# Pike Medical Consultants

# Primary Care Questionnaire

**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.

Do not be put off by the apparent length of the questionnaire. We hope you will find the form to be self-explanatory. If there is a question that you do not understand, please leave it blank and put a question mark in the left-hand margin. Please be prepared for a 40 minute long appointment.

**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 between the hours of 9am and 4pm.

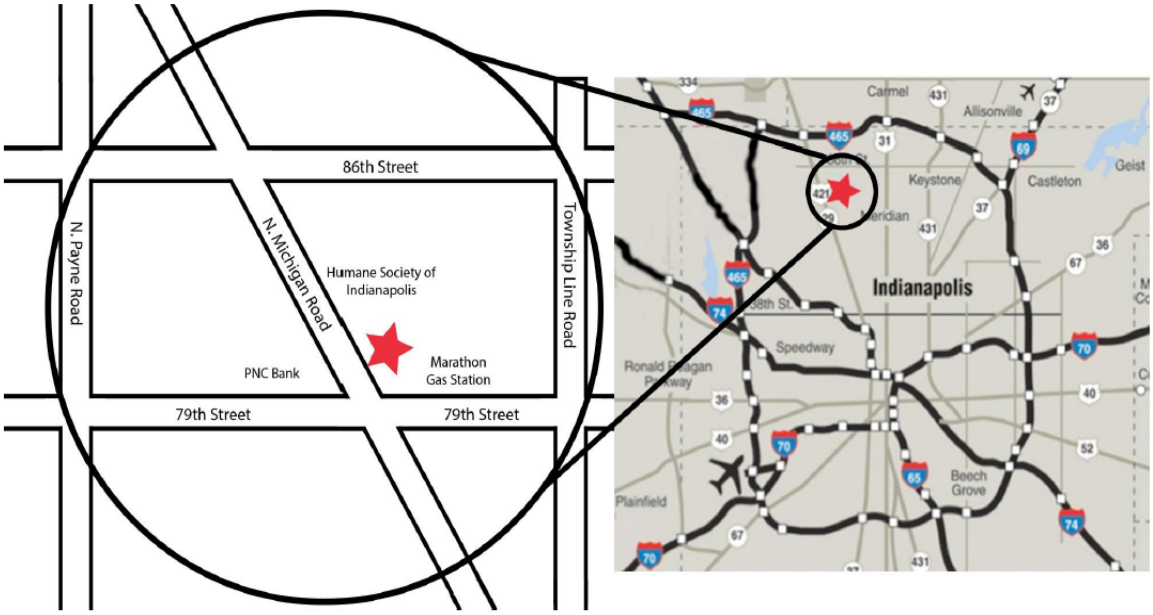
**Please note: We do NOT offer pain management of any kind. No exceptions.**

# Pike Medical Consultants

UrgentCare Indy | WeightCare Indy | GeriCare Indy

PULMONARY | OCCUPATIONAL HEALTH | COUNSELING SERVICES

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?** ***(As a rule, we do not provide pain management or prescribe ADD/ADHD medications.)***

_____

_____

**What medications are you allergic to?**

_____

_____

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

**Past Medical History (include date of onset)**

| | | |
|---|---|---|
| ☐Abdominal Aortic Aneurysm | ☐Allergic Rhinitis | ☐CVA |
| ☐Atrial Fibrillation (Flutter) | ☐Chronic Sinusitis | ☐Dementia |
| ☐ Carotid Stenosis | ☐Hearing Loss | ☐Headache |
| ☐Congestive Heart Failure | ☐Anticoagulant Therapy | ☐Multiple Sclerosis |
| ☐Chronic Ischemic Heart Disease | ☐Iron Deficiency Anemia | ☐Peripheral Neuropathy |
| ☐Deep Venous Thrombosis | ☐Pernicious Anemia | ☐Post Herpetic Neuralgia |
| ☐High Blood Pressure | ☐Thrombocytopenia | ☐Restless Leg Syndrome |
| ☐Myocardial Infarction | ☐Vitamin B12 Deficiency | ☐Seizure Disorder |
| ☐Palpitations | ☐Degenerative Disc Disease | ☐Tremors |
| ☐Peripheral Vascular Disease | ☐Fibromyalgia | ☐Allergic Conjunctivitis |
| ☐Phlebitis | ☐Gout | ☐Cataracts |
| ☐Renal Artery Stenosis | ☐Hip Fracture | ☐Diabetic Retinopathy |
| ☐Diabetes Type II | ☐Lupus | ☐Glaucoma |
| ☐Diabetes Type I | ☐Osteoarthritis | ☐Iritis |
| ☐Hyperlipidemia | ☐Rheumatoid Arthritis | ☐Alcoholism |
| ☐Hyperthyroidism | ☐Sciatica | ☐Anxiety Disorder |
| ☐Hypoglycemia | ☐Vertebral Compression Fracture | ☐Attention Deficit Disorder |
| ☐Impaired Glucose Tolerance | ☐Bladder Outlet Obstruction | ☐Attention Deficit with Hyperactivity |
| ☐Obesity | ☐BPH | ☐Depression |
| ☐Morbid Obesity | ☐Erectile Dysfunction | ☐Drug Abuse |
| ☐Osteopenia | ☐Incontinence, Urge | ☐Insomnia |
| ☐Osteoporosis | ☐Prostate Cancer | ☐Panic Disorder |
| ☐Thyroid Nodule | ☐Prostatitis | ☐Asthma |
| ☐Cirrhosis | ☐Stress Incontinence (Female) | ☐COPD/Emphysema |
| ☐GERD | ☐Recurring Urinary Tract Infection | ☐Obstructive Sleep Apnea |
| ☐Hemorrhoids | ☐Stress Incontinence (Male) | ☐Pneumonia |
| ☐Irritable Bowel Syndrome | ☐Urge Incontinence | ☐Pulmonary Embolism |
| ☐Bleeding | ☐Neurogenic Bladder | ☐Tobacco Abuse |
| ☐Crohn's Disease | ☐Bladder CA | ☐Pulmonary Fibrosis |
| ☐History of GI Bleed | ☐Infectious Mononucleosis | ☐CKD |
| ☐Chlamydia | ☐Lyme Disease | ☐Chronic Renal Failure |
| ☐Genital Herpes | ☐Tuberculosis | ☐Chronic Renal Insufficiency |
| ☐Genital Warts | ☐History of C. diff | ☐Hematuria |
| ☐Gonorrhea | ☐History of MRSA | ☐Kidney Stones |
| ☐HPV | ☐History of VRE | ☐Proteinuria |
| ☐Syphilis | ☐History of Tuberculosis | ☐Pyelonephritis |
| | ☐Hepatitis B | ☐Renal Transplant |
| | ☐Hepatitis C | ☐Acne |
| | | ☐Eczema |
| | | ☐Psoriasis |

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

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

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

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

**Preventive Care**

| | EKG | Lipid Panel | Blood Sugar | PSA | Colonoscopy | Full Skin Exam | Dental Exam | Eye Exam | Pap Smear | Mammogram | Bone Density | Pneumonia Vaccination | Flu Vaccination |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WHEN | | | | | | | | | | | | | |
| WHERE | | | | | | | | | | | | | |

**What other symptoms are you currently experiencing?**

| | | | | |
|---|---|---|---|---|
| ☐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 a Physician/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**