



**Family Medicine
NEW PATIENT PACKET**

Patient to fill in all yellow sections

PATIENT INFORMATION:

Patient Legal Name: _____

Preferred Name: _____ Birth Date: _____

Gender: Male Female

Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Emergency Contact: _____

Phone #: _____

PARENT/GUARDIAN INFORMATION (if patient is a minor):

Name: _____

Relationship to patient: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

INSURANCE INFORMATION (Primary):

Policyholder's Name: _____ DOB: _____

Policyholder's Address: _____

Insurance Company: _____

Policy Holder's ID#: _____

Group #: _____

Employer: _____

Patient Relationship to Policyholder: Self Spouse Child Other

If other please specify: _____

REQUESTED PRIMARY CARE PROVIDER: _____

PREVIOUS DOCTOR/FACILITY: _____

REASON FOR VISIT: _____



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.**
- **We DO NOT accept any unvaccinated (not including COVID/Influenza vaccines) patients under the age of 18.**

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

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESSES: (Please check all that apply)

- Measles Mumps Rubella Chickenpox Rheumatic Fever Polio

IMUNIZATION AND DATES:

- Tetanus _____ Pneumonia _____
 Hepatitis _____ Chickenpox _____
 Influenza _____ MMR _____

LIST ALL MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED:

SURGERIES:

<u>Year</u>	<u>Reason</u>	<u>Hospital</u>

OTHER HOSPITALIZATIONS:

<u>Year</u>	<u>Reason</u>	<u>Hospital</u>

Have you ever had a blood transfusion? Yes No

LIST ALL MEDICATIONS YOU ARE TAKING:

<u>Name</u>	<u>Strength</u>	<u>Frequency</u>

ALLERGIES/ADVERSE REACTIONS TO MEDICATIONS:

<u>Name of the Drug</u>	<u>Reaction you had</u>

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 you currently seeing one? Yes No
Have you ever been diagnosed with depression, 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? Yes No

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: _____