Joseph C. Chavarria, MD
Orthopedic Surgery of The Spine
972.817.7450

New Patient Form

Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Age: _____ DOB: _____/_____/_____ Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

Physician Who Referred You: _____

Name of Primary Care Physician (PCP): _____

Chief Complaint:

Chief Compliant: _____

_____

_____

When did it start?: _____

How did it start?: _____

Please circle the quality of the complaints/pain:

Dull	Aching	Sharp	Stabbing	Sore
Burning	Tingling	Throbbing	Deep	Nagging

Does the pain radiate or move to any part of the body? Where? _____

_____

_____

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Severity of Complaint (1-10) with 0 being no pain/symptoms and 10 the worst pain imaginable:

0 1 2 3 4 5 6 7 8 9 10

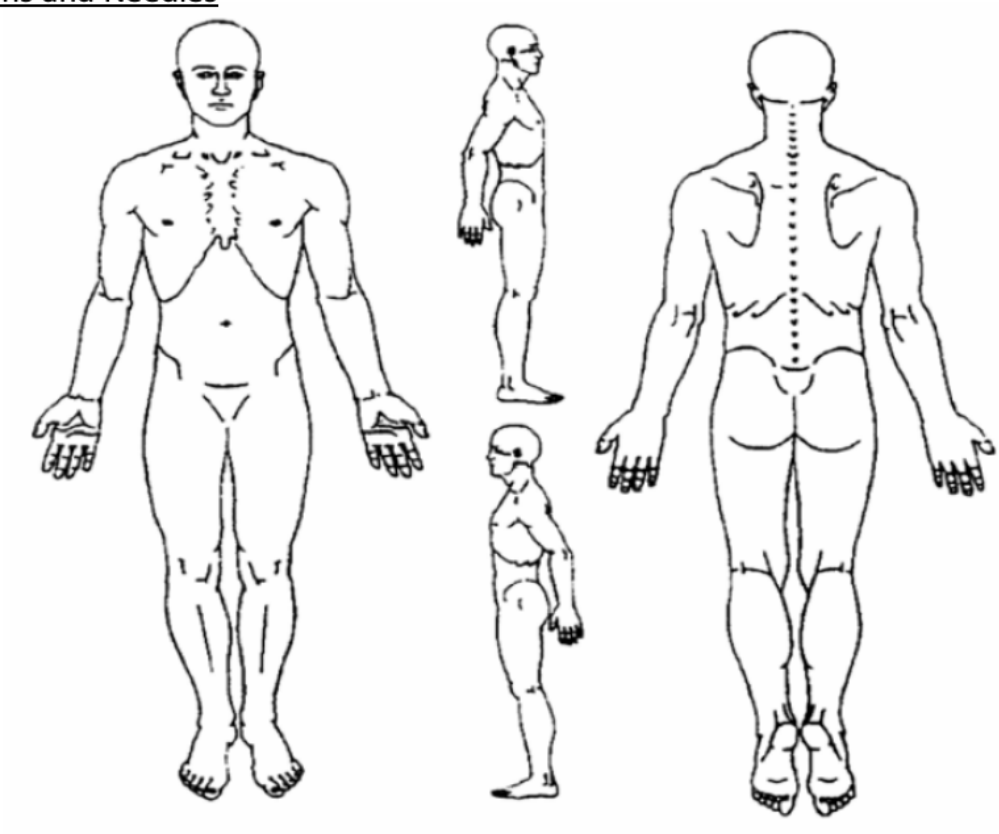
How Often Does it Bother You:

Occasional (0-25% of time) Intermittent (25-50% of time)

Frequent (50-75% of time) Constant (75-100% of time)

Please mark the area of discomfort on the diagram below using the appropriate symbols

Pain or burning **x x x x x**
Numbness **o o o o o**
Pins and Needles = = = = =



What makes it better? _____

_____

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What makes it worse? _____

_____

What have you tried (Medications, Physical therapy, Chiropractor, Braces, Injections, Traction, Etc.)? When did you start/for how long have you used it? Did it make you better, worse or no change? _____

_____

_____

_____

_____

_____

Have you seen any other doctors for this problem? If so, who and when? _____

_____

What imaging have you had for the problem? _____

_____

How much work have you missed because of the problem? _____

_____

Neck/Arm Pain: Skip if not applicable

What percentage of your pain is neck pain _____ versus arm pain _____

Example: 70% neck pain + 30% arm pain = 100%

Is it mainly left arm, right arm or both? _____

Do you have difficulty pick up small objects like coins or buttoning buttons? Do you drop things?

_____

_____

Do you feel unsteady or off-balance on your feet? _____

_____

Do you have weakness in one or both of your arms or hands? _____

_____

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Back/Leg Pain: Skip if not applicable

What percentage of your pain is back pain _____ versus leg pain _____

Example: 70% back pain + 30% leg pain = 100%

Is it mainly left leg, right leg or both? _____

Worst Position:

Standing Sitting Walking

How long can you stand/walk before you need to rest:

<5 minutes <30 minutes <60 minutes 60+ minutes

Sitting makes the pain better, worse or no different? _____

Bending forward makes the pain better, worse or no different? _____

Leaning makes the pain better, worse or no different? _____

Lying down makes the pain better, worse or no different? _____

Do you have bowel or bladder control issues? _____

_____

General Questions:

History of Spine Surgery? If so, what kind/where/when? Any complications? _____

_____

_____

_____

History of Abdominal/Pelvic Surgery? If so, what kind/where/when ? _____

_____

Do you take any blood thinning medications? If so, what kind/why ? _____

_____

Do you have Diabetes? If so, what was your most recent A1c? _____

_____

Baylor Scott & White
SPINE & SCOLIOSIS CENTER

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Are you taking any weight loss medications? If so, what medication? _____

_____

Are you taking any narcotic medications? If so, what kind/dose? _____

_____

Are you using any nicotine products? If so, what kind? _____

_____

Do you drink alcohol? If so, what kind and how much? Any illicit drug use? _____

_____

Have you had a DEXA or Bone Density Scan? Are you taking any medications for this? _____

_____

Have you had a vitamin D check? Are you taking any medications for this? _____

_____

Past Surgical History:

Type of Surgery	Approximate Year	Type of Surgery

Past Medical History:

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Bleeding disorder
- ☐ Blood clot in leg
- ☐ Blood clot in lung
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Heart disease
- ☐ Heart failure (CHF)
- ☐ Heart attack (MI)
- ☐ Stroke
- ☐ Lung disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Seizures
- ☐ Thyroid trouble
- ☐ Mental Illness
- ☐ Anemia
- ☐ Gout
- ☐ HIV
- ☐ Cancer
- ☐ Stomach ulcers
- ☐ Alcoholism
- ☐ Substance Abuse
- ☐ Serious injury
- ☐ Other _____

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Medications: Please list ALL current medications and doses

Allergies: Please list all known allergies to medications/foods and their reactions; Please include any reactions to anesthesia

Review of Symptoms:

Are you currently or have had problems with:			*** Please explain and describe all YES answers below**
Hematological / Bleeding problems	□ Yes	□ No	Describe _____
Unexplained weight loss	□ Yes	□ No	Describe _____
Skin	□ Yes	□ No	Describe _____
Ear, Nose, Throat	□ Yes	□ No	Describe _____
Stomach / Digestion	□ Yes	□ No	Describe _____
Bladder / Bowel problems	□ Yes	□ No	Describe _____
Musculoskeletal	□ Yes	□ No	Describe _____
Neurological	□ Yes	□ No	Describe _____
Psychiatric problems	□ Yes	□ No	Describe _____
Fever / Chills	□ Yes	□ No	Describe _____
Night sweats	□ Yes	□ No	Describe _____
Night pain / Pain at rest	□ Yes	□ No	Describe _____

Is there anything else you think we need to know/want us to address?