VASCULAR & INTERVENTIONAL PHYSICIANS

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SPINE HISTORY — PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE IN FULL.
THE INFORMATION YOU PROVIDE IS IMPORTANT FOR YOU CARE.

PATIENT NAME_____ DATE OF BIRTH_____ DATE_____

ADDRESS_____

PHONE NUMBER_____ EMAIL_____

MARITAL STATUS ☐SINGLE ☐MARRIED ☐SEPARATED ☐DIVORCED ☐WIDOWED

OCCUPATION_____ DO YOU HAVE CHILDREN?_____ IF SO, HOW MANY?_____

HOW DID YOU HEAR ABOUT US_____

DO YOU SMOKE?_____ IF SO, HOW MUCH PER DAY?_____ HOW LONG HAVE YOU SMOKED? _____

HOW MANY GLASSES OF ALCOHOL DO YOU HAVE PER WEEK?_____ DO YOU USE RECREATIONAL DRUGS?_____

IF SO, WHAT KIND?_____ IF SO, HOW OFTEN?_____

PREFERRED LANGUAGE_____GENDER_____RACE_____

HISTORY OF ONSET

WHEN DID THIS CURRENT EPISODE OF PAIN / YOUR PROBLEM BEGIN?_____

DID THE PAIN / PROBLEM BEGIN: ☐ GRADUALLY ☐ SUDDENLY

HOW DID THIS EPISODE OF PAIN BEGIN?

☐ BENDING ☐ TWISTING ☐ PUSHING / PULLING ☐ LIFTING ☐ FALL

☐ MOTOR VEHICLE ACCIDENT ☐ OTHER: _____

IF YOUR PAIN IS DUE TO AN INJURY, BRIEFLY DESCRIBE THE EVENTS THAT LED TO THE INJURY.

_____

_____

WHERE ARE YOU EXPERIENCING YOUR PAIN? (CHECK ALL THAT APPLY)

☐ BACK ☐ HIP ☐ THIGH ☐ KNEE ☐ LOWER LEG

☐ ANKLE/FOOT ☐ NECK ☐ SHOULDER ☐ UPPER ARM ☐ ELBOW

☐ FOREARM ☐ WRIST/HAND

IF YOU HAVE BACK PAIN WITH LEG PAIN OR NECK PAIN WITH ARM PAIN, PLEASE ANSWER THE FOLLOWING:

DO YOU EVER HAVE YOUR BACK OR NECK PAIN WITHOUT YOUR LEG / ARM PAIN? ☐ YES ☐ NO

WHICH STATEMENT BEST DESCRIBES THE RATIO BETWEEN YOUR BACK/NECK PAIN AND LEG/ARM PAIN?

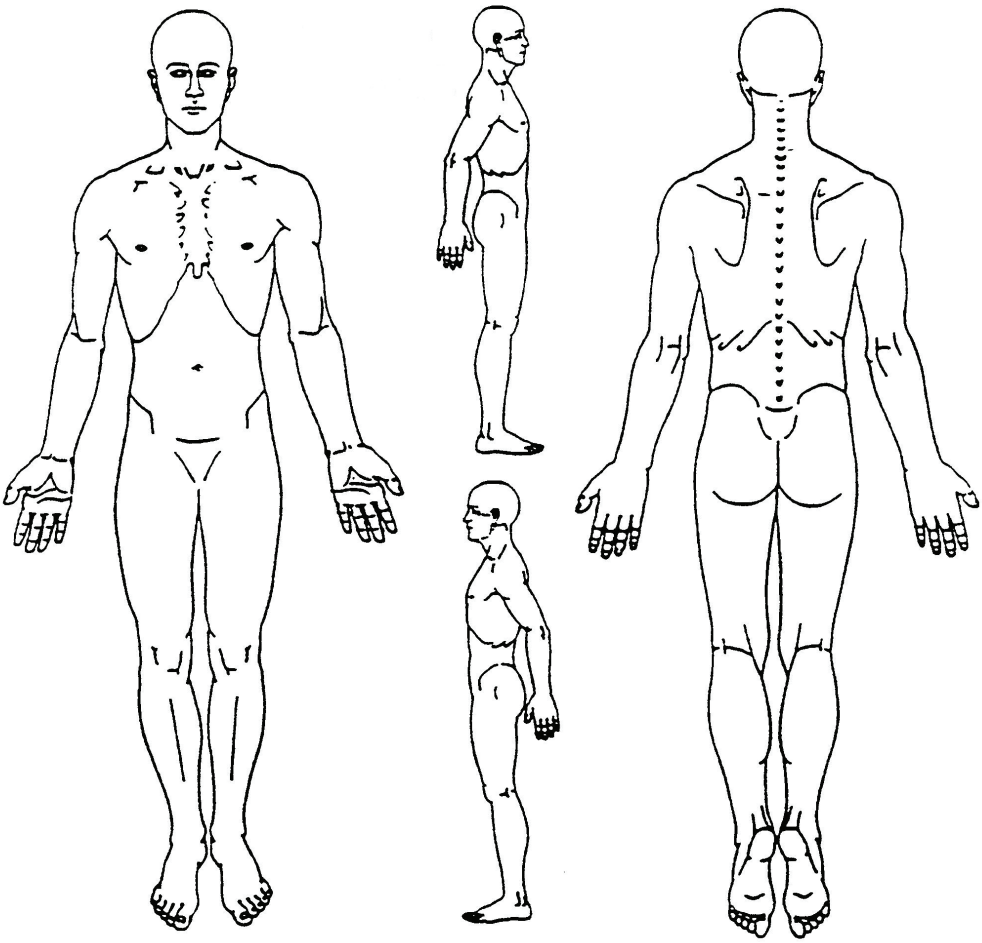
- ☐ 90% BACK OR NECK PAIN AND 10% LEG OR ARM PAIN
- ☐ 75% BACK OR NECK PAIN AND 25% LEG OR ARM PAIN
- ☐ 50% BACK OR NECK PAIN AND 50% LEG OR ARM PAIN
- ☐ 25% BACK OR NECK PAIN AND 75% LEG OR ARM PAIN
- ☐ 10% BACK OR NECK PAIN AND 90% LEG OR ARM PAIN

PLEASE CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR AVERAGE PAIN.

WHAT IS THE LEAST?	0	1	2	3	4	5	6	7	8	9	10
WHAT IS THE MOST?	0	1	2	3	4	5	6	7	8	9	10
WHAT IS IT TODAY?	0	1	2	3	4	5	6	7	8	9	10

USE THE DIAGRAM AND SYMBOLS TO INDICATE WHERE YOUR PAIN IS.

ACHE: AAA BURNING: XXX NUMBNESS: OOO PINS/NEEDLES: ... STABBING: ///



MEDICATIONS

LIST ALL THE MEDICATIONS YOU ARE CURRENTLY TAKING.

PLEASE INCLUDE OVER THE COUNTER, PRESCRIPTIONS AND VITAMINS.

NAME OF DRUG	DOSAGE	FREQUENCY

ALLERGIES

DESCRIBE ANY ALLERGIES TO MEDICATION AND THE REACTION YOU EXPERIENCE

OTHER ALLERGIES (FOOD, ADHESIVE TAPE, X-RAY CONTRAST DYE, LATEX, ETC)

LIST ANY PROBLEMS WITH MOBILITY OR SELF CARE:

DO YOU USE ANY MEDICAL EQUIPMENT AT HOME?

☐ WHEEL CHAIR ☐ WALKER ☐ CRUTCHES ☐ CANE ☐ PROSTHESIS

☐ HOME OXYGEN ☐ OTHER DEVICES:

IS THERE ANYTHING ELSE YOU WANT TO TELL US?

PLEASE CHECK THE ACTIVITIES THAT AFFECT THE PAIN OR YOUR PROBLEM.

	BETTER	WORSE	NO CHANGE		BETTER	WORSE	NO CHANGE
COUGHING				SNEEZING			
BENDING FORWARD				STRAINING			
BENDING BACKWARD				STANDING			
LYING ON BACK				WALKING			
LYING ON STOMACH				SITTING			
OVERHEAD REACHING				LIFTING			
SQUATTING				PUSHING/ PULLING			
KNEELING				DRIVING			
TYPING / WRITING				DURING ACTIVITY			
AFTER ACTIVITY							

MEDICAL ILLNESSES / PROBLEMS

PLEASE CHECK IF YOU HAVE HAD OR CURRENTLY HAVE PROBLEMS WITH ANY OF THESE:

☐ DIABETES ☐ HYPOTHYROID ☐ DEPRESSION ☐ HIGH BLOOD PRESSURE ☐ OSTEOPOROSIS
☐ ANXIETY DISORDER ☐ HEART DISEASE ☐ OSTEOARTHRITIS ☐ HEAD INJURY ☐ STROKE
☐ RHEUMATOID / LUPUS / GOUT OR OTHER CONNECTIVE TISSUE DISORDER ☐ OTHER_____

SURGICAL HISTORY

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SURGERIES

☐ CARDIAC BYPASS OR STENT ☐ GALLBLADDER SURGERY ☐ C - SECTION ☐ TONSILLECTOMY
☐ APPENDECTOMY ☐ HYSTERECTOMY (IF SO, THE AGE WHEN IT OCCURRED_____)
☐ PROBLEMS WITH SEDATION ☐ SPINE SURGERY ☐ JOINT SURGERY

FAMILY HISTORY

PLEASE CHECK IF ANYONE IN YOUR IMMEDIATE FAMILY HAS ANY OF THESE ILLNESSES / PROBLEMS

☐ DIABETES ☐ HYPOTHYROID ☐ DEPRESSION ☐ HIGH BLOOD PRESSURE ☐ OSTEOPOROSIS
☐ ANXIETY DISORDER ☐ HEART DISEASE ☐ OSTEOARTHRITIS ☐ CANCER ☐ STROKE
☐ RHEUMATOID / LUPUS / GOUT OR OTHER CONNECTIVE TISSUE DISORDER

REVIEW OF SYSTEMS

DURING THE PAST YEAR, HAVE YOU HAD ANY OF THE FOLLOWING?

☐ UNEXPLAINED FEVERS ☐ CHEST PAIN OR TIGHTNESS ☐ VALLEY FEVER ☐ NIGHT SWEATS
☐ TROUBLE BREATHING ☐ CHANGE IN BOWEL HABITS ☐ UNEXPLAINED WEIGHT LOSS
☐ PERSISTENT COUGH ☐ BLACK OR BLOODY STOOLS ☐ EXCESSIVE FATIGUE ☐ DEPRESSION
☐ SWOLLEN ANKLES/LEGS ☐ CHANGE IN BLADDER HABITS ☐ STIFFNESS IN JOINTS ☐ HOARSENESS
☐ PAINFUL URINATION ☐ JOINT SWELLING / WARMTH ☐ DIFFICULTY SWALLOWING ☐ ANXIETY
☐ URINARY INCONTINENCE ☐ UNUSUAL RASHES ☐ MENSTRUAL PROBLEMS ☐ EASY BRUISING
☐ UNUSUAL STRESS IN HOME LIFE ☐ SWOLLEN LYMPH NODES ☐ DIFFICULTY SLEEPING
☐ UNUSUAL STRESS IN WORK LIFE

VASCULAR & INTERVENTIONAL PHYSICIANS

PERMISSION TO DISCUSS MEDICAL INFORMATION

Do you authorize Vascular and Interventional Physicians & Medical Diagnostic Imaging Group to discuss your care and treatment with any party beside yourself? ☐NO ☐YES

Name_____Relationship_____Number_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending a written notification to the following person:

Medical Diagnostic Imaging Group

Attn: Privacy Officer

P.O. Box 17049

Phoenix, AZ 85011

CONSENT TO LEAVING PHI ON TELEPHONE MESSAGING SERVICES

At the discretion of Medical Diagnostic Imaging Group & Vascular and Interventional Physicians, its employees, medical staff, and agents (MDIG & VIP) and upon your agreement to the terms outlined within this consent form, you authorize (MDIG & VIP) to leave protected health information (PHI) on voice mail or other telephone messaging services. These messages may contain your personal health information such as test results and medication changes. If you authorize this, you should be aware that voice mail and other telephone messaging services are not secure or private, and such, unauthorized people may be able to retrieve and hear such communications.

I understand that information used to or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. By signing this form, I authorize you to disclose the protected health information described above.

Patient Name_____Date of Birth_____

Signature_____Date_____

Relationship to patient_____

VASCULAR & INTERVENTIONAL PHYSICIANS

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

Original to be maintained in patient's permanent medical record.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient or legally authorized individual signature	Date
Printed name if signed on behalf of the patient	Relationship (Parent, legal guardian, personal representative, etc)