

PIKE MEDICAL CONSULTANTS



PULMONARY | OCCUPATIONAL HEALTH | COUNSELING SERVICES

Physicians - Dr. James D. Pike

Providers - Larry Vandermolen PA-C, Heather Foxworthy ANP-BC

Dear _____,

Your surgeon has referred you to our office so that we may perform a preoperative assessment prior to your upcoming procedure. You will meet with one of our providers for a detailed medical history and brief physical exam, including electrocardiogram and blood work. Please take your usual medications and eat in your usual manner before your visit. Our goal is to provide you with the safest environment possible for your procedure and your recovery. **The visit to our office will be approximately 1 to 2 hours long.**

PLEASE BRING:

- **Insurance cards and a photo identification.**
- **Completed preoperative history forms (attached).**
- A **current list of medications** (including dose and frequency). Remember to include insulin, inhalers, eye drops, vitamins, and herbal preparations.
- **IF APPLICABLE, any cardiac testing reports and/or other procedure notes** within the past five years (this includes: electrocardiograms, stress testing, laboratory testing, etc.). You may also have these faxed to our office by your physician.

Your Appointment is on _____, _____ **at** _____.

Please arrive at _____.

You may be asked to reschedule if you are more than 15 minutes late for your arrival time. If you are required by your insurance policy to pay an office visit copay we will collect it at the time of registration.

If you have any questions, please call our office between the hours of 9am and 4pm. We look forward to treating you at our preoperative center.

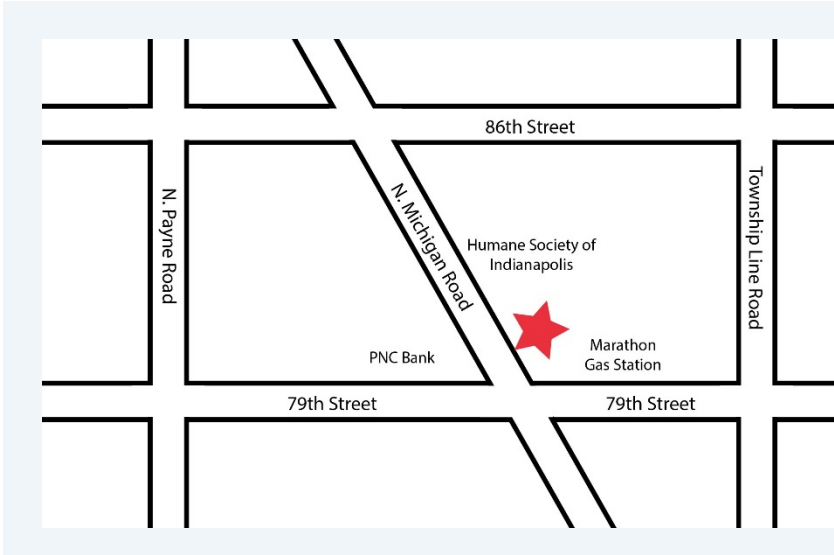
"The best care, the best way, each day, with compassion, devotion, and respect."

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



Pike Medical Consultants is located at 79th and Michigan Rd.

If North of Indianapolis	If South of Indianapolis	If East of Indianapolis	If West of Indianapolis
<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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 	<ul style="list-style-type: none"> - 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

Pike Medical Consultants Preoperative Evaluation

PLEASE COMPLETE ALL SECTIONS PRIOR TO YOUR APPOINTMENT

Patient Name _____

Date of Birth _____

Primary Care Physician _____

Pharmacy Name _____

Phone (____) _____

Other Specialists (include type) _____

Have you been seen by Pike Medical before? No Yes When? _____

Past Medical History

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Dementia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Allergies	<input type="checkbox"/> Depression	<input type="checkbox"/> HIV	<input type="checkbox"/> Recent Urinary Tract Infection
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> High Triglycerides	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Infections	<input type="checkbox"/> Skin Problems
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Sleep Apnea (CPAP use Y/N)
<input type="checkbox"/> Blood Clot (DVT or PE)	<input type="checkbox"/> Gastroesophageal Reflux	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Staph infections/MRSA
<input type="checkbox"/> Bowel Obstruction	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Heart Disease (heart attack, stent, bypass)	<input type="checkbox"/> Lupus	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Colitis/Crohn's Disease	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Vascular Disease
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Murmur	
<input type="checkbox"/> Constipation		<input type="checkbox"/> Pneumonia	

Patient Name _____

Previous Heart Testing

TEST	WHERE	WHEN	WHY WAS IT DONE?	RESULTS, IF KNOWN
EKG				
Echocardiogram				
Stress Test				
Heart Cath				
Who is your cardiologist?				
When were you last seen?				

Current Medications List is attached

Name	Dose	Frequency

Herbs, Supplements and Vitamins

Allergies

Medication Allergy	Reaction

Past Surgical History

Would you accept blood products or blood transfusions if necessary? Yes No

Surgery	Date	Surgeon	Hospital	Outcome	Complications?








Patient Name _____

Social History

Type	Quantity Daily	Years of Use	Ever Tried to Quit (Y/N)? When?	Ever Had Withdrawal (Y/N)?
Tobacco				
Drugs				
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed
Exercise	<input type="checkbox"/> Very Physically Active	<input type="checkbox"/> Moderately Active	<input type="checkbox"/> Inactive	
Occupation				
Religion				

Alcohol Use

Circle the type of alcohol you typically consume and indicate below the quantity daily

Beer	Malt Liquor Craft Beer	Table Wine Sparkling Wine	Sherry/Port	Cordial/Aperitif	Brandy	Hard Liquor
12 fl oz	8-9 fl oz	5 fl oz	3-4 oz	2-3 oz	1.5 oz	1.5 fl oz
						
5% alcohol	7% alcohol	12% alcohol	17% alcohol	24% alcohol	40% alcohol	40% alcohol

Have you ever had symptoms of alcohol withdrawal (seizures, shaking, jitteriness)? Yes No

Family History

	Living or Deceased (Age of death)	Heart Disease (include details and age at onset)	Stroke	Cancer	Blood Clot	Diabetes	Other Inherited Illness
Mother							
Father							
Siblings							
Children							

Anxiety/Depression

Have you ever been treated for anxiety or depression? Yes No If so, when? _____ Currently in treatment? Yes No

Are you anxious about your upcoming surgery? Yes No

Have you experienced depression following your past surgeries? Yes No

Would you like to talk with our counselor about your feelings? Yes No

Patient Name _____

Bone Health

Have you ever had a bone density (DEXA) test? Yes No

Where _____ When _____ Results: Normal Osteopenia Osteoporosis

Are you currently being treated for Osteopenia or Osteoporosis?

No

Yes Medication _____ How long have you taken it? _____

Have you broken a bone in your adult life? Yes No

Location of break _____ How did you break it? _____

Have you lost more than 1 ½ inches (women) or 2 inches (men) in height? Yes No

Did anyone related to you break their hip or spine? Yes No Details _____

Within the Past 12 Months, Have You Had

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

Additional Information

To the best of my knowledge, all of the above statements are true and accurate.

Patient Signature _____

Date _____

Reviewed By _____

American Urological Association Urinary symptom score (International Prostate Symptom Score [IPSS])

Questions to be answered	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost always
(Circle one number on each line)						
1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
3. Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
4. Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
7. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0 (none)	1 (1 time)	2 (2 times)	3 (3 times)	4 (4 times)	5 (5 or more times)
Sum of circled numbers (AUA symptom score): _____						
0 to 7: Mild symptoms						
8 to 19: Moderate symptoms						
20 to 35: Severe symptoms						

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		<input type="checkbox"/> Male <input type="checkbox"/> Female		Email Address	
	What is your preferred method of contact? <input type="checkbox"/> Phone <input type="checkbox"/> Email			May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			Preferred Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
	Race <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other:			Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		
	Current Employer or Employment Status		City	State	Phone Number	
	How did you hear about us: <input type="checkbox"/> Physician Referral <input type="checkbox"/> Internet: Google/Bing/Yahoo <input type="checkbox"/> Word of Mouth <input type="checkbox"/> 86 th Street Sign <input type="checkbox"/> KLOVE <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Current Billing Information	Responsible Party's Name <input type="checkbox"/> Self		Relationship to Patient		Date of Birth	
	Street Address		City		State	Zip Code
	<input type="checkbox"/> 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