Pikes Peak Internal Medicine Associates, L.L.C.

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Please print all sections below: **PATIENT REGISTRATION**

PATIENT INFORMATION

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name:_____ _____ _____
last name *first name* *initial*

Mailing Address:_____Apt#_____City_____State_____Zip_____

Home Phone:(_____**)**_____ **Work Phone:(**_____**)**_____ **Cell Phone:(**_____**)**_____

Birth Date:_____/_____/_____ **Age**_____ **Social Security #**_____ **Driver's License:**_____

Employer/Name of School:_____ Occupation:_____ ☐ Full time ☐ Part time

Employer's Address:_____ City:_____ State:_____ Zip:_____

RESPONSIBLE PARTY / SPOUSE

Responsible Party is: *(check one)* ☐ Self ☐ Spouse ☐ Other

Name:_____ _____ _____
last name *first name* *initial*

Mailing Address:_____Apt#_____City_____State_____Zip_____

Home Phone:(_____**)**_____ **Work Phone:(**_____**)**_____ **Cell Phone:(**_____**)**_____

Birth Date:_____/_____/_____ **Age**_____ **Social Security #**_____ **Driver's License:**_____

PRIMARY INSURANCE: *(name)*_____

Ins. type: ☐ PPO ☐ HMO ☐ Medicare ☐ Commercial

Insurance Address:_____**City:**_____**State:**_____**Zip:**_____

Name of Insured:_____ Birth Date:_____/_____/_____ Relationship to Insured:_____

Insurance ID#_____ **Group #**_____

Insured's Employer:_____ Deductible_____ ☐ Met ☐ Not Met Copay_____

SECONDARY INSURANCE: *(name)*_____

If accident, date occurred: _____/_____/_____

Insurance Address:_____**City:**_____**State:**_____**Zip:**_____

Name of Insured:_____ Birth Date:_____/_____/_____ Relationship to Insured:_____

Insurance ID#_____ **Group #**_____

Insured's Employer:_____ Deductible_____ ☐ Met ☐ Not Met Copay_____

EMERGENCY CONTACT: (Other than spouse)

Name:_____ **Phone # (** _____**)**_____ **Relationship:**_____

Do you have an advance directive or living will? ☐ **Yes** ☐ **No** **Referred By:**_____ **Previous Dr:**_____

I understand and have completed this form completely, and certtify that I am the patient or duly authorized general agent to furnish the information requested. I authorize payment of medical benefits to Pikes Peak Internal Medicine. I am fiinancially responsible for all charges whether or not they are covered by my insurance. I authorize the release of any medical information necessary to process this claim and all future claims. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____ _____/_____/_____
SIGNATURE OF PATIENT (or authorized agent) **PRINT NAME** **DATE**

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HEALTH QUESTIONNAIRE

NAME_____ **Date of Birth:**___-___-____ **Today's Date:**___-___-____

PAST MEDICAL HISTORY:

Diagnosis	(circle)	When?	Diagnosis	(circle)	When?	Diagnosis	(circle)	When?
Heart Disease.....	NO YES	_____	High Cholesterol....	NO YES	_____	Anemia.....	NO YES	_____
Hypertension.....	NO YES	_____	Diabetes.....	NO YES	_____	Blood Clot.....	NO YES	_____
Stroke.....	NO YES	_____	Thyroid Disease.....	NO YES	_____	Venereal Disease..	NO YES	_____
Cancer of _____	NO YES	_____	Hepatitis.....	NO YES	_____	Tuberculosis.....	NO YES	_____
Pneumonia.....	NO YES	_____	Liver Disease.....	NO YES	_____	Measles.....	NO YES	_____
Asthma.....	NO YES	_____	Kidney Disease.....	NO YES	_____	Chicken Pox.....	NO YES	_____
Emphysema.....	NO YES	_____	Peptic Ulcer.....	NO YES	_____	Rheumatic Fever....	NO YES	_____

HOSPITALIZATIONS, SERIOUS ILLNESS:

Illness	Year	&/or Age

SURGERIES:

Type of Surgery	Year	&/or Age

MEDICATIONS: (List all current)

Name:	Dose:	Frequency:	Name:	Dose:	Frequency:
1. _____	_____	_____X daily	6. _____	_____	_____X daily
2. _____	_____	_____X daily	7. _____	_____	_____X daily
3. _____	_____	_____X daily	8. _____	_____	_____X daily
4. _____	_____	_____X daily	9. _____	_____	_____X daily
5. _____	_____	_____X daily	10. _____	_____	_____X daily

ALLERGIES:(Medication & Food)

Name:	Reaction:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SOCIAL HISTORY: (circle)

Marital Status: S M Sep D W **# Children**_____

Occupation: _____ **# Hrs/Wk**_____

Do You Smoke? NO YES # Pack/Day_____ #Yrs_____

Former Smoker? NO YES When did you quit?_____

Alcohol? NO YES Kind?_____ Amt_____ per_____

Drug Use? NO YES Kind?_____ Amt_____ per_____

Caffeine? NO YES Kind?_____ Amt_____ per_____

Regular Exercise? NO YES Kind?_____ Amt_____ per_____

Do You Have An Advance Directive/Living Will ? NO YES

PREVENTIVE HEALTH / SCREENING:

Vaccine: Year		Mo/Yr
Influenza	_____	Last Physical Exam? ___/___
Pneumonia	_____	Last Lab Work? ___/___
Tetanus	_____	PAP/Prostate Exam? ___/___
Other	_____	Mammogram? ___/___
		Colonoscopy? ___/___
		Bone Density? ___/___
		Chest XRay? ___/___
		EKG? ___/___
		Treadmill/Stress Test ___/___

FAMILY HISTORY:

	If Living: Age:	Health:	If Deceased: Age at death & cause:	
Father.....	_____	_____	_____	_____
Mother.....	_____	_____	_____	_____
Brother/Sister.....	_____	_____	_____	_____
Brother/Sister.....	_____	_____	_____	_____
Brother/Sister.....	_____	_____	_____	_____
Son/Daughter.....	_____	_____	_____	_____
Son/Daughter.....	_____	_____	_____	_____
Son/Daughter.....	_____	_____	_____	_____

Has any blood relative ever had:

	(circle)	Which One?
High Blood Pressure	NO YES	_____
Heart Disease	NO YES	_____
Stroke	NO YES	_____
High Cholesterol	NO YES	_____
Diabetes	NO YES	_____
Cancer (what type?) _____	NO YES	_____
Thyroid Problems	NO YES	_____
Asthma	NO YES	_____

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SYSTEM REVIEW

NAME_____ **Date of Birth:**____-____-____ **Today's Date:**____-____-____

GENERAL	(circle)	
Do you eat a well balanced diet?	NO	YES
Approx Wt. now _____ 1 yr ago _____	NO	YES
Maximum Weight _____		
Do you have excessive or unexplained fatigue?	NO	YES
EAR, NOSE, THROAT		
Glasses or contacts	NO	YES
Poor vision or vision loss	NO	YES
Cataracts	NO	YES
Glaucoma	NO	YES
Have you seen an eye doctor? (when_____)	NO	YES
Allergies or Hay fever	NO	YES
Septal deviation or Nasal polyps	NO	YES
Frequent nosebleeds	NO	YES
Sinus infections	NO	YES
Ear infections	NO	YES
Hearing loss	NO	YES
Ringing in ears	NO	YES
Persistent, unexplained hoarseness	NO	YES
NECK		
Injury, pain, stiffness	NO	YES
Swollen glands	NO	YES
RESPIRATORY		
Shortness of breath	NO	YES
Wheezing or asthma	NO	YES
Chronic cough	NO	YES
Coughing up blood	NO	YES
Night sweats	NO	YES
How many blocks can you walk without having to stop to catch your breath? _____		
Have you had a positive skin test for Tuberculosis? (if so, when_____)	NO	YES
CARDIOVASCULAR		
Chest pain or angina	NO	YES
Rapid, hard, or skipped beats	NO	YES
Heart murmer	NO	YES
Shortness of breath when lying flat	NO	YES
Ankles often badly swollen	NO	YES
Leg muscle pain on walking, relieved by rest	NO	YES
GASTROINTESTINAL		
Decreased appetite or weight loss	NO	YES
Frequent heartburn or indigestion	NO	YES
Intolerance to spicy foods, coffee or alcohol	NO	YES
Intolerance to milk products	NO	YES
Intolerance to fatty foods	NO	YES
Hiatal hernia	NO	YES
Pancreatitis	NO	YES
Gallbladder trouble	NO	YES
Frequent vomiting	NO	YES
Frequent diarrhea	NO	YES
Chronic constipation	NO	YES
Frequent abdominal pain	NO	YES
Bloody or black bowel movements	NO	YES
Hemorrhoids	NO	YES

GENITOURINARY	(circle)	
Loss of urine when you cough or sneeze	NO	YES
Kidney or bladder infection (circle)	NO	YES
Burning or frequent urination	NO	YES
Feeling you must go immediately	NO	YES
Do you have to get up at night to urinate? #____	NO	YES
Blood in urine	NO	YES
Kidney stones	NO	YES
Difficulty starting urination	NO	YES
Decrease in strength of stream	NO	YES
Penile discharge	NO	YES
MUSCULOSKELETAL		
Significant joint pain (where?)_____	NO	YES
Low back pain	NO	YES
Muscle tenderness or weakness	NO	YES
Fractures (where?)_____	NO	YES
DERMATOLOGIC		
Rash	NO	YES
Skin cancers	NO	YES
New or changing skin lesions	NO	YES
NEUROLOGIC/PSYCHIATRIC		
Numbness (where?)_____	NO	YES
Paralysis (where?)_____	NO	YES
Fainting or passing out	NO	YES
Frequent dizziness or loss of balance	NO	YES
Memory loss	NO	YES
Migraine or frequent headaches	NO	YES
Are you often depressed?	NO	YES
Are you often anxious?	NO	YES
Have you even been under psychiatric care?	NO	YES
HEMATOLOGIC		
Have you ever been diagnosed as anemic?	NO	YES
Have you ever been told not to give blood?	NO	YES
Excessive bleeding or bruising	NO	YES
ENDOCRINE		
Excessive thirst	NO	YES
Excessive urination	NO	YES
Intolerance to slightly warm rooms	NO	YES
Intolerance to slightly cold rooms	NO	YES
Change in texture of hair or skin	NO	YES
Decreased libido	NO	YES
GYNECOLOGICAL (women only)		
Breast mass or lump or nipple discharge	NO	YES
Family history of breast cancer	NO	YES
Abnormal PAP smear	NO	YES
Pelvic inflammatory disease	NO	YES
Sexually transmitted disease	NO	YES
Pain with intercourse	NO	YES
Irregular menstrual periods	NO	YES
Painful menstrual periods	NO	YES
Menopausal Age?_____	NO	YES
Number of pregnancies____ C sections____		
Deliveries____ Miscarriages____ Abortions____		
Did someone help you to fill this out?	NO	YES

Patient Signature:_____ **Reviewing Physician:**_____