# Pike Medical Consultants

UrgentCare Indy | WeightCare Indy | GeriCare Indy

PULMONARY | OCCUPATIONAL HEALTH | COUNSELING SERVICES

## Primary Care Clinic

**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) 956-6288**

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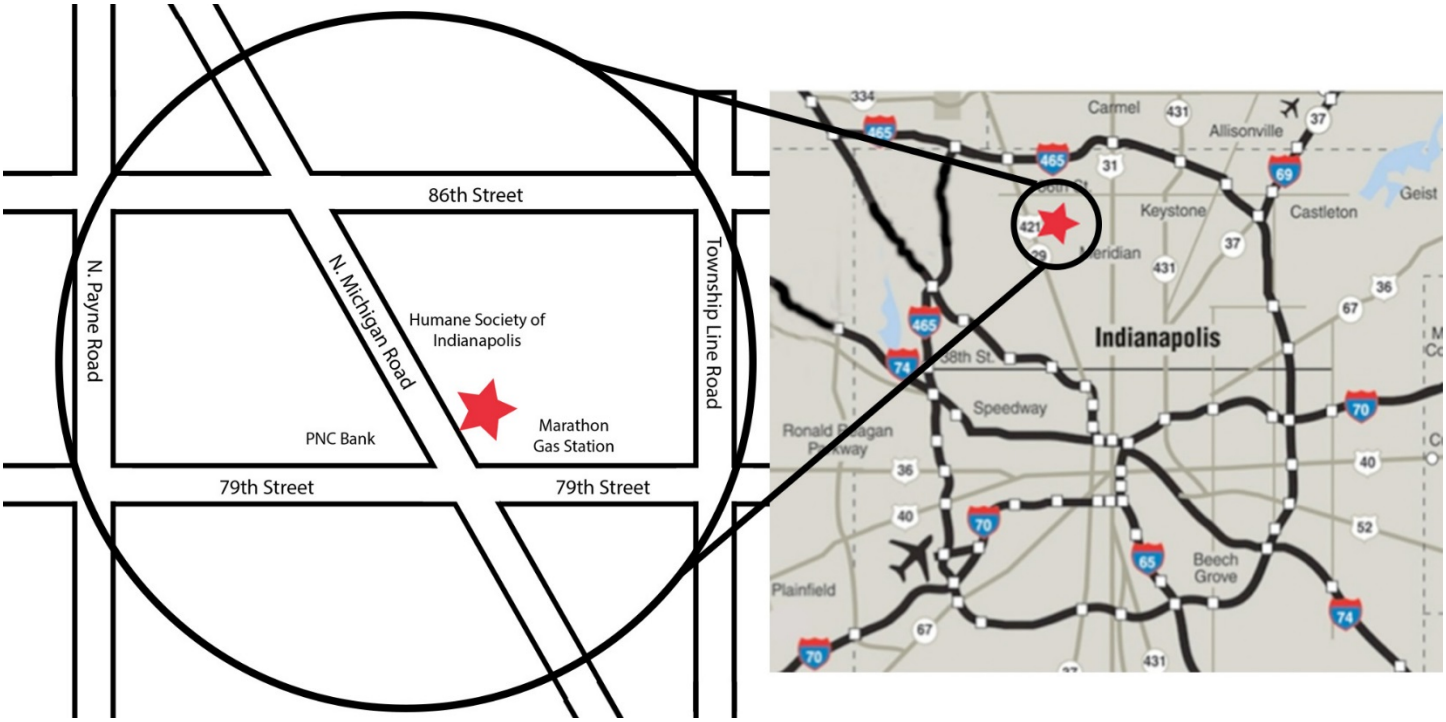
7911 N. Michigan Road Indianapolis, IN 46268 | 317.956.6288 | pikemedical.com




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

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

**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**

**Email Form to PrimaryCare Indy**