

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 certify 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 financially 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

HEALTH QUESTIONNAIRE

NAME _____

Date of Birth: ___-___-___

Today's Date: ___-___-___

PAST MEDICAL HISTORY: Table with 3 columns: Diagnosis, (circle) YES/NO, When? Includes categories like Heart Disease, High Cholesterol, Anemia, etc.

HOSPITALIZATIONS, SERIOUS ILLNESS: and SURGERIES: Table with columns for Illness/Surgery, Year, &/or Age.

MEDICATIONS: and ALLERGIES:(Medication & Food) Table with columns for Name, Dose, Frequency, Name, Dose, Frequency, Name, Reaction.

SOCIAL HISTORY: and PREVENTIVE HEALTH / SCREENING: Table with various sub-sections for marital status, smoking, alcohol, exercise, and health screenings.

FAMILY HISTORY: Table with columns for Family Member, If Living (Age, Health), If Deceased (Age at death & cause), and Has any blood relative ever had (circle) YES/NO, Which One?

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 murmur 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: _____