HILLSBORO health PRIMARY CARE

New Patient Questionnaire

DEMOGRAPHICS

FIRST NAME_____MIDDLE NAME: _____LAST NAME: _____

DATE OF BIRTH: _____BIRTH SEX: _____PREFERRED SEX: _____

NAME YOU PREFER TO BE CALLED: _____SSN: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

OCCUPATION: _____ MARITAL STATUS: _____

EMPLOYMENT STATUS: (PLEASE CIRCLE) F/T ☐ P/T ☐ PRN ☐ UNEMPLOYED ☐

EMAIL ADDRESS: _____

RACE/ ETHNICITY: _____ PRACTICED RELGION: _____

PREFERRED PHARMACY: _____

NAME OF SPOUSE/PARENT/GUARDIAN: _____ PHONE #: _____

HOW DID YOU HEAR ABOUT US? _____

INSURANCE INFORMATION

NAME OF INSURED: _____ RELATIONSHIP TO PATIENT: _____

BIRTHDATE: _____ SSN: _____

NAME OF EMPLOYER: _____ TELEPHONE: _____

ADDRESS OF EMPLOYER: _____

INSURANCE CARRIER: _____

ADDRESS OF INSURANCE CARRIER: _____

GROUP NUMBER: _____ PLAN OR ID NUMBER: _____

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Alcohol

How often do you have a drink containing alcohol?
☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Caffeine

Do you consume any caffeine? ☐ No ☐ Yes: How often? How much?

Exercise

Do you exercise? ☐ No ☐ Yes: How often? How long?

Smoking

Do you smoke(electronic cigarettes included)? ☐ No ☐ Yes: How many cigarettes per day? _____
Start Date: _____ How many years total: _____
If you are a former smoker, please list quit date: _____

Drug Use

Do you use recreational drugs? This includes marijuana, cocaine, meth, etc. ☐ No ☐ Yes
How often are you using? _____
If you have a history, please list quit date: _____

Medical History

Medical Problem	Age of Onset	Medical Problem	Age of Onset

Family History

Relationship to you	Medical Problem	Age of Onset	Age Deceased

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Immunization History

Type of Vaccination	Last Given	Type of Vaccination	Last Given
Influenza			
Pneumonia			
Shingles			

Medications

Name of Medication	Dose	Name of Medication	Dose
Place an X on the line if none: _____			

Allergies

Name	Type of Reaction	Name	Type of Reaction
Place an X on the line if no known allergies: _____			

Surgical History

Surgery/Procedure Type	Surgeon Name	Date

Have you ever had Staph Infection (MRSA)? Yes ☐ or No ☐
Do you object to blood transfusions? Yes ☐ or No ☐

Women's Health

Screening Type	Last Completed
Cervical Cancer Screening (Pap Smear)	
Breast Cancer Screening (Mammogram)	
Bone Density Scan (Dexa Scan)	

Men's Health

Screening Type	Last Completed
Prostate Cancer Screening	
Abdominal Aortic Aneurysm Screening	

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Advanced Directives

Please select one of the following:		
☐ I do not have an advanced directive.		
☐ I have an advanced directive.		
☐ POA HEALTHCARE	☐ LIVING WILL	☐ DNR

If you selected one of the above listed advanced directives, please bring a copy with you to your first appointment.

Do you have any concerns? If yes, please describe below.

_____
_____
_____
_____
_____

Signatures

_____ _____
Signature of Patient(or parent/guardian if patient is a minor) Date

FOR OFFICE USE ONLY		
Accepted as a new patient:	YES	NO
Copies of advanced directives received:	YES	NO

Completed form may be returned in the following ways:

- **Mail:** Hillsboro Health Primary Care, 1220 E. Tremont Street, Suite A., Hillsboro, IL 62049
- **In Person:** Hillsboro Health Primary Care, 1220 E. Tremont Street, Suite A., Hillsboro, IL 62049
- **Fax:** 217-545-4350
- **Email:** ccmnurse@hhealth.us
    - *Note: Please allow a minimum of 2 business days for electronic submissions*

For Questions or concerns please call: 217-532-4351.