

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.

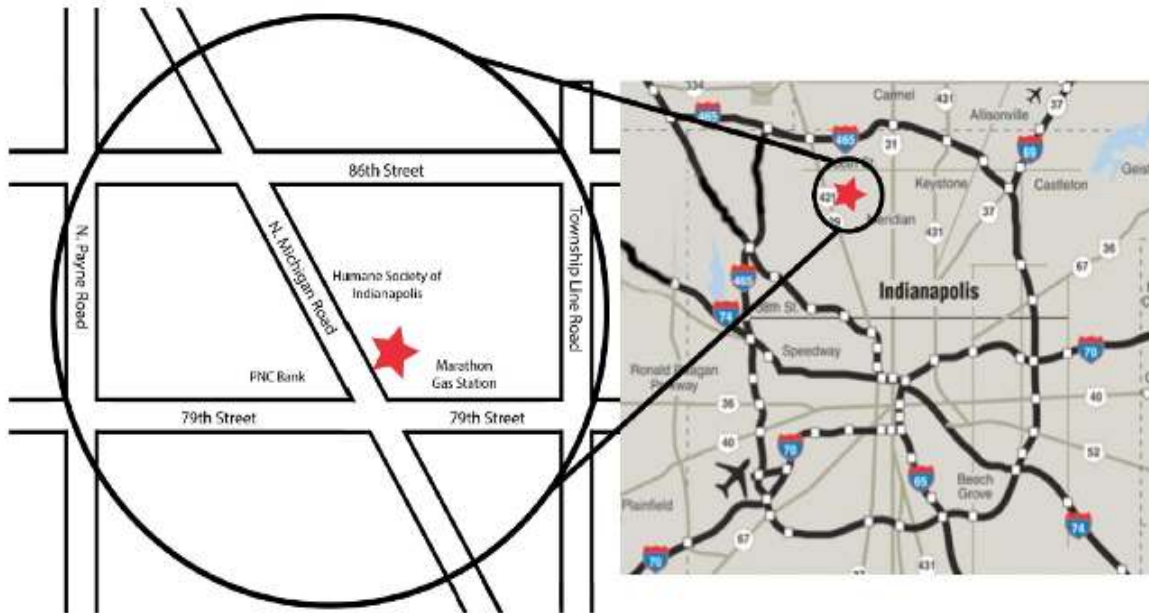
Please note: We do NOT offer pain management of any kind. No exceptions.

PIKE MEDICAL CONSULTANTS



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
<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

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

What other symptoms are you currently experiencing?

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