When? \_\_\_\_\_

Which facility?: \_\_\_\_\_ Phone: \_\_\_\_\_

#### INSURANCE INFORMATION

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Claims Phone#: \_\_\_\_\_

Secondary (if applicable): \_\_\_\_\_ ID#: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Claims Address: \_\_\_\_\_ Claims Phone#: \_\_\_\_\_

#### SOCIAL HISTORY

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital status:  single  married  divorced  widowed

Tobacco usage:  yes  no  former

If yes or former: Type: \_\_\_\_\_ Cigarettes/day: \_\_\_\_\_ Years smoked: \_\_\_\_\_ Year quit: \_\_\_\_\_

Alcohol usage:  yes  no  former

If yes or former: Drinks/ week: \_\_\_\_\_ Type: \_\_\_\_\_

Exercise level (circle one):  yes  no

If yes: Type: \_\_\_\_\_ Frequency: \_\_\_\_\_



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### SPINE HEALTH QUESTIONNAIRE

1. What is the main purpose of your visit?

2. Describe your problem(s):

a. Date of onset: \_\_\_\_\_

b. Describe the nature of your problem: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Alleviating factors:  nothing     elevation     ice     heat     gait aids  
 muscle relaxants     narcotics     NSAIDs     OTC medications     rest  
 steroid injections     other: \_\_\_\_\_

d. Aggravating factors:  bending     standing     sitting     driving     working  
 walking     bearing weight     other: \_\_\_\_\_

e. If you have pain:

• Frequency of pain:  Constant     Intermittent     Occasional

• Average pain level from 0 (none) to 10 (worst) : \_\_\_\_\_ / 10

f. Do you have numbness and tingling?

Yes, indicate where: \_\_\_\_\_  No

g. Do you have weakness?

Yes, indicate where: \_\_\_\_\_  No

h. Have you had other epidurals or facet injections?

Yes, indicate when and by whom: \_\_\_\_\_  No

i. Have you had physical therapy or chiropractic treatment?

Yes, indicate where and how many sessions: \_\_\_\_\_  No

3. Have you had any spinal surgeries?

Yes, indicate where and by whom: \_\_\_\_\_  No

4. Is your problem related to an accident?

Yes     No



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### PAST MEDICAL HISTORY

- |  |  |
|--|--|
| <input type="checkbox"/> Aneurysm              | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Brain Tumor           | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer, type: _____   | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Diabetes, type: _____ | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Other: _____        |

### FAMILY HISTORY

Relative	Condition	Living or deceased

If no known family history, please check here:

### SURGICAL HISTORY

Date	Surgeon	Surgery Name	Facility

If no surgical history, please check here:



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### PRIOR HOSPITALIZATIONS

Date	Reason	Facility

If no history of hospitalizations, please check here:

### CURRENT MEDICATIONS

Medication Name	Dosage	Frequency

If not taking any medications, please check this box:

### ALLERGIES AND SENSITIVITIES

Allergen	Sensitivity

If no allergies, please check this box:



**REVIEW OF SYSTEMS**

<b>General Health</b>		<b>Cardiovascular</b>	
Recent weight change?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain or angina pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No
Good general health for most of your life?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath walking/ lying down	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Head/ Eye/ Ear/ Nose/ Throat</b>		Difficulty walking 2 blocks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye disease or injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble/ heart attacks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of hands/ feet/ ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Awaking in the night smothering	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Itching eyes or nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gynecological (if applicable)</b>	
Sneezing or runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain with menstrual periods	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nosebleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pelvic conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Genitourinary</b>	
Ear disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Impaired hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness or transient unconscious episodes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night time urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Neck</b>		Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney stones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enlarged glands	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bright's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Respiratory</b>		<b>Musculoskeletal</b>	
URI (cold)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Varicose veins	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spitting up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness of muscles or joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic/ frequent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty walking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma or wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in calves or buttocks	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain relieved by rest?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lung problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Allergic</b>	
Pleurisy or pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any allergies, including medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Neuropsychiatric		Skin	
Have you ever had psychiatric care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been advised to see a psychiatrist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives, eczema, rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent infections or boils	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Open wounds	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hematological		Gastrointestinal	
Slow to heal after cuts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Peptic ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting blood or food	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful bowel movements	<input type="checkbox"/> Yes <input type="checkbox"/> No
Excessive bleeding after surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding with bowel movements	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal bruising or bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black stools	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocrine		Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent change in bowel habits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hormonal therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in hair growth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Changes in skin temperature and texture	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain or cramping	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Thank you for taking the time to fill out our forms. The following list will allow us to send letters to the appropriate people.

**Internist/ Primary Care Physician:** \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

**Pain Management Physician:** \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

**Neurologist:** \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

**Cardiologist:** \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_



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### HIPAA Authorization Release Form

#### Medical Information Release

I, \_\_\_\_\_, (your name), authorize Dr. Taghva to disclose my medical information to the following people:

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Unless specified, Dr. Taghva will divulge information strictly in the clinic or hospital settings. Should you wish to be contacted with potentially private information in other ways, please check the areas below:

- Ok to leave message on cell phone
- Leave message with callback number only
- Ok to email at the following email address: \_\_\_\_\_
- Ok to leave message on home phone with detailed message

#### Social Media Release

I, \_\_\_\_\_, (your name), volunteer to have my medical images (such as MRI and X-Ray films) used and disclosed as set forth in this authorization, primarily on social media (e.g. “before and after photos” on Instagram) to inform the public about neurosurgical procedures. I understand that my name, face, or any patient identifying information will not be disclosed in these posts unless specifically discussed with me.

- Check here if you do not wish to have your medical images used on social media.

This authorization will remain in effect until revoked by myself. I understand that I have the right to terminate this authorization by submitting a written statement to Dr. Taghva.

For any further questions regarding Dr. Taghva’s privacy statements, please feel free to discuss your concern with your doctor. This notice describes how the doctor may use and disclose patient information, restrictions on the use of and disclosure of healthcare information for patient listed on form, as well as the rights each patient has regarding privacy and protection of information.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_





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Thank you for taking the time to fill these forms out. We are grateful you are allowing us the opportunity to participate in your care. Our goal for each patient is to provide you with the highest level of service possible, and the most comprehensive visit with your provider. We look forward to seeing you soon.

Please mail/ bring these completed forms to the office at least 1 week prior to your appointment.

OR

You may email them back via [melissa@alextaghvamd.com](mailto:melissa@alextaghvamd.com)