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:
Tetanus/Pertussis	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.)? Yes No
  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

___Cold 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? Y/N

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?
(Please circle your answer.)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
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.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

---

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

Social Security # (Used for secure phone 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

May we leave messages regarding test results or appointments via text or patient portal? _____Yes _____No

Please choose preference Patient portal _____ Text_____

Demographic Information

Ethnicity (please circle) Hispanic Not Hispanic

Race (please circle) Asian Black or African American Hispanic White

Other (please specify) _____

Language (please circle) 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_____

Circle One (PATIENT/ PARENT/ GUARDIAN)

Updated 3/24/16

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 if I do not show up for my apt, or appointments that I do not call to cancel or reschedule more than 24 hours prior to the scheduled appointment time.

_____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. If this is done at your yearly physical, it is an office visit in addition to yearly physical.** *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.*

_____***I understand that a physical will be done at my New Patient appointment; then yearly***

_____***I understand that a physical is for prevention, and an office visit will also be charged for any other service done at the time of the physical***

_____	_____	_____
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
(480) 924-4422

PATIENT INFORMATION
(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.

Skyline Medicine

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 or medication refills, 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.

PLEASE FILL OUT IF AGE 65 OR OLDER

Annual Wellness Exam

Patient Name_____ Date of Birth_____
Today's Date_____

- Do you live in a private residence: **yes** **no** assisted living facility: **yes** **no**
  Please list other doctors currently treating you:

- Are you unsteady or have difficulty rising from a sitting position? **Yes** **No**
- Do you currently need help with phone, transportation, shopping, preparing meals, housework, laundry, medications or managing money? **YES** **NO**
- Does your home have any of the following:

  Rugs in the hallway **YES** **NO** Grab bars in the bathroom **YES** **NO**

  Handrails on the stairs **YES** **NO** **N/A** Poor lighting **YES** **NO**

- Have you had difficulty hearing? **YES** **NO**
- Regarding Advanced Care Planning, please circle item if you have a:

1) LIVING WILL 2) POWER OF ATTORNEY (FINANCIAL) 3)MEDICAL POWER OF ATTORNEY

4) DO NOT RESUSCITATE ORDER

- Are you currently seeing an ophthalmologist/optometrist? Y N
- Have you had a vision exam over the last 12 months? Y N
- If applicable, please indicate the year you received the following immunizations:

Flu_____ Pneumonia_____ Tetanus_____ Zostavax (Shingles)_____

- Have you smoked 100 cigarettes or more during your lifetime? YES NO
- Where applicable, please indicate the month and year you last had a(n):
  Colonoscopy _____
  Mammogram _____
  DEXA scan (osteoporosis screening) _____
  Ultrasound of Aorta (to rule out aneurysm)_____

Do you exercise regularly? YES NO Do you have a healthy diet? YES NO