

Upper Chesapeake Primary Care • Bel Air Office

Robert Ishak, MD • Nancy Piercy, CRNP • Mary Gardiner, CRNP

Thank you for choosing Upper Chesapeake Primary Care for your healthcare needs. We look forward to working with you. Below, you will find general information about our office. Please keep this page for your records.

Address: 520 Upper Chesapeake Drive, Suite 308
Klein Ambulatory Care Center
Bel Air, MD 21014

Phone: (443) 643-4800

Fax: (443) 643-4801

Patient Portal: www.nextmd.com

Appointment Hours: Monday, Wednesday, Thursday 8:00 – 4:00
Tuesday 8:00 – 5:30
Friday 8:00 – 2:30

Phone Hours: Monday, Wednesday, Thursday 8:00 – 4:00
Tuesday 8:00 – 5:00
Friday 8:00 – 3:00

Nights/Weekends: For life-threatening emergencies, call 911 or report to your nearest Emergency Room. For urgent matters that cannot wait until the next business day, call our office at (443) 643-4800 and remain on the line to reach our answering service. Your call will be returned within 30 minutes. For routine matters, you can simply call our office to leave a message or send us a message via the patient portal and we will respond the next business day.

Patient History Questionnaire

NAME: _____ DATE OF BIRTH: _____

Previous medical providers name and address: _____

Emergency contact name (and relation to patient) and phone number: _____

ALLERGIES: _____

MEDICATIONS (prescription & over the counter medicine) include name, dosage and frequency:

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS:

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

Have you had a transfusion of blood or blood products? Yes No If yes, did you have any reaction? Yes No

PERSONAL & SOCIAL HISTORY

ALCOHOL/TOBACCO/DRUGS RISK SCREEN:

- Do you use cigarettes, pipes, cigars or chewing tobacco? Yes No
- Do you drink alcohol?
 - Ever tried to cut back on the amount of alcohol you drink? Yes No
 - Ever become angry when people discuss your alcohol? Yes No
 - Ever felt guilty about anything you did because of your drinking? Yes No
 - Ever had a drink before noon (eye opener)? Yes No
 - Has your drinking affected your relationship with your family or friends? Yes No
 - Has your drinking affected your work or school? Yes No
 - Have you ever drunk alcohol while or before driving or driven while intoxicated? Yes No
- Do you drink coffee, sodas or other caffeinated beverages? Yes No
- Do you use any street drugs or abuse prescription pain medication? Yes No

SOCIAL HISTORY

- Do you think you are at risk for HIV, AIDS or other sexually transmitted disease? Yes No
- Have you ever been tested for HIV? Yes No
 - If yes, when ____/____ What was the result? ____
- Marital status: Married Single Divorced Widow(er) Separated
- Education: Jr. High School High School/GED Vocational School College Other
- Occupation: _____ Do you have an Advance Directive? Yes No

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE/DECEASED	HEALTH	CAUSE OF DEATH
Father				
Mother				
1.				
2.				

NAME: _____

DATE OF BIRTH: _____

FAMILY HISTORY		RELATIVE		RELATIVE
Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Iron Storage Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Ovarian Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		Prostate Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression, Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No		Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No		Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No		Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH MAINTENANCE

Last stools, occult blood test: ___/___ Colonoscopy/Sigmoidoscopy: ___/___

Dental Exam: ___/___ Dilated Eye Exam: ___/___ Foot Exam: ___/___

WOMEN: Last PAP smear: ___/___ Mammogram: ___/___ Breast Exam: ___/___ Menstrual Period: ___/___

MEN: Last Rectal/Prostate exam: ___/___ Testicular exam: ___/___ PSA: ___/___

IMMUNIZATIONS: (last date/year received) Tetanus: _____ Hepatitis B vaccine: _____ MMR: _____

Pneumonia: _____ Flu: _____ Tuberculosis Skin Test (date & results): _____

Please review the list of symptoms below

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months: Check "No" box if you do not.

CONSTITUTIONAL		SKIN		MUSCULAR SKELETAL	
Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin change	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexplained weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injury to limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry skin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nausea or Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	GASTROINTESTINAL	<input type="checkbox"/> Yes <input type="checkbox"/> No	Locking joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in movements	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red or swollen in joints	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	HEMATOLOGY/ONCOLOGY	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia or low blood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Red eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Easily bruise	<input type="checkbox"/> Yes <input type="checkbox"/> No
ENMT	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart burn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding from gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Black tarry stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	PSYCHIATRIC	<input type="checkbox"/> Yes <input type="checkbox"/> No
Change in your voice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea or vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression or sadness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Denture	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feel like hurting someone	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nose bleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	GENITOURINARY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feel like hurting yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hoarse voice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems urinating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with memory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ringing in ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernias	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems concentrating	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mouth ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems sleeping	<input type="checkbox"/> Yes <input type="checkbox"/> No
CARDIOVASCULAR	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urination at night	<input type="checkbox"/> Yes <input type="checkbox"/> No	NEUROLOGY	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in memory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary urgency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	WOMEN ONLY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Leg pain with walking	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with your period	<input type="checkbox"/> Yes <input type="checkbox"/> No	Imbalance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems with exercise	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal dryness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with sex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems lying flat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tremors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skipping heart beats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in breast	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Short of breath at night	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lumps in breast	<input type="checkbox"/> Yes <input type="checkbox"/> No	ENDOCRINE	<input type="checkbox"/> Yes <input type="checkbox"/> No
RESPIRATORY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breast discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with heat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	MEN ONLY	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with cold	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Problems with erections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling in neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coughing up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dribbling of urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weak urine stream	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in testicles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in hair	<input type="checkbox"/> Yes <input type="checkbox"/> No

Upper Chesapeake Primary Care – Bel Air

Authorization to Release Patient Health Information

Patient Name _____

Date of Birth ____/____/____

Daytime Telephone _____

Social Security No: _____

I authorize the following organization to release information as stated below from the patient health information record. This authorization covers the time period beginning: ____/____/____ and ending ____/____/____.

INFORMATION TO BE RELEASED FROM:

INFORMATION TO BE RELEASED TO:

Organization/Contact Name

Upper Chesapeake Primary Care, LLC

520 Upper Chesapeake Drive

Suite 308

Street Address

Bel Air, MD 21014

443-643-4800

443-643-4801 FAX

City, State, Zip

Telephone Number

TYPES OF RECORDS REQUESTED (Charges for copies of records may be associated with your request).

Health care information related to the following treatment or condition _____

Laboratory/diagnostic tests _____

Other _____

Purpose or need for this information: Continuing Care Copies for Own Use Other

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Upper Chesapeake Primary Care has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition or obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, complete a Revocation of Authorization form, which are available in each Upper Chesapeake Primary Care office.

I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to redisclosure by the recipient and no longer be protected by federal or state law. I understand that I do have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits).

I acknowledge that I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize the release of patient health information to the above name person or organization. This authorization is valid for one year from the date signed, unless I revoke this authorization. Upper Chesapeake Primary Care may contact me to extend this authorization, but I do not have to do so.

Date

Signature of Patient or Legally Responsible Party

Authority to Sign, if not Patient

Upper Chesapeake Primary Care – Bel Air

“Patient-Centered Medical Home”

Our office has received Level One recognition as a Patient-Centered Medical Home (PCMH), which is responsible for overseeing and managing all aspects of your healthcare. Our entire practice is designed to help you establish and meet your individualized healthcare goals. We will work with you to address any concerns you may have, help you establish specialized care when needed, and make sure that your plan of care is one you can live with. Your health care team includes a physician, nurse practitioners, a nurse, medical assistants, and support staff. It is important for you to select one of our clinicians as your primary provider in order to ensure continuity of care. Rest assured, however, our entire team is available to assist in your care whenever needed.

Access to Care

- The best way to stay healthy is to maintain regular, scheduled visits with your primary provider.
- We offer same-day appointments for urgent and routine care.
- Bring your insurance card and photo ID to every visit.
- If you cannot keep your appointment, we kindly request 24 hours notice.
- Update your information at each visit so we can always reach you.
- NextMD (www.nextmd.com) gives you 24-hour access to your health information, including the ability to send a message to your provider, request appointments, and request prescription refills.

Care Coordination

- If you have recently seen another provider, facility, or Emergency Room, bring your discharge papers and any reports you received with you to your next appointment.
- Bring a list of all current medications to every visit.
- Your provider wants to be engaged with other providers you see. Make sure we are aware of all health care services you're receiving so that we can effectively coordinate your care.

After-hours Advice

- For life-threatening emergencies, call 911 or go to your nearest Emergency Room.
- For urgent matters that cannot wait until the next business day, call our office at (443) 643-4800 and remain on the line to reach our answering service. Your call will be returned within 30 minutes.
- For routine matters, you can simply call our office to leave a message or send us a message via the patient portal and we will respond the next business day.

New Patients

- We participate with most health plans. Call our office or contact your insurance company to determine if we participate with your plan.
- For help obtaining health insurance under the Affordable Care Act, call Maryland Health Connection at (855) 642-8572.
- If you are transferring your care from pediatrics or another internal medicine practice, be sure to complete an authorization for us to obtain your medical records to ensure continuity of care.
- As part of UM Upper Chesapeake Health, we can connect you to a range of providers, including:
 - OB/GYN
 - Endocrinology
 - Behavioral Health
 - Gastroenterology
 - Cardiology
 - General Surgery
 - Dermatology
 - Ear, Nose, & Throat
 - Orthopedics
 - Hematology/Oncology
 - Radiation Oncology
 - Ophthalmology