Navarro Pain Control Group, Inc.
Rosa M. Navarro, MD

Board Certified Anesthesiology
Subspecialty Certification in Intervention in Pain Management

# PATIENT REGISTRATION

**PATIENT LEGAL NAME (i.e. Social Security, Driver's License)**

| | | | | | |
|---|---|---|---|---|---|
| **LAST NAME** | | **FIRST NAME** | | **MIDDLE NAME** | |
| AKA | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **DATE OF BIRTH** | MONTH | DAY | YEAR | **DRIVER'S LICENSE** | | **SOCIAL SECURITY** | |

| | | | | | |
|---|---|---|---|---|---|
| **GENDER** | □MALE □FEMALE □OTHER □DECLINE TO ANSWER | **LANGUAGE (CHOOSE ONE)** | □ENGLISH □SPANISH □OTHER: _____ | **MARITAL STATUS** | □SINGLE □MARRIED □DIVORCED □WIDOWED □SEPARATED |

| | | | | | |
|---|---|---|---|---|---|
| **HOME PHONE** | | **CELL PHONE** | | **EMAIL ADDRESS** | |

**HOME ADDRESS – NO PO BOX**

| | | | | | |
|---|---|---|---|---|---|
| **STREET ADDRESS** | | | | | |
| **CITY** | | **STATE** | | **ZIP CODE** | |

**MAILING ADDRESS (IF DIFFERENT)**

| | | | | | |
|---|---|---|---|---|---|
| **STREET ADDRESS** | | | | | |
| **CITY** | | **STATE** | | **ZIP CODE** | |

| | | | | | |
|---|---|---|---|---|---|
| **WORK STATUS** | □EMPLOYED □UNEMPLOYED □ RETIRED □DISABLED □ SELF-EMPLOYED | **EMPLOYER** | | **WORK PHONE** | |

| | | | |
|---|---|---|---|
| **RACE (CHOOSE ONE)** | □AMERICAN INDIAN □ASIAN □AFRICAN AMERICAN □NATIVE HAWAIIAN □WHITE □OTHER □DECLINE TO DISCLOSE | **ENTHNICITY (CHOOSE ONE)** | □HISPANIC/LATINO □OTHER □NON-HISPANIC/LATINO □ DECLINE TO DISCLOSE |

**EMERGENCY CONTACT**

| | | | | | |
|---|---|---|---|---|---|
| **NAME** | | **RELATIONSHIP** | | **PHONE** | |

| | |
|---|---|
| **REFERRING PHYSICIAN** | |

**ASSIGMENT & RELEASE**

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NAVARRO PAIN CONTROL GROUP, INC. OR TO ROSA M. NAVARRO, MD. I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES.

| | | | |
|---|---|---|---|
| **PATIENT SIGNATURE** | | **DATE** | |

# DO NOT WRITE BELOW-OFFICE USE ONLY

**PATIENT NAME AS IT APPEARS ON INSURANCE CARD IF DIFFERENT**

| | | | | | |
|---|---|---|---|---|---|
| **LAST NAME** | | **FIRST NAME** | | **MIDDLE NAME** | |

**INSURANCE-PRIMARY**

| | | | | | |
|---|---|---|---|---|---|
| **INSURANCE NAME** | | **ID #** | | **GROUP #** | |
| **INSURED'S NAME** | | **DOB** | | **RELATIONSHIP** | |
| **INSURED'S SSN** | | **MEDICARE:** | | **MEDICAL:** | |

**INSURANCE-SECONDARY**

| | | | | | |
|---|---|---|---|---|---|
| **INSURANCE NAME** | | **ID #** | | **GROUP #** | |
| **INSURED'S NAME** | | **DOB** | | **RELATIONSHIP** | |
| **INSURED'S SSN** | | **MEDICARE:** | | **MEDICAL:** | |

| | | | |
|---|---|---|---|
| **CHECKED/COMPLETED BY** | | **DATE** | |



2452 Fenton Street Suite 101/203•Chula Vista, CA 91914•Phone (619)600-5309•Fax (619)655-4700

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## NEW PATIENT QUESTIONAIRE

| PATIENT NAME | | DATE OF BIRTH | |
|---|---|---|---|
| DATE OF SERVICE | | AGE | |

Please tell us why you are here (**CC**): _____

Which words **BEST** describe your pain, please check all that apply

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | THROBING | ☐ | ACHING | ☐ | SHARP | ☐ | DULL |
| ☐ | BURNING | ☐ | NUMBNESS | ☐ | STABBING | ☐ | ELECTRIC |
| ☐ | PINS & NEEDLES | ☐ | SHOOTING | ☐ | THIGHNESS | | |

**YOUR PAIN IS:**

| | | |
|---|---|---|
| ☐ | CONSTANT | |
| ☐ | ON/OFF | |
| ☐ | DURATION | |
| ☐ | TIMING | |
| ☐ | LOCATION | |

| **SELECT YES OR NO** | YES | NO |
|---|---|---|
| Did your PAIN start sudden? | | |
| Did your PAIN start gradually? | | |
| Where you in an MVA? | | |
| Where you injured at work? | | |
| Is legal action pending? | | |

| ****ALLERGIES**** | **YES** | **NO** |
|---|---|---|
| Allergy to any Medication? | | |
| Do you have any Allergies | | |
| If YES, please list Allergies | | |
| | | |
| | | |
| | | |

**ARE YOU TAKING ANY OF THESE MEDICATIONS:**

| | ****BLOOD THINNERS**** | | |
|---|---|---|---|
| ☐ | Aggrenox/Dipyridamole | ☐ | Heporin/Heporin |
| ☐ | Aritra/Foundaparinux | ☐ | Lovenox/Enoxaparin |
| ☐ | Bevyxxa/Betrixaban | ☐ | Plavix/Clopidogrel |
| ☐ | Brilinta/Tricagrelor | ☐ | Prodaxa/Dabigatran |
| ☐ | Cilostazol/Pletal | ☐ | Savaysa/Edoxaban |
| ☐ | Coumadin/Warfarin | ☐ | Trental/Pentoxifylline |
| ☐ | Effient/Prasugel | ☐ | Ticlid/Ticlopidine |
| ☐ | Eliquis/Apixaban | ☐ | Xarelto/Rivaroxaban |
| ☐ | Fragmin/Dalteparum | ☐ | None |

Please rate your pain on the following scale **ZERO** is **NO PAIN**, while **10** is the **WORST IMAGINABLE**

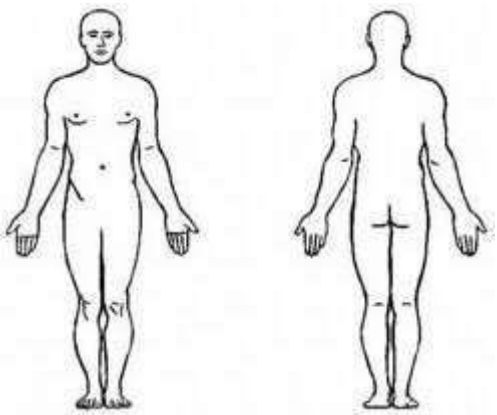
0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

**NO PAIN** **WORST PAIN**

How severe is your pain: ☐**MILD** ☐**MODERATE** ☐**SEVERE** ☐**INTOLERABLE**

**PLEASE MARK EVERYWHERE YOU EXPERIENCE PAIN**

FRONT BACK



RIGHT LEFT LEFT RIGHT

| Have you had any | **YES** | **NO** | cervical | thoracic | lumbar | other | |
|---|---|---|---|---|---|---|---|
| MRI'S | | | | | | | |
| X-Rays | | | | | | | |
| CT Scan | | | | | | | |
| CT Mylogram | | | | | | | |

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**IN THE BOXES BELOW PLEASE TELL US IF YOUR PAIN LIMITS THE FOLLOWING ACTIVITIES**

| | | |
|---|---|---|
| | Does pain affect you appetite? YES/NO/Explain | How many hours per day you work?<br>Type of work? |
| | How many hours do you sleep? | How does the pain limit your activities?<br>Type of activity: |
| | What makes your pain worst? | **Is pain causing depression or anxiety? YES/NO<br>Explain: |
| | What makes your pain better? | **Do you smoke tobacco? If NO, ☐FORMER ☐NEVER<br>If YES, ☐Since (date): ☐Frequency: |
| | Urinary Problems? YES/NO/Explain | **Do you drink alcohol? If NO, ☐FORMER ☐NEVER<br>If YES, ☐Since (date): ☐Frequency: |
| | Bowel problems? YES/NO/Explain | **Do you do any recreational drugs? YES/NO<br>(Cocaine, Heroin, or Marijuana) |

**PLEASE INDICATE IF YOU HAVE TRIED ANY OF THESE TREATMENTS AND IF THEY WERE EFFECTIVE**

| Treatment | Yes/No | Was the Treatment Effective? |
|---|---|---|
| Surgery | | |
| Physical Therapy | | |
| Chiropractor | | |
| Acupuncture | | |
| Massage | | |
| Biofeedback | | |
| TENS unit | | |
| Steroid Injections/Nerve Blocks | | |

**HOW IS YOUR PAIN TODAY:**

| | |
|---|---|
| | Improving |
| | Worsening |
| | Unchanged |

****PLEASE LIST ALL YOUR MEDICATIONS****

| Name of Drug, and Supplements | Strength or Dosage | Number of tablets | Total number of tablets per day | Reason for taking medication |
|---|---|---|---|---|
| | | | | |
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| | | | | |

| **PHARMACY NAME** | ADDRESS | PHONE & FAX |
|---|---|---|
| | | |

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| REVIEW OF SYSTEMS | (SELECT YES OR NO) | YES | NO | COMMENTS |
|---|---|---|---|---|
| CONSTITUTIONAL | Fever | | | |
| | Weight Loss | | | |
| EYES | Vision Problems | | | |
| EARS/NOSE/MOUTH | Hearing Aids? | | | |
| CARDIOVASCULAR | Chest Pain | | | |
| | Shortness of breath | | | |
| | Palpitations | | | |
| | Pedal Edema | | | |
| RESPIRATORY | Cough | | | |
| | Wheezing | | | |
| GASTROINTESTINAL | Reflux | | | |
| GENITOURINARY | Urinary Tract Infection | | | |
| MUSCULOSKELETAL | Muscle Pain | | | |
| INTEGUEMENTARY | Skin | | | |
| NEUROLOGICAL | Syncope (loss of consciousness) | | | |
| | Dizziness | | | |
| PSYCHIATRIC | Depression | | | |
| ENDOCRINE | Diabetes | | | |
| HEMATOLOGY/LYMPHATIC | Bleeding tendencies | | | |
| CANCER | Prior or Current | | | Type: □Chemo □ Radiation |

****PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS****

| | | | |
|---|---|---|---|
| □ Stroke | □ Heart Attack | □ Insulin dep. diabetes | □ Kidney Stones |
| □ Cancer | □ Heart Failure | □ Joint Pain | □ Easy Bruising |
| □ Headaches | □ Murmurs | □ Muscle Disease | □ Asthma |
| □ Memory Loss | □ Irregular Heart Beat | □ Broken Bones | □ Bronchitis |
| □ Pace Maker | □ High Blood Pressure/Hypertension | □ Fibromyalgia | □ Ulcer |
| □ Thyroid Disease | □ Emphysema | □ Peripheral Neuropathy | □ Shingles |
| □ Radiculopathy | □ Arthritis | □ Migraine | □ Low Back Pain |
| □ Pregnancy Now | □ Leg Pain | □ Arm Pain | □ Dialysis |
| □ High Cholesterol | □ Sleep apnea | □ Lupus | □Other |

****PLEASE LIST ALL SURGERIES****

| Surgery | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |

**SOCIAL HISTORY**

| MARITAL STATUS | | LIVING STATUS | | CHILDREN | |
|---|---|---|---|---|---|
| Married | | Lives alone | | YES | |
| Single | | Lives w/spouse | | NO | |
| Divorced | | Lives w/family | | How many? | |
| Widow | | Other | | Boy | |
| | | | | Girl | |

**FAMILY HISTORY**

| PATERNAL | YES/NO | MATERNAL | YES/NO |
|---|---|---|---|
| Alcohol Abuse | | Alcohol Abuse | |
| Drug Abuse | | Drug Abuse | |
| | | | |
| | | | |
| | | | |