Family Medicine

NEW PATIENT TRACKING FORM

Patient to fill in all yellow sections

WE DO NOT ACCEPT ANYONE UNVACCINATED UNDER THE AGE OF 18

Name: _____ DOB:_____

Address: _____

Phone: _____ Gender: ☐ Male ☐ Female

Requested Provider: _____

Reason for Visit: _____

Previous Doctor/Facility: _____

If patient is under 18 years old, list legal guardian to contact

Person to Contact: _____ Relationship: _____

For office use:

- ☐ New patient paperwork mailed date/initials: _____
- ☐ New patient paperwork picked up/initials: _____
- ☐ New patient paperwork returned date/initials: _____
- ☐ Health History Questionnaire given to Annilee date/initials: _____
- ☐ Health History Questionnaire returned from Annilee date/initials: _____
- ☐ New patient paperwork scanned into chart date/initials: _____
- ☐ Release for medical records faxed date/initials: _____
- ☐ Patient contacted and visit scheduled date/initials: _____
- ☐ Medical records received and uploaded date/initials: _____

Notes: _____
_____
_____

FAMILY MEDICINE

Phone (217) 937-5284 Fax (217) 937-5280

WELCOME LETTER

Enclosed you will find the new patient documents necessary to begin the process for establishing care at Warner Hospital and Health Services Family Medicine. The first step is to complete the Health History Questionnaire and Authorization for Release of Health information.

Our Medical Director will review your Health History Questionnaire for medical appropriateness. Once this is complete, our reception staff will fax the Authorization for Release of Health Information and contact you to schedule a new patient appointment. We will schedule these appointments three (3) weeks out to allow for the receipt of all medical records.

On the day of your New Patient Appointment, please arrive ten (10) minutes early and bring the following information with you:

- Photo Identification
- Insurance and Prescription Card
- Copay
- Medication List

A few things to know about our office:

- **Cancellation of Appointments:** If you are unable to keep your appointment, we ask that you give, at least 24 hours notice prior to your scheduled appointment. This helps us to meet the needs of clinic patients waiting for openings.
- **No-Show Appointments:** Failure to cancel within 24 hours or failure to attend any scheduled appointments is considered a No-Show. After three (3) No-Show appointments within one (1) year, you may be subject to discharge from the clinic, including our Walk-in Clinic.
- **Our Clinic is a safe and healing environment.** Aggressive behavior towards any staff member will not be tolerated. This includes physical assault, verbal harassment, abusive language and threats. If such behaviours are observed, you may be subject to immediate discharge from the Clinic.
- **Our Clinic does not manage chronic pain and will refer you to a pain management specialist.**

By signing below, you acknowledge understanding of the New Patient process and Guidelines of our Clinic.

_____	_____	_____
Patient Name Printed	Patient Signature	Date

We thank you for choosing Family Medicine! Our purpose is to serve our community in the best way possible. If you have any additional questions or concerns, please feel free to contact our office at (217) 937-5284.

FAMILY MEDICINE
HEALTH HISTORY QUESTIONNAIRE

Legal Name :_____ DOB:_____ Gender: ☐ M ☐ F

Preferred Name: _____ Phone Number: _____

Marital Status_____

Previous Doctors/Facilities: _____ Date of Last Visit:_____

Language Spoken at Home: _____ Insurance:_____

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESSES: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio
(Please heck all that apply)

IMUNIZATION AND DATES: ☐ Tetanus _____ ☐ Pneumonia _____
(If known) ☐ Hepatitis _____ ☐ Chickenpox _____
☐ Influenza _____ ☐ MMR_____

LIST ALL MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED: _____

_____

_____

_____

_____

SURGERIES:

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER HOSPITALIZATIONS:

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a blood transfusion? ☐ Yes ☐ No

LIST ALL MEDICATIONS YOU ARE TAKING:

Name	Strength	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES/ADVERSE REACTIONS TO MEDICATIONS:

Name of the Drug	Reaction you had
_____	_____
_____	_____
_____	_____
_____	_____

HEALTH HABITS AND PERSONAL SAFETY

Exercise

☐ Sedentary (no exercise)
☐ Mild exercise
☐ Occasional vigorous exercise
☐ Regular vigorous exercise

Diet

Are you dieting? ☐ Yes ☐ No
If yes, are you on a physician prescribed diet? ☐ Yes ☐ No
Type of diet: _____

Caffeine

# of cups per day? _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No
If yes, what kind? _____
How many drinks per week? _____
Are you concerned about the amount you drink? ☐ Yes ☐ No
Have you considered stopping? ☐ Yes ☐ No
Have you ever experienced black outs? ☐ Yes ☐ No
Are you prone to binge drinking? ☐ Yes ☐ No
Do you drive after drinking: ☐ Yes ☐ No

Tobacco

Do you use tobacco? ☐ Yes ☐ No
Type of tobacco used: _____
# of years: _____ Or year quit: _____

Drugs Do you currently use recreational or street drugs? ☐ Yes ☐ No
Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Sex Are you sexually active? ☐ Yes ☐ No
Do you practice safe sex? ☐ Yes ☐ No
Contraceptive or barrier methods used? _____
Any discomfort with intercourse? ☐ Yes ☐ No

Personal Safety Do you live alone? ☐ Yes ☐ No
Do you have frequent falls? ☐ Yes ☐ No
Do you have vision or hearing loss? ☐ Yes ☐ No
Do you have an Advanced Directive or Living Will? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

Father: Significant health problems:_____
_____
_____
_____
_____
_____

Mother: Significant health problems:_____
_____
_____
_____
_____
_____

MENTAL HEALTH

Do you feel depressed? ☐ Yes ☐ No
Do you have problems with eating or your appetite? ☐ Yes ☐ No
Do you cry frequently? ☐ Yes ☐ No
Have you ever attempted suicide? ☐ Yes ☐ No
Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No
Do you have trouble sleeping? ☐ Yes ☐ No
Is stress a major problem for you ☐ Yes ☐ No
Do you panic when stressed? ☐ Yes ☐ No
Have you ever been to a counselor or are your currently seeing one? ☐ Yes ☐ No
Have you ever been diagnosed with depressing, anxiety or another mental issue? ☐ Yes ☐ No
Diagnosis:_____

PHYSICAL SYMPTOMS

Please check if you have, or have had, any symptoms in the following areas:

☐ Skin ☐ Nose ☐ Intestinal ☐ Throat ☐ Bowel ☐ Chronic Pain
☐ Head/Neck ☐ Chest/Heart ☐ Bladder ☐ Lungs ☐ Circulation
☐ Ears ☐ Back ☐ Recent change in weight, energy level, sleep pattern

WOMEN ONLY

Age of onset on menstruation: _____
Date of last menstruation:_____
Period every _____ days
Heavy periods, irregular, spotting, pain or discharge? ☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____
Are you pregnant or breastfeeding? ☐ Yes ☐ No
Have you had a D&C, hysterectomy or Cesarean?
Any urinary tract, bladder or kidney infections within the last year? ☐ Yes ☐ No
Any blood in your urine? ☐ Yes ☐ No
Any problems with control or urination? ☐ Yes ☐ No
Any hot flashes or sweating at night? ☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around time of your period? ☐ Yes ☐ No
Experience any recent breast tenderness, lumps or nipple discharge? ☐ Yes ☐ No
Date of last pap and rectal exam: _____
Date of last mammogram: _____
Date of last colonoscopy: _____

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No
If yes, # of times _____
Do you feel pain or burning with urination? ☐ Yes ☐ No
Any blood in your urine? ☐ Yes ☐ No
Do you feel burning discharge from your penis? ☐ Yes ☐ No
Has the force of your urination decreased? ☐ Yes ☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Yes ☐ No
Do you have any problems emptying your bladder completely? ☐ Yes ☐ No
Any difficulty with erection or ejaculation? ☐ Yes ☐ No
Any testicle pain or swelling? ☐ Yes ☐ No
Date of last prostate and rectal exam: _____
Date of last colonoscopy: _____

AUTHORIZATION

Patient Authorization for Disclosure of Health Information

PLEASE PRINT

Patient Name:_____ Date of Birth:_____/_____/_____

Address:_____ City:_____ State:_____Zip:_____

E-mail Address:_____ Phone:_____

I request that my Protected Health Information (PHI) *from* _____
be disclosed to: *(Doctor name, address, phone #, fax #)*

Recipient Name: Family Medicine

Address: 422 West White Street City: Clinton State: IL Zip: 61727

E-mail Address:_____ Phone: 217-937-5284

Fax: 217-937-5280

I authorize the following PHI to be released from my medical record(s): *Please check box*

☐ Emergency Room Record ☐ Laboratory Report(s) ☐ Radiology Report(s) ☐ Pathology Report ☐ Cardiology Report(s)

☐ Immunization Record ☐ Provider Office Visit ☐ Cornerstone Counseling ☐ Any and All Records

☐ Abstract/Summary (Includes Discharge Summary, History & Physical, Operative Report(s), Consultations and Test Result(s):

☐ Test Result(s) of:_____

☐ Radiology film/imaging studies/tracing/media

☐ Itemized Billing Records

☐ Other:_____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please Indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug or Substance Abuse Records	☐ Yes	☐ No	Dates: _____
HIV Testing and Results	☐ Yes	☐ No	Dates: _____
Mental Health	☐ Yes	☐ No	Dates: _____
Psychotherapy Records	☐ Yes	☐ No	Dates: _____

Covering the period of healthcare from: Specific Date(s): _____ to _____

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care

☐ Other (*Please specify on line below*):

_____

Disclosure Format (Paper is default if not marked):

☐ US Mail – Paper Format ☐ Fax ☐ E-mail (Secure Format with Encryption)
☐ E-Mail (Unsecure Format, i.e., Gmail, Yahoo) ☐ CD (Radiology Images Only)
☐ Flash Drive – Secure Format
☐ Other (Please Specify): _____

(**Over)**

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state guidelines.
- I have the right to revoke this Authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: *422 W. White St., Clinton, IL 61727.* Revocation will not apply to information that has already been disclosed in response to this Authorization.
- Unless otherwise revoked, this Authorization will expire on the following date/event/condition:
  _____
- If I fail to specify an expiration date/event/condition, this Authorization will expire *90 DAYS* from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this Authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date and Time

_____ _____
Print Name Relationship to Patient (if applicable)

(For Office Use Only)
Account Number: _____ **Medical Record Number:** _____

ID Verified By: ☐ **Driver's License:** _____ ☐ **Known to Me** ☐ **Other**

Released By: _____

Release Date & Time :_____