Pike Medical Consultants

PrimaryCare Indy UrgentCare Indy LungCare Indy

We listen with our hearts.

Appointment Date: _____ Appointment Time: _____

Thank you for choosing Pike Medical Consultants for your medical needs. Our goal is to provide you with the same compassion, devotion, and respect we demonstrate to every patient who comes into our office.

Like most physician groups, our practice uses a history questionnaire for first-time patients. We have designed this questionnaire for the specifics of our practice. It should serve three functions:

1. Act as a checklist to ensure that important questions are always asked
2. Improve the quality of the history by giving you time to recall important details
3. Save time during the office visit

PLEASE BRING:

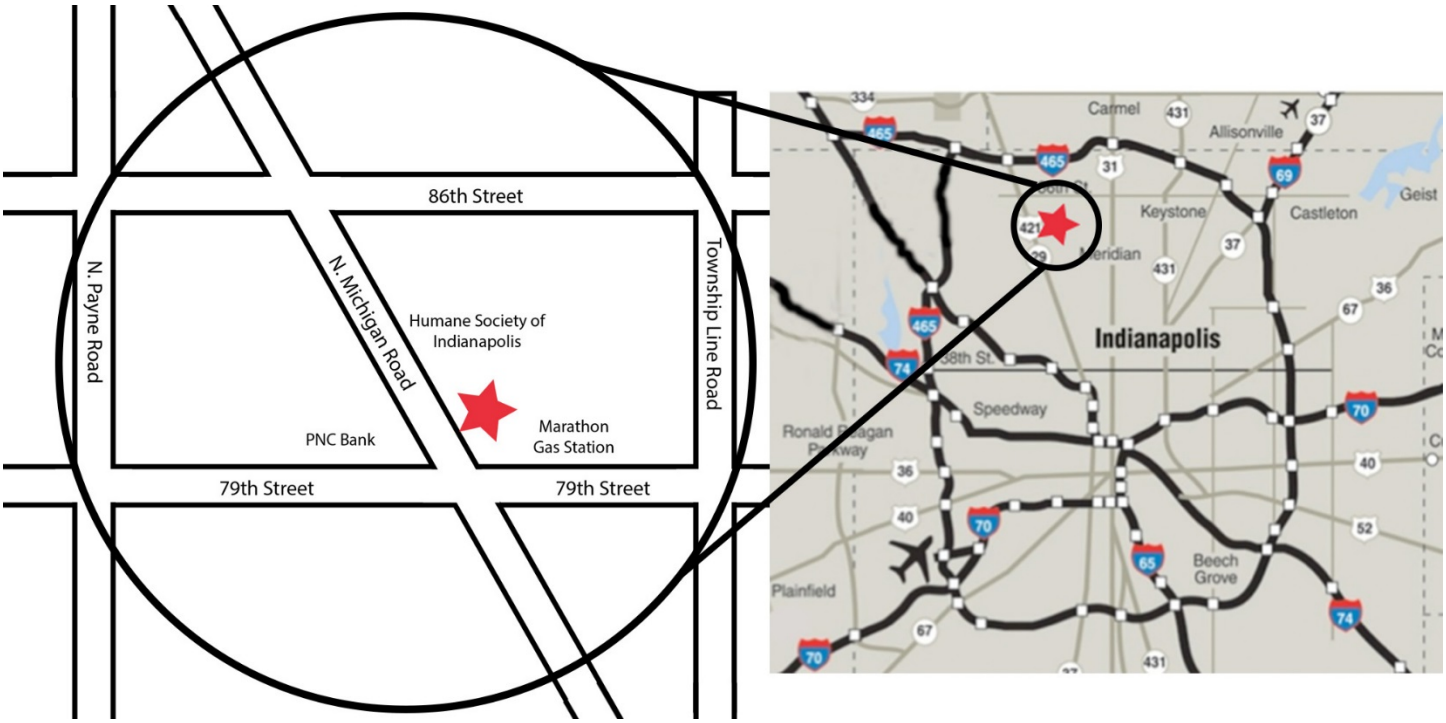
- **Insurance cards and a photo ID.**
- **All forms attached to this coversheet filled out to the best of your ability.**
- **A current list of medications** (including dose and frequency). Remember to include insulin, inhalers, eye drops, vitamins, and herbal supplements.

YOU MAY BE ASKED TO RESCHEDULE IF YOU ARE MORE THAN 15 MINUTES LATE FOR YOUR ARRIVAL TIME. If your insurance policy has an office visit co-pay, it will be collected upon registration. We accept cash and credit/debit cards with a Visa, MasterCard, or Discover logo.

If you have any questions, please call our office **(317) 956-62**

PRIMARYCARE Indy

7911 N. Michigan Road Indianapolis, IN 46268 | 317.956.6288 | pikemedical.com



If North of Indianapolis	If South of Indianapolis	If East of Indianapolis	If West of Indianapolis
- Take I-65 South - Merge onto I-865 E - Merge onto I-465 S - Take exit 27, Michigan Road - Turn right off the exit ramp - Continue on Michigan Road/US-421 N. - Destination is on the left just before 79th street	- Take I-74 West to I-65 North - Take exit 116 toward 30th St. - Merge onto W. 30th St. via the ramp on the left toward Indianapolis Museum of Art/Butler Univ. - Turn right onto Martin Luther King Jr. St. This becomes Michigan Rd. - Destination is on the right	- Take I-70 W or 69 S - Merge to 65 N. via exit 83B - Take exit 116 toward 30th St. - Merge onto W. 30th St. via the ramp on the left toward Indianapolis Museum of Art/Butler Univ. - Turn right onto Martin Luther King Jr. St. This becomes Michigan Rd. - Destination is on the right	- Take US I-70 or I-74 East - Merge onto I-465 N - Take exit 21 onto 71st St. - Keep left to take the 71st St. ramp - Turn right onto 71st St. - Turn left onto Michigan Road - Destination is on the right

Adult Medical History Form

*****PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT*****

Patient Name_____ **Date of Birth** _____**Date of Service:**_____

What is your ***main complaint*** today?

_____

_____

_____

Please be aware that our clinic will refer you to a psychiatrist or other specialist for management of ADD/ADHD medications.
Our medical practice declines to manage and write prescriptions for chronic pain conditions.

Prescription Medications (including Herbs/ Supplements/ Vitamins)	**Dose**	**Frequency**

Medication Allergy	Reaction

Past Medical History (include date of onset)

☐ADD/ADHD	☐Diabetes	☐Kidney Stones
☐ADD/ADHD	☐Diarrhea	☐Liver Disease
☐Abdominal Pain	☐Dizziness/Vertigo	☐Lupus
☐Allergies	☐Emphysema	☐Mononucleosis
☐Anemia	☐Fibromyalgia	☐Pneumonia
☐Anxiety	☐Gastroesophageal Reflux	☐Prostate Problems
☐Arthritis	☐Glaucoma	☐ Infections
☐Atrial Fibrillation	☐Gout	☐Skin Problems
☐Bleeding Disorder	☐Headache	☐Sleep Apnea (CPAP use Y/N)
☐Blood Clot (DVT or PE)	☐Heart Disease (heart attack, stent, bypass)	☐Staph infections/MRSA
☐Bowel Obstruction	☐Hemorrhoids	☐Stroke/TIA
☐Cancer (type _____)	☐Hepatitis B	☐Thyroid Disease
☐Chronic Cough	☐Hepatitis C	☐Ulcers
☐Chronic Pain	☐Hernia	☐Recent Urinary Tract Infection
☐COPD/Emphysema	☐HIV	☐Vascular Disease
☐Colitis/Crohn's	☐High Blood Pressure	
☐Congestive Heart Failure	☐High Cholesterol	**Females Only**
☐Constipation	☐High Triglycerides	Age at first menses _____
☐Dementia	☐Insomnia	Age at menopause _____
☐Depression	☐Kidney Failure	Number of pregnancies _____

Surgical History	**Date**	**Surgeon**	**Hospital**	**Complications?**

Family History	Living/Deceased	Heart Disease (? age of onset)	Stroke	Cancer (? type)	Diabetes	Other Illness
Mother						
Father						
Siblings						
Children						

Social History	Quantity Daily	Years Used	Tried to Quit (Y/N)?	Had Withdrawal (Y/N)?	Continued Use (Y/N)?
Tobacco (? type)					
Alcohol					
Drugs					

Exercise ☐Very Active ☐Moderately Active ☐ Sedentary
Marital Status ☐Single ☐Married ☐Divorced ☐ Widowed

Occupation_____

Patient Health Questionnaire (PHQ-9):

Over the past 2 weeks, how often have you been bothered by any of the following problems?
Please circle or mark on the number to indicate your answer

Questions:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tires or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bas about yourself – or that you are failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating or things, such as reading that newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3

Add columns: _____+ _____ +_____

Total Score: _____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Drive 4 COPD:

Please place a "X" in the box that best describes your answer for each question below.

1. During the past 4 weeks, how much of the time did you feel short of breath?

☐ 0	☐ 0	☐ 1	☐ 2	☐ 2
None of the time	A little of the time	Some of the time	Most of the time	All of the time

2. Do you ever cough up any "stuff," Such as mucus or Phlegm?

☐ 0	☐ 0	☐ 1	☐ 1	☐ 2
No, Never	Only with occasional colds or chest infections	Yes, a few days a month	Yes, most days a week	Yes, every day

3. Please select the answer that best describes you in the <u>past 12 months,</u> I do less that I used to because of my breathing problems?

☐ 0	☐ 0	☐ 0	☐ 1	☐ 2
Strongly agree	Disagree	Unsure	Agree	Strongly agree

4. Have you smoked at least 100 cigarettes in your ENTIRE LIFE?

☐ 0	☐ 2	☐ 0
No	Yes	Don't Know

5. How old are you?

☐ 0	☐ 1	☐ 2	☐ 2
Age 35 to 49	Age 50 to 59	Age 60 to 69	Age 70+

Please leave this for the Physician to complete:

Score = _____ + _____ + _____ + _____ + _____ = _____

#1 #2 #3 #4 #5 Total Score

Total Score= 5 or more
Problems may be caused by COPD

Total Score= 0 to 4
If you are experiencing issues, then please let us know at your upcoming appointment

Preventive Care

	Pneumonia Vaccination	ASA 81mg	Shingrix Vaccination	PSA	Colonoscopy	Skin Exam	EKG	Lipid Panel	Blood sugar	Dental Exam	Eye Exam	Flu Vaccination
WHEN	Prevnar: Y or N Pnemovax: Y or N											
	Hysterectomy	Pap Smear	Mammogram	**Women:**						65 AAA Ultrasound	55 Low Dose CT	**Smokers:**
WHEN	Y or N											

Within the past 12 months, have you experienced:

☐Fever	☐Chills	☐Feeling Poorly	☐Feeling Tired	☐Weight Gain/Loss
☐Eye Pain	☐Eye Redness	☐Vision Change	☐Eye Discharge	☐Nosebleeds
☐Dry Eyes	☐Itchy Eyes	☐Earache	☐Hearing Loss	☐Runny Nose
☐Sore Throat	☐Hoarseness	☐Slow Heart Rate	☐Fast Heart Rate	☐Palpitations
☐Leg Swelling	☐Chest Pain	☐Wheezing	☐Cough	☐Snoring
☐Shortness of Breath	☐Nausea	☐Vomiting	☐Constipation	☐Diarrhea
☐Abdominal Pain	☐Bloody Stool	☐Tarry Stool	☐Heartburn	☐Incontinence of Stool
☐Urinary Burning	☐ Incontinence of Urine	☐Pelvic Pain	☐Urinary Frequency	☐Urinary Retention
☐ Urinary Infection	☐Skin Lesions	☐Skin Wounds	☐Skin Infections	☐Dry Skin
☐Itching	☐Breast Pain	☐Breast Lump	☐ Breast Discharge	
☐ Headaches	☐Confusion	☐Convulsions	☐Dizziness	☐Fainting
☐Weakness	☐Insomnia	☐Anxiety	☐Depression	☐Suicidal Thoughts
☐Easy Bleeding	☐Easy Bruising	☐Blood Clots	☐Swollen Glands	

Additional Information

_____

_____

_____

All of the above statements are true and accurate. **Patient Signature**_____

Reviewed by Medical Provider_____ **Date**_____

PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT **PATIENT REGISTRATION**

Patient Information

First Name	Middle Initial(s)	Last Name	
Street Address	City	State	Zip Code
Date of Birth	Primary Phone Number	Secondary Phone Number	
Social Security Number	□ Male □ Female	Email Address	
What is your preferred method of contact? □ Phone □ Email		May we leave a message? □ Yes □ No	
Marital Status □ Single □ Married □ Divorced □ Widowed	Preferred Language □ English □ Spanish □ Other:		
Race □ Asian □ Black or African American □ Native American □ White □ Other:		Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino	
Current Employer or Employment Status	City	State	Phone Number
How did you hear about us: □ Physician Referral □ Internet: Google/Bing/Yahoo □ Word of Mouth □ 86th Street Sign □ KLOVE □ Other:			
Emergency Contact Name	Phone Number	Relation to Patient	
Family Physician Name	Physician Phone Number	Preferred Pharmacy	Pharmacy Phone Number
If necessary, may we verify your prescriptions with pharmacy records? □ Yes □ No			

Current Billing Information

Responsible Party's Name □ Self		Relationship to Patient	Date of Birth
Street Address		City	State / Zip Code
□ I do not currently have medical insurance (check box and skip to signature line)			
Primary Insurance Company		Group Number	Policy/ID Number
Policy Holder's Name	Date of Birth	Social Security Number	Relation to Patient
Employer	City, State and Zip Code		Phone Number
Secondary Insurance Company		Group Number	Policy/ID Number
Policy Holder's Name	Date of Birth	Social Security Number	Relation to Patient
Employer	City, State and Zip Code		Phone Number
Prescription Plan Name (if applicable)	Prescription Plan ID Number		Contact Number

Authorization and Assignment

(APPLIES TO MEDICARE PATIENTS ONLY) I request that payment of authorized MEDICARE benefits be made either by me or on my behalf to provide for any services furnished to me by a medical provider. I authorize the holder of my medical information to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

(APPLIES TO MEDIGAP PATIENTS ONLY) I request that payment of authorized MEDIGAP benefits be made either by me or on my behalf to provide for any services furnished to me by a medical provider. I authorize any holder of medical information about me to release to my MEDIGAP insurance any information needed to determine these benefits payable for related services.

ALL PATIENTS/GUARANTORS: I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to the medical provider, the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. If for any reason my account should become delinquent, I agree to pay for all collection and legal fees. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain valid until revoked by me or my legal representative.

Signature of Responsible Party **Today's Date** **v11/13**