ALEXANDER TAGHVA, MD
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

- ☐ Aneurysm
- ☐ Asthma
- ☐ Brain Tumor
- ☐ Cancer, type: _____
- ☐ Diabetes, type:_____
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Stroke
- ☐ Other: _____
- ☐ Other: _____
- ☐ 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: ☐

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REVIEW OF SYSTEMS

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

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

_____

_____

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