

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? _____

Where was your imaging study done? _____

Please remember to bring your disc on the day of your appointment or upload via our portal.

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: _____

VIKAS RAO, MD INC.
ORANGE COUNTY NEUROSURGICAL ASSOCIATES

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

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: _____

REASON FOR VISIT

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: _____

3. If you have pain, what makes it better? nothing elevation ice heat

gait aids muscle relaxants narcotics NSAIDs OTC medications

rest steroid injections other: _____

4. If you have pain, what makes it worse? bending standing sitting driving

working walking bearing weight other: _____

PAST MEDICAL HISTORY

Aneurysm

High blood pressure

Asthma

High cholesterol

Brain Tumor

Stroke

Cancer, type: _____

Other: _____

Diabetes, type: _____

Other: _____

Heart disease

Other: _____

SURGICAL HISTORY

Date	Surgeon	Surgery Name	Facility

If no surgical history, please check here:

PRIOR HOSPITALIZATIONS

Date	Reason	Facility

If no history of hospitalizations, please check here:

FAMILY HISTORY

Relative	Condition	Living or deceased

If no known family history, 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

Do you have any of the following?

General Health		Cardiovascular	
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
Head/ Eye/ Ear/ Nose/ Throat		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	Gynecological (if applicable)	
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	Genitourinary	
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
Neck		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
Respiratory		Musculoskeletal	
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	Allergic	
Pleurisy or pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any allergies, including medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

HIPAA Authorization Release Form

Medical Information Release

I, _____, (your name), authorize Dr. Rao to disclose my medical information to the following people:

Unless specified, Dr. Rao 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. Rao.

For any further questions regarding Dr. Rao’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 bring these forms to the office on the day of your appointment.

OR

You may send them back using the button below: