Skyline Medicine Patient Medical History

Patient Name ______________________________________ Date of Birth_________________________

- Please list all **prescriptions** and **over-the-counter medications** you are taking along with their doses:

Name of medication (e.g. Atorvastatin)	**Dose (e.g. 10mg/day)**

- Please list all **CURRENT medical conditions** (e.g. diabetes, high blood pressure, depression, etc.) of which Skyline Medicine should be aware:

____

- Please list all **PAST medical concerns** of which Skyline Medicine should be aware (e.g. treated for depression in 1999):

____

- Have you had any of the following exams done **within the last five years?**

Mammogram	☐ Yes	☐ No	Date: _____________
Colonoscopy	☐ Yes	☐ No	Date: _____________
Eye Exam	☐ Yes	☐ No	Date: _____________
Bone Density Scan (DEXA)	☐ Yes	☐ No	Date: _____________
Flu Shot	☐ Yes	☐ No	Date: _____________
Pneumovax Pneumonia Shot	☐ Yes	☐ No	Date: _____________
Prevnar Pnuemonia Shot	☐ Yes	☐ No	Date: _____________

- Please list any **surgeries** you've had along with the year they were done (i.e. – appendectomy-2001):

____

- Do you have **allergies** to any **medications**? ☐ Yes ☐ No

  If yes please list them and what your reaction symptoms were:

____

- Are you sexually active? ☐ Yes ☐ No
- If yes, have you had sex with more than one partner over the past month? ☐ Yes ☐ No
- If yes, how many? Male or Female?

  ____
- Do you drink alcoholic beverages? ☐ Yes ☐ No
  If yes, please list average weekly consumption (e.g.4 beers/week)

  ____
- Do you drink caffeinated beverages? ☐ Yes ☐ No
  If yes, please list average weekly consumption (e.g. 2 cups coffee/week)

  ____
- Do you currently smoke? ☐ Yes ☐ No
  If yes, how many packs per day?

  ____
- Have you ever smoked? ☐ Yes ☐ No
- If yes, how many packs per day did you smoke? For how many years? When did you quit?

  ____
- Do you use any recreational drugs (e.g. marijuana, heroin, amphetamines, etc.)?
  If yes, please list which one(s):

  ____
- Do you exercise? ☐ Yes ☐ No
  If yes, please list average weekly frequency (i.e. – run 3 days/week)

  ____

Family History:

Have any of your **blood relatives** ever had:	Yes	List Relative Relation
Anemia	☐	
Bleeding tendency	☐	
Cancer	☐	
Diabetes mellitus	☐	
Epilepsy/seizures	☐	
Heart attack or heart disease	☐	
High blood pressure	☐	
Mental or emotional problems	☐	
Stroke	☐	

FATHER - ALIVE: ☐ YES ☐ NO AGE___ MOTHER - ALIVE: ☐ YES ☐ NO AGE___

I hereby certify that the information given herein is accurate and a fair representation of my current and past medical issues. I recognize that any updates to my medical history are ultimately my responsibility and will, therefore, inform Skyline Medicine of any new hospitalizations, surgeries, and other medical procedures that occur.

______________________ ______________________ ______________________
Signature Print Name Date

Patient Name________________________________ **Date of Birth**______________

Please Check Any Of The Following Symptoms That *Currently* or *Recently* Apply To You.

Respiratory

- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Chest Congestion
- ☐ Cough

Cardiac

- ☐ Dizziness
- ☐ Chest Pain
- ☐ Fast Heart Rate
- ☐ Leg Edema

Constitutional

- ☐ Night Sweats
- ☐ Heat Intolerance
- ☐ Heat Intolerance
- ☐ Fever
- ☐ Weakness
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Loss of Appetite
- ☐ Fatigue

Skin

- ☐ Rash
- ☐ Mole
- ☐ Lumps
- ☐ Hives

Psychiatry

- ☐ Depression
- ☐ Suicidal Ideation
- ☐ Abuse Mental or Physical

☐ **Seasonal Allergies**

Ophthalmology

- ☐ Diminished Vision
- ☐ Eye Irritation
- ☐ Blurring of Vision

ENT

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Cough
- ☐ Sore Throat

Gynecology

Have you ever had an abnormal mammogram?

☐ Yes ☐ No

If yes, when? _____________

Date of last mammogram:

____

- ☐ Heavy/Abnormal Periods
- ☐ Infertility
- ☐ Pelvic Pain
- ☐ Breast Pain/Mass
- ☐ Hot Flashes

Male Reproduction

- ☐ Difficulty with Erection
- ☐ Diminished Sex Drive

Gastroenterology

- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in Stool

Blood Disorders

- ☐ Anemia
- ☐ Swollen Glands
- ☐ Easy Bruising

Musculoskeletal

- ☐ Joint Stiffness
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Sciatica

Neurology

- ☐ Migraine Headache
- ☐ Tension Headache
- ☐ Numbness
- ☐ Seizures
- ☐ Insomnia
- ☐ Memory Loss
- ☐ Dizziness

Urology

- ☐ Difficulty Urinating
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urinary Incontinence
- ☐ Voiding Dysfunction

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Osteoporosis

PHQ-9 Patient Questionnaire

Nine symptom checklist

Patient Name: ____ Date: ________

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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10. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

SKYLINE MEDICINE
(Please Print)

PATIENT'S NAME:____
Last Name, First Name Middle Initial

PERMANENT ADDRESS:____ APT#_________

CITY:__________________________ STATE___________________ ZIP____________________

PHONE #:(_____)_________-_________________ CELL #:(_____)__________-_________________

WORK #: (______)_________-_____________

ARE YOU A WINTER VISITOR? ☐ Yes ☐ No (If yes, please fill out alternate address & phone number)

ALTERNATE MAILING ADDRESS:__________________________________ APT#_________

CITY:__________________________ STATE___________________ ZIP__________________

ALTERNATE TELEPHONE NUMBER (______)_________-_____________

DATE OF BIRTH: ____/____/_____ SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D
Month Day Year

SS # (Used for secure electronic messaging) _____- _____-______ EMPLOYER: _________________

Primary Insurance

Insurance Company Name: ____

Insurance Company Claims Address: ____

Policy #:________________________________ Group #:_________________________________

Insured's name:___________________________ Insured's Date of Birth: ____________ ☐ M ☐ F

Insured's Employer: ______________________ Insured's SS# ___________________________

Relationship to Patient:_______________________________

Secondary Insurance

Insurance Company Name: ____

Insurance Company Claims Address: ____

Policy #:________________________________ Group #:_________________________________

Insured's name:___________________________ Insured's Date of Birth: ____________ ☐ M ☐ F

Insured's Employer: ______________________ Insured's SS# ___________________________

Relationship to Patient:_______________________________

Would you like access to our online patient portal? ☐ Yes ☐ No
If yes, **please provide your E-mail:**____

May we leave messages regarding test results and appointments on your answering machine? ☐ Yes ☐ No

Demographic Information

Ethnicity: ☐ Hispanic ☐ Not Hispanic

Race: ☐ Asian ☐ Black or African American ☐ Hispanic ☐ White

Other (please specify) ____

Language: ☐ English ☐ Spanish

Other (please specify) ____

Emergency Contact

Name_________________________ **Phone #**______________________**Relation**________________

Address____

May we release your health information to this individual? ☐ **Yes** ☐ **No**

Who may receive information regarding your Protected Health Information? (List all that apply)

Name: ________________________________ Relation:______________Phone #:_________________
Name: ________________________________ Relation:______________Phone #:_________________
Name: ________________________________ Relation:______________ Phone #:_________________

PHARMACY NAME & TELEPHONE ____

Do you have an Advanced Directive (Living Will)? ☐ Yes ☐ No

Are any of your direct family members also patients at Skyline? If so, please list them below:

Name	Relation	Date of Birth	Gender

I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider.

I also give permission to Skyline Medicine to forward my (or my dependent's) medical records to my insurance company. I recognize that my insurance company may request these records to verify eligibility and medical claims Skyline Medicine submits thereto. I also recognize that payment to Skyline Medicine is my responsibility and that my insurance company may or may not cover services provided during this or any other visit.

Date:___________ Signature____

☐ PATIENT ☐ PARENT ☐ GUARDIAN

SKYLINE MEDICINE POLICIES

(Please read and initial each line and sign and date below.)

Initial

_______*As a patient paying for today's office visit (**SELF PAY PATIENTS**), I understand that **payment of cash or credit card is due at time of service.***

______I understand that ***all co-pays are due at time of service*** and that it is my responsibility to contact insurance as to what is a covered service and that ***I am responsible for paying for any non-covered services.***

______I understand that a ***$25.00 late fee*** will be added to my account on any unpaid patient balances and after 60 days my account will be turned over to a collection agency.

______I understand that a ***$50.00 no show fee*** will be added to my account for any appointments that I do not call to cancel or reschedule.

______I understand that a ***$25.00 fee will be added for all returned checks.***

______ I understand that **refills on medications must be written in an appointment setting.** *Please have medications and refill expiration dates available to discuss with the doctor. Depending on the medication will determine how often a prescription needs to be refilled.*

______________________	______________________	__________
Signature	Print Name	Date

If you would like a copy of this form please ask the receptionist at the front desk.

Skyline Medicine

MAIN OFFICE	*PATIENT INFORMATION*
(480) 924-4422	*(480) 481-6487*

To our patients:
In our continuing effort to provide the very best care possible for you, our valued patient, we have added an additional service.

This service will enable you to quickly access information such as laboratory test results, Doctor's instructions and other pertinent information by calling our private patient information line. We have implemented new technology that will help make us more effective in providing you with timely information. Please review this information and feel free to ask the nurse if you have questions.

It is also very important that you notify us with any changes in your home phone number, as this will affect our success in contacting you.

Lab: When you have lab work done or tests performed in our office, your results will be called in to a private mail box on our patient information line. We will then contact you, to let you know you have a message to retrieve. You can call the Patient Information Line at **(480) 481-6487** and follow the easy instructions to retrieve your message. The information you will be given will be very specific and you should listen to the entire message for further instructions or information regarding medication changes. ***Please listen to the entire message to ensure you receive all the information that our staff has left on the Patient Information Line.***

At the end of your message you will be given three options:

- Press 1 to repeat the message,
- Press 2 to delete the message,
- Press 3 to save the message.

The maximum amount you can save a message is two days from the time you first listen to the message. At the end of the two days, the message will be automatically deleted from the system.

If you have any questions after receiving your results you may call our main office phone at (480) 924-4422 during normal business hours. You may need to leave a message with the receptionist as to the nature of your questions and the phone number where you can be reached so we can have your chart available when we call you back.

Just follow this simple guide to retrieve your information:

- Using a "Touch-Tone" telephone (a phone that beeps when you dial) call **(480) 481-6487.**
- Listen to the prompts in English, press 1.
- Dial your **identification number** (your **social security number** unless otherwise specified).
- Record your name. End your recording by pressing 1.

BE SURE TO LISTEN TO YOUR ENTIRE MESSAGE

After listening to your message, press 1 to repeat, 2 to delete or 3 to save.

6112 E. Brown Rd. Mesa, AZ 85205
(480) 924-4422

Patient Information

Office Visit vs. Well Visit or BOTH?

- **Office Visit** – This is an office visit for an acute problem or flare-up of a chronic problem. This could also be an office visit to follow-up on chronic problems (Diabetes, Cholesterol, Blood Pressure, etc.).

- **Well Visit** – This is an office visit for a routine physical exam or yearly health maintenance exam.

- **Office/Well Visit** – This is a ***combination visit*** of a routine physical exam where an acute or chronic issue is addressed as well. For example, if you presented today for a well visit and you have an acute or chronic issue you would like addressed, it is considered a ***combination visit*** and must be billed differently than just a well visit or just a sick visit.

- **Why is it billed differently?** - It is billed differently to account for the additional work, expertise and time required for a combination visit (additional lab work, x-ray, referrals, and/or prescription medications). It involves additional documentation as well. For example, think about taking your vehicle in for an oil change (routine maintenance), and mentioning to the mechanic that your brakes are squeaking and your windshield wipers were not working well. In addition to the oil change, you might require additional brake work if a problem was found and replacement windshield wipers. Since additional services were provided, you would be charged more than just for the oil change.

- **How does this affect me?** Although many insurance companies acknowledge the office/well visit combination, some of them still require the patient to pay two co-pays or have additional costs applied to his/her annual deductible.

We realize this can be confusing and if you have ANY questions or concerns after reviewing this material, please ask.