PRIVIUM
SPINE.PAIN.REHAB.

INTAKE AND HISTORIES

Past Medical History (please check all that apply):

- Δ Anemia, Chronic
- Δ Anxiety
- Δ Asthma
- Δ Atrial fibrillation
- Δ Breast Cancer
- Δ Chronic Pain
- Δ Colon Cancer
- Δ COPD
- Δ Coronary Artery Disease
- Δ Depression
- Δ Diabetes, Insulin Dependent
- Δ Diabetes, Non-Insulin Dependent
- Δ End Stage Renal Disease
- Δ GERD
- Δ Hepatitis
- Δ HIV/AIDS
- Δ High Cholesterol
- Δ Hyperparathyroidism
- Δ Hypertension
- Δ Hyperthyroidism
- Δ Hypothyroidism
- Δ Leukemia
- Δ Lung Cancer
- Δ Lymphoma
- Δ Multiple Myeloma
- Δ Obesity, Morbid
- Δ Obesity
- Δ PBPH
- Δ Prostate Cancer
- Δ Radiation Therapy
- Δ Seizures
- Δ Stroke
- Δ **None**
- Δ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other_____

Past Orthopedic History (please check all that apply):

- Δ Ankle Fracture
- Δ Ankylosing Spondylitis
- Δ Bursitis
- Δ DISH
- Δ Epidural Injections, Spine
- Δ Fracture
- Δ Gout
- Δ Hip Fracture
- Δ Herniated Disc, Cervical
- Δ Herniated Disc, Lumbar
- Δ Metastatic Bone Disease
- Δ Osteoarthritis
- Δ Osteopenia
- Δ Osteoporosis
- Δ Primary Bone Sarcoma
- Δ Psoriatic Arthritis
- Δ Rheumatoid Arthritis
- Δ Ricketts
- Δ RSD
- Δ Sciatica
- Δ Scoliosis
- Δ Spine Fracture
- Δ Soft Tissue Sarcoma
- Δ Spinal Stenosis, Cervical
- Δ Spinal Stenosis, Lumbar
- Δ Vertebral Body Compression Fracture
- Δ Vitamin D Deficiency
- Δ Wrist Fracture
- Δ **None**

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INTAKE AND HISTORIES

Past Orthopedic Surgery (please check all that apply):

- ☐ Ankle Fracture ORIF
  ☐Right ☐Left ☐Both
- ☐ Carpal Tunnel Decompression
  ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Femur
  ☐Right ☐Left ☐Both
- ☐ Intermedullary Nailing Tibia
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee
  ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder
  ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy
  ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Rotator Cuff Repair
  ☐Right ☐Left ☐Both
- ☐ Other _____
- ☐ **None**

Medications (please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

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INTAKE AND HISTORIES

Allergies (please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front deskreceptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (please inform us of your family members' medical history by marking the appropriate box)**:**

	Mother	Father	Sister	Brother	Daughter	Son	Other:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes							
*Other*_____							

- ☐ **No Family History** (checking this box indicates no past family medicalhistory)

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - ○ # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other_____

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - ○ _____

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INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Pain w/ breathing		
Joint swelling			Palpitations		
Difficulty Walking			Ankle Swelling		
Muscle Pain			Labored breathing w/exertion		
Weakness			Nausea		
Numbness			Vomiting		
Tingling			Diarrhea		
Fever			Constipation		
Weight Gain			Heartburn		
Rash			Ulcers		
Chest Pain			Blood in Stool		
Incontinence			Urinary Incontinence		
Shortness of Breath			Urinary hesitancy		
Suicidal thoughts			Urinary retention		
Weight loss			Blood in urine		
Chills			Genital pain		
Fatigue			Excessive bruising		
Discoloration			Excessive bleeding		
Scarring			Cancer		
Environmental Allergies			Excessive thirst		
Immunosuppression			Heat/Cold intolerance		
HIV/AIDS			Diabetes		
Blurred Vision			Thyroid Disease		
Double Vision			Joint Stiffness		
Glaucoma			Dizziness		
Eye pain			Fainting		
Ringing in the Ears			Headaches		
Loss of hearing			Tremor		
Nose bleeds			Seizure		
Hoarseness			Memory Loss		
Difficulty Swallowing			Depression		
Cough			Anxiety		
Wheezing			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker Diabetic			Hepatitis B or C		
Defibrillator			HIV/ADS		
Premedicate Prior to Procedure			Diabetes		
Hepatitis B or C					