



St. Vincent Headache Center

Office Phone: 317 582 8270
Office Fax: 317 582 8271
13430 North Meridian Street, Suite 165
Carmel, IN 46032
headache.stvincent.org

Thank you for choosing the St. Vincent Headache Center, office of Edward D. Zdobylak, M.D., for your headache concerns. We appreciate the opportunity to serve you. This letter is designed to provide you information about our practice.

Office Hours: Our office hours are Monday through Thursday from 7:00 am to 3:00 pm and 7:00 am to 12:00 pm on Friday. We are closed for lunch from 12:00 pm to 12:30 pm. If you need immediate assistance when the office is closed, please go to your nearest approved Urgent Care or Emergency Facility.

Scheduling an Appointment: 317 582 8270 extension (2)

Please call the above number and press "2". If we are unavailable to take your call, we are either on the phone or assisting a patient. Please leave a message so we can return your call the same business day.

Prescription Refills: 317 582 8270 extension (3)

Please have your pharmacy fax your request to the fax number shown above and allow 24 hours for processing. Prescription refill requests taken after office hours will be processed the following day. Prescription refill requests taken after noon on Friday will be processed on Monday.

To speak to a Medical Assistant: 317 582 8270 extension (4)

Our medical assistants are often caring for patients in our office or assisting those on the phone. If we are unavailable at the time of your call, please leave a message and your call will be returned the same business day.

Insurance: We are a participating provider with most major insurance companies. Please call our office with any questions you may have regarding your specific insurance company participation. ****It is your responsibility to know your benefits and eligibility requirements.****

New Patient Paperwork: Thank you for completing the New Patient Paperwork. You can fax this information to our office at the fax number above prior to your initial visit, or if you bring it with you to your initial visit, please plan to arrive at least 20 minutes early so we can enter your information into your patient chart.

Advanced Migraine Care, PC

PATIENT INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	Sex:
City:	
State: Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also authorize Medicare and all Commercial payers to pay Advanced Migraine Care, PC on my behalf for any services furnished to me by the Provider, Edward D Zdobyak, MD.

Authorization To Release Medical Information: I hereby authorize my Provider, Edward D Zdobyak MD of Advanced Migraine Care, PC to release any information necessary for my course of treatment, including general health care operations. This includes allowing the release of information to any Primary Care Physician, Specialty Care Provider or entity that I am referred to.

'No Show' Policy: Advanced Migraine Care, PC has a 'no show' policy for missed appointments. An appointment is considered a 'no show' if you do not attend a scheduled appointment and do not cancel within 48 hours of your scheduled appointment. A \$25 fee will be applied to 'no show' appointments. I understand and agree to abide by the above cancellation policy.

Financial Consent: I hereby guarantee payment in full within thirty (30) days of all charges established by Advanced Migraine Care, PC for services rendered to me. I understand and acknowledge that if any unpaid amounts are owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including collection agency fees.

Signed (patient or parent if minor)

Date



St. Vincent Headache Center

Name: _____ Date of Birth: _____

Primary Care Physician

Name _____ Phone _____

Address _____ Fax _____

Referring Physician (if different than above)

Name _____ Phone _____

Address _____ Fax _____

Pharmacy

Name _____ Phone _____

Address _____ Fax _____

HEADACHES

How old were you when your headaches began? _____

Initially, how frequent were your headaches? _____

If this is a new and recent problem, what date did your headaches start? _____

How many days per month do you have a headache of any type? _____

How long have your headaches been this frequent? _____

How many days per month are your headaches moderate to severe in intensity? _____

Is there anything different about your current headaches? (Yes/No) If yes, please describe _____

Do you have more than one type of headache? (Yes/No) If yes, please describe _____

On a scale of 1-10 (10 being the most severe), how painful is your headache, on average? _____

If **untreated**, how long does your average headache last? _____

If **treated**, how long does your average headache last? _____

Based on my predominant headache type: (please circle all that apply)

I can continue with (normal activity, slight decrease in function, moderate decrease in function, severe decrease in function, bed ridden)

The pain is located at the (temple, back of head, forehead, eyes, neck, jaw, other)

The pain is located on the (right side, left side, both sides, varies)

The pain changes sides (during attacks, between attacks, both between and during attacks)

The character of the headache is (throbbing, pulsating, achy, squeezing, pressure, burning, shooting, sharp, other)

Please circle if any of the following occur before or during the headaches.

Please asterisk (*) if any of the following occur and you don't get the headache.

Soft touch hurts

Sensitivity to light

Changes in vision

Sensitivity to noise

Blind spots

Sensitivity to smell

Loss of vision

Neck movements that aggravate pain

Numbness or tingling of any body part

Neck muscles that are tender to touch

Difficulty speaking

Exercise aggravates the pain

Difficulty concentrating

Light-headedness

Nausea

Loss of consciousness

Vomiting

Weakness of any body part

Diarrhea

Decreased ability to move your neck

Nasal congestion

Do any of the following symptoms happen on the same side of your head where the headache is occurring?

Nose running

Puffy eyelid

Forehead sweating

Red eye

Small pupil size

Stuffy nose

Droopy eye-lid

HEADACHE TRIGGERS: Please describe if applicable

Stress _____

Physical Activity _____

Dietary _____

Environmental _____

FEMALES ONLY

Currently pregnant? (Yes/No) Planning to be pregnant? (Yes/No) If yes, when? _____

Do the following change your headache patterns? (Menstrual periods, Birth control pills, Pregnancy, Hormonal replacement) If yes, how? _____

HEADACHE TREATMENTS

What non-medical actions help relieve your headache? (Rest, Exercise, Quiet and darkness, Cold compress, Massage, Warm shower, Pressure over headache area)

ALLERGIES AND OTHER REACTIONS TO MEDICATIONS

Food Allergies: _____

Iodine or Contrast Dye? _____ Side Effect: _____

Medication: _____ Side Effect: _____

Medication: _____ Side Effect: _____

Medication: _____ Side Effect: _____

MEDICATIONS

Acute Headache Medication (Yes/No):

Medications taken once the headache occurs

Number of doses of medication needed per month for relief _____

What was your response to the medication in 2 hours? _____

Did you need a second dose of medication within 24 hours? (Yes/No) _____ % of the time

After 24 hours my headache returns _____ % of the time

Acute Headache Medications:

Medication	Dose/Schedule	Side Effects?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preventive Headache Medications:

Medications taken to prevent headaches

Medication	Dose/Schedule	Side Effects?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Headache Medications:

Medication	Dose/Schedule	Side Effects?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all other non-headache medications, vitamins or supplements that you take every day.

Medication	Dose/Schedule	Reason	Month/Year Started

DIAGNOSTICS

Labs (Yes/No) If yes, date? _____

Neck x-ray (Yes/No) If yes, date? _____

Head CT Scan (Yes/No) If yes, date? _____

Head MRI (Yes/No) If yes, date? _____

Neck MRI (Yes/No) If yes, date? _____

Describe Results _____

Previous Evaluations for Headache (Please circle)

Neurologist, Chiropractor, Primary Care MD, Acupuncture, Physical Therapy, Massage Therapy, Psychiatrist, Other _____

PAST MEDICAL HISTORY: Please circle all that apply

Cardiovascular - High blood pressure, Coronary artery disease

Neurological – Stroke, TIA, Seizures, Optic Neuritis, Bell's Palsy, Tremor, Transverse Myelitis, Trigeminal Neuralgia

Endocrine – Diabetes I, II, Thyroid (hypo or hyper),

Surgery – Carpal tunnel, Craniotomy, Discectomy, Spinal fusion

Other medical problems: _____

SUBSTANCES

I drink an average of _____ alcoholic beverages per week/month (circle)

Much heavier use in past? Yes/No

I drink an average of _____ caffeinated beverages per day (Coffee, Tea, Cola, Energy drink)

Present smoker?(Yes/No) Past Smoker?(Yes/No) _____packs/day for _____years

Current Drug Use: Please circle all that apply

Cocaine, Ecstasy, Hallucinogens, Heroin, Inhaled glue/paint, Marijuana,
Methamphetamine, Prescription painkillers

Past Drug Use: Please circle all that apply

Cocaine, Ecstasy, Hallucinogens, Heroin, Inhaled glue/paint, Marijuana,
Methamphetamine, Prescription painkillers

SLEEP:

Average hours of sleep per night _____

Do you have trouble with any of the following? (Falling asleep, Staying asleep, Snoring,
Grinding teeth, Legs kick during sleep, Awaken with headache)

LIFESTYLE:

Single, Married, Divorced, Widowed (circle)

Disabled (Yes/No), Retired (Yes/No)

Employed (Yes/No) Position _____ Student (Yes/No) Level _____

Military Service (Yes/No) Status _____

Who lives with you at home? _____

Regular exercise? (Yes/No) If yes, _____ times per week. Activity _____

Special diet? If yes, please describe _____

Would you like to see a dietician? (Yes/No)

Biggest sources of stress in your life (list): _____

FAMILY HISTORY: Please list affected family members

Diabetes _____ Multiple Sclerosis _____
Hypertension _____ Lupus _____
Brain Tumor _____ Sleep Disorder _____
Stroke/Mini-Stroke (TIA) _____ Seizures _____
Migraines _____

REVIEW OF SYSTEMS: Please circle all that you are currently experiencing:

GENERAL Sleep pattern changes, weight loss, appetite loss, fatigue or fever

SKIN Bruising, dryness, rash

HEENT Head injury, double vision, ringing in the ears

NECK Neck pain, neck stiffness

RESPIRATORY Cough, snoring, shortness of breath

CARDIOVASCULAR Fainting, blackout, irregular heart beat, hypertension

GASTROINTESTINAL Constipation, diarrhea

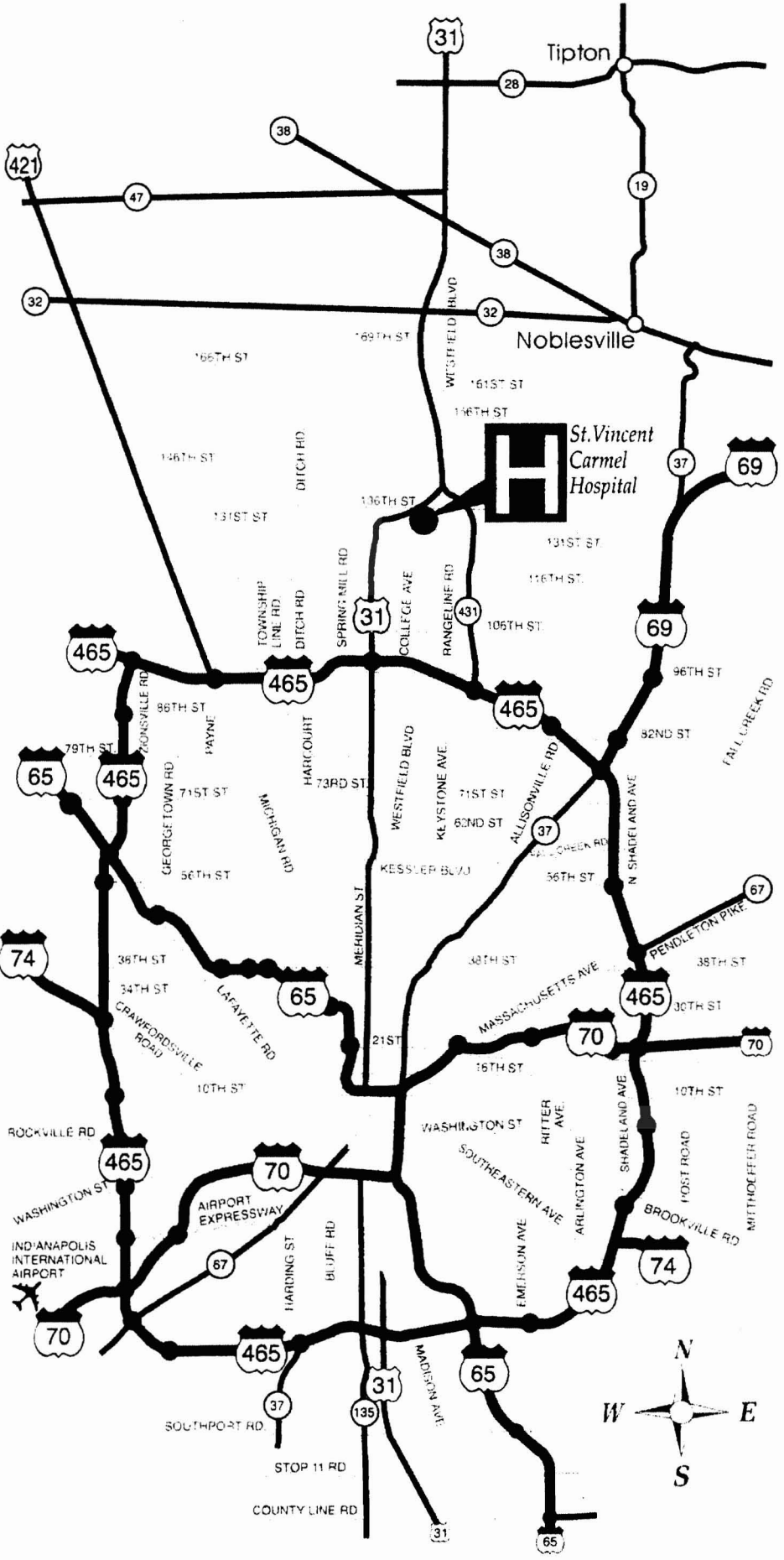
NEUROLOGICAL Numbness, dizziness, headaches, seizures, stroke, tremors

PSYCHIATRIC Depression, hallucinations, mood changes

ENDOCRINE Thyroid problems

Signature

Date



ENTRANCE #4



SUITE
165

*St. Vincent
Carmel Hospital*

From North of Carmel

Take U.S. Highway 31. Go south to 136th Street, turn left. St. Vincent Carmel Hospital is on the right, and can be entered from the first or second drive.

From Southeast of Carmel

Take Interstate 465 west to the U.S. 31 (Meridian Street) exit. Turn right and head north to 136th Street, turn right. St. Vincent Carmel Hospital is on the right, and can be entered from the first or second drive.

From Southwest of Carmel

Take Interstate 465 east to the U.S. 31 (Meridian Street) exit. Turn left and head north to 136th Street, turn right. St. Vincent Carmel Hospital is on the right, and can be entered from the first or second drive.

From East of Carmel

Take Interstate 69 south to Interstate 465 west to the U.S. 31 (Meridian Street) exit. Turn right and head north to 136th Street, turn right. St. Vincent Carmel Hospital is on the right, and can be entered from the first or second drive.

From West of Carmel

Take Interstate 65 south to Interstate 465 east to the U.S. 31 (Meridian Street) exit. Turn left and head north to 136th Street, turn right. St. Vincent Carmel Hospital is on the right, and can be entered from the first or second drive.