UnityPoint Clinic

ADULT HEALTH QUESTIONNAIRE

Please Print All Information

Clinic _____

Date: / /

Name: Birthdate: / /

Preferred Language: _____ Interpreter needed? Y N

Referring Doctor: _____

List any allergies to medications, or anything else, including latex and describe your reaction:

_____

LATEX ALLERGY PRE-SCREEN

1. Do you ever have a rash, redness, or swelling after use of gloves, lasting 1-2 days? Y N
2. Do you have allergies, asthma, rhinitis after use of rubber, latex products? Y N
3. Do you have frequent contact with rubber, latex products? Y N
4. Do you have allergic reactions to any of the following foods: avocadoes, bananas, chestnuts, papaya, kiwi, hazelnut, cherry or peach? Y N

Nutrition Screening Questions

- Have you lost more than 10 lbs. in the last 6 months without trying? Y N
- Do you have any open sores that are not healing? (decubitus) Y N
- Are you having difficulty in chewing or swallowing that is affecting your food intake? Y N
- **Is a nutritional assessment necessary? (to be completed by practitioner)**

Pain Assessment Screening:

- Are you experiencing any pain? Y N
- **Is a pain assessment necessary?(to be completed by nurse/practitioner)** Y N

Functional/Mental/Psycho/Social Assessment:

Do you live alone? Y N Whom do you rely on for emotional/social support? _____

Have you had any changes in your life that could affect your coping abilities? (job, move, divorce, death, disabilities) Y N

If yes, explain: _____

Are you able to care for yourself without the assistance of anyone else? _____

Do you require any assistive devices such as wheelchair, walker, cane, etc.? _____

Do you have any social, cultural, or religious beliefs or values that may affect your treatment plan or healthcare needs?

_____

Abuse Assessment Screen:

Have you felt unsafe where you have been living? Y N Explain: _____

Have you been emotionally, physically, or sexually hurt by anyone? Y N

Do you have an advance directive? Y N Have you provided this office with a copy? Y N

Would you like information on this? Y N

Immunizations:

DATE OF LAST: Flu Vaccine _____ Pneumonia Vaccine _____ Tetanus Vaccine _____

UnityPoint Clinic

MEDICATION LIST

Patient Name: _____ Date: _____

Name of Medication, Over-the-Counter Medications, Vitamins or Herbals	Dosage/Strength	How Often Taken

Past Medical History

Please indicate if you have or have had the following conditions:

A-FIB	___Yes ___No	Coronary stent	____Yes ____ No	Nerve/muscle disease	_____Yes _____No
Allergies	___Yes ___No	Deep vein thrombosis	____Yes ____ No	Neuropathy	_____Yes _____No
Anemia	___Yes ___No	Dementia	____ Yes ____No	Osteopenia	
Anesthetic complications	___Yes ___No	Depression	_____Yes ____No	(low bone density)	_____Yes _____No
Anxiety	___Yes ___No	Diabetes Mellitus	_____Yes ____No	Osteoporosis	_____Yes _____No
Arthritis	___ Yes ___No	Emphysema	_____Yes ____No	Parkinson's disease	_____Yes _____No
Asthma	___ Yes ___No	GERD	_____Yes ____No	Pregnancy	_____Yes _____No
Breast cancer	___Yes ___No	Glaucoma	_____Yes ____No	Prostate cancer	_____Yes _____No
CABG	___Yes ___No	Heart disease	_____Yes ____No	Pulmonary embolism	_____Yes _____No
Cancer	___Yes ___No	HIV/AIDS	_____Yes ____No	PVD	_____Yes _____No
Cataracts	___Yes ___No	Hypertension	_____Yes ____No	Seizures	_____ Yes _____No
CHF	___Yes ___No	Hypothyroidism	_____Yes ____No	Sickle cell anemia	_____Yes _____No
Clotting disorder	___Yes ___No	Kidney disease	_____Yes ____No	Sleep apnea	_____Yes _____No
Colon cancer	___Yes ___No	Lung cancer	_____Yes ____No	Stroke	_____Yes _____No
COPD	___Yes ___No	Migraines	_____Yes ____No	Substance abuse	_____Yes _____No
				Thyroid disease	_____Yes _____No

Surgical History

Please indicate if you have had any of the following procedures:

Appendectomy	_____Yes _____No	Coronary stent	____Yes ____No	Prostate surgery	_____Yes ____No
Brain surgery	_____Yes _____No	Cosmetic surgery	____Yes ____No	Skin biopsy	_____Yes ____No
Breast surgery	_____Yes _____No	Eye surgery	____Yes ____No	Small intestine surgery	_____Yes ____No
C-Section	_____Yes _____No	Fracture surgery	____Yes ____No	Spine surgery	_____Yes _____No
CABG	_____Yes _____No	Heart surgery	____Yes ____No	Tubal Ligation	_____Yes _____No
Carotid stent placement	_____Yes _____No	Hernia repair	____Yes ____No	Upper GI endoscopy	_____Yes _____No
Cholecystectomy	_____Yes _____No	Hysterectomy	____Yes ____No	Valve replacement	_____Yes _____No
Colon surgery	_____Yes _____No	Joint replacement	____Yes ____No	Vasectomy	_____Yes _____No
Colonoscopy	_____Yes _____No	Orthopedic surgery	____Yes ____No	Other _____	

FAMILY HISTORY

Relationship	Status (Alive/Deceased)	No Known Problems	Alcohol Abuse	Aneurysm	Arthritis	Asthma	BRCA 1/2	Breast Cancer	Cloting Disorder	Colon Cancer	COPD	Coronary Heart Disease	Depression	Diabetes	Drug Abuse	Early Death	Hearing Loss	Hyperlipidemia	Hypertension	Kidney Disease	Mental Illness	Miscarriages	Ovarian Cancer	Prostate Cancer	Stroke	Vision Loss	Uterine Cancer	Thyroid Disease
Mother																												
Father																												
Sister																												
Brother																												
Daughter																												
Son																												
Mat Aunt																												
Mat Uncle																												
Pat Aunt																												
Pat Uncle																												
MGM																												
MGF																												
PGM																												
PGF																												
Cousin																												

SOCIAL HISTORY

Alcohol Use Yes _____ No _____

Drinks/Week

_____ Glasses of wine _____ Shots of liquor

_____ Cans of beer _____ Not specified

Sexually Active Yes _____ No _____ Not Currently _____

Partners Female _____ Male _____

Birth Control/ Protection	Abstinence	Coitus Interruptus	Condom	Diaphragm	Implant	Injection	Insets	IUD	OCP	Patch	Post-menopausal	Rhythm	Spermicide	Sponge	Surgical	None	Other

DRUG USE

Yes _____ No_____ per week _____

Type	Amphetamines	Amyl nitrate	Anabolic steroids	Barbiturates	Benzodiazepines	"Crack" Cocaine	Cocaine	Codeine	Fentanyl	Flunitrazepam	GHB	Hashish	Heroin	Hydromorphone	Ketamine	LSD	Marijuana	MDMA (Ecstacy)	Mescaline	Methamphetamines	Methaqualone	Methylphenidate Morphine	Nitrous Oxide	Opium	Oxycodone	PCP	Psilocybin	Solvent Inhalants

TOBACCO USE

Current Smoker _____ Former Smoker _____ Never Smoked _____ Quit Date _____

Packs per day _____ Years _____

SMOKELESS TOBACCO

Current User _____ Former User _____ Never Used _____ Quit Date_____

Ready to Quit Yes _____ No _____ Comment _____

Additional Social History

Adopted	Yes _____	No _____	Comment
Are you having sex?	Yes _____	No _____	Comment
Are you trying to get pregnant?	Yes _____	No _____	Comment
Caffeine Use	Yes _____	No _____	Comment
Exercise	Yes _____	No _____	Comment
Hobbies	Yes _____	No _____	Comment
Living Arrangement	Yes _____	No _____	Comment
Military Service	Yes _____	No _____	Comment
Bike Helmet	Yes _____	No _____	Comment
Occupational Exposure	Yes _____	No _____	Comment
Seat Belt/Car Seat	Yes _____	No _____	Comment
Special Diet	Yes _____	No _____	Comment
Other Explain			

UnityPoint Clinic

General Patient Information

Patient Name:	***Date of Birth:***	***Gender:***	***Social Security Number:***
Address:	***City:***	***State:***	***Zip:***

Home Phone:	*Work Phone:*	*Mobile Phone:*	*Email:*

Marital Status:	☐ ***Hispanic or Latino*** ☐ ***Non-Hispanic or Latino***	***Race:***	***Primary Care Physician:***

Employer:	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***
Emergency Contact: ***Relationship to patient:*** ***Phone:***	*Second Emergency Contact:* *Relationship to patient:* *Phone:*

Guarantor Information *(Only required for patients less than 18 years old.)*

Guarantor's Name (Adult residing with child):	***Date of Birth:***	***Relationship to Patient:***

Social Security Number:	***Employer:***	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***

Insurance Information

Primary Insurance Company:	***ID#:***	*Group No./ Name:*	***Insurance Phone:***
Address:		*City, State, Zip:*	

Subscriber's Name (Policy Holder):	***Date of Birth:***	***Gender:***	***Relationship to Patient:***

Social Security Number:	***Employer:***	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***

Secondary Insurance Company:	***ID#:***	*Group No./ Name:*	***Insurance Phone:***
Address:		*City, State, Zip:*	

Subscriber's Name (Policy Holder):	***Date of Birth:***	***Gender:***	***Relationship to Patient:***

Social Security Number:	***Employer:***	***Employment Status:*** □ ***Full Time*** □ ***Part Time*** □***Retired***

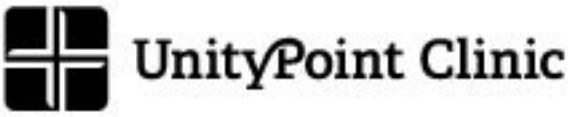
By signing below, I hereby acknowledge receipt of UnityPoint Health – Methodist's Notice of Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

_____ _____20_____

Signature of Patient (Legal or Personal Representative) Date of Signature

_____ _____

Print Patient Name Date of Birth



UnityPoint Clinic

FINANCIAL RESPONSIBILITY

Methods of Payment Accepted: Visa, MasterCard, Discover, cash and checks. Payment of co-pays and deductibles are due at the time of service.

Individual/Group Insurance: As a courtesy to you, UnityPoint Clinic will submit the appropriate claims to your insurance company(s). If your insurance requires an employee claim form, or any other information from you, please submit it to them in a timely manner. Your insurance policy is a contract between you and your insurance company. Therefore, you are ultimately responsible for payment of all charges. It is your responsibility to resolve disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, and use of any special forms. UnityPoint Clinic requires that your account be paid in full within 60 days of the date of service, regardless of the status of your insurance claim. If you need an extended payment plan, please contact our Billing Office at (309) 672-4809 or (888) 772-5351

Liability: Services incurred resulting from injury or accident are considered the responsibility of the patient / guarantor. It is your responsibility to ensure that the UnityPoint Clinic is paid promptly regardless of pending disputed or litigated claims. As we are unable to file claims to a third party insurance carrier, services rendered as a result of automobile accidents must be filed with your personal automotive insurance.

Medicare: UnityPoint Clinic is a participating provider and accepts assignment on all Medicare claims. For your convenience, appropriate claims will also be sent to your Medicare Supplemental Insurance. Any deductible, co-payment amounts or routine non-covered services are your responsibility and will be billed to you after Medicare and your supplemental insurance has processed and paid appropriate benefits.

No Insurance Coverage: UnityPoint Clinic requires payment for all charges at the time services are rendered. A self-pay discount is offered when payment is made at the time of service. If you are unable to pay at the time of service, please contact our Billing Office to make payment arrangements.

Worker's Compensation: If you are injured on the job, we will process claims to your employer in compliance with the Illinois law. If your employer or the employer's Worker's Compensation Insurance Carrier determine that your illness or injury is not related to your employment or is otherwise determined not to be covered by the Worker's Compensation guidelines, than all charges will be your responsibility.

Financial Assistance: We will be pleased to assist you with any questions regarding available payment options. UnityPoint Clinic is committed to providing service to those who may need financial assistance. If you have questions regarding financial assistance or would like a Financial Assistance application, please contact our Billing Office at (309) 672-4809 or (888) 772-5351.

ASSIGNMENT OF BENEFITS

Insurance Authorization / Release: I hereby authorize the physician/provider to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any and all services rendered.

Medicare Authorization / Release: I request that payment of authorized Medicare benefits to be made on my behalf to the physician/provider for any and all service provided to me by that physician/provider. I hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

My signature below indicates that I have read and understood the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required to process claims and benefits to which I am entitled.

Patient Signature_____ Date: _____

Patient Name Printed: _____ DOB:_____

Patient Social Security Number:_____ Patient Acct #_____

Responsible Party: _____ Date: _____
On behalf of a minor child.

Witness: _____ Date: _____

UnityPoint Clinic

Office Use: H P

INFORMED CONSENT TO TREAT

This Informed Consent to Treat Form was signed for treatment at the following UnityPoint Clinic location: _____

General

By signing below, I hereby present for medical treatment with UnityPoint Clinic and I do hereby voluntarily consent to and authorize physicians, nurses or other healthcare professionals to render such medical care, examinations, diagnoses, and treatments as may be ordered or requested by the physicians or other healthcare professionals rendering care and treatment to me and which they, in their professional judgment, deem necessary or beneficial.

I understand that among those who attend patients at UnityPoint Clinic may be medical, nursing and other healthcare personnel in training who, unless requested otherwise, may be present during patient care as part of their education.

I acknowledge that I have received no warranties or guarantees regarding the results of such care, procedures, examinations or treatment.

I understand that I can revoke this consent at any time by contacting my UnityPoint Clinic provider.

Release of Information

I also understand that, in certain cases, UnityPoint Clinic is required by law to disclose certain patient information and data relating to infectious diseases (including: HIV, tuberculosis, viral meningitis, and certain other diseases) to the designated local, State and Federal entities such as public health departments or the Center for Disease control and Prevention or other governmental agencies.

I CERTIFY THAT THIS FORM HAS BEEN EXPLAINED TO ME, THAT I HAVE READ IT AND I UNDERSTAND IT.

_____ _____

Signature of Patient/Guardian Today's Date

_____ _____

Printed Name of Patient Patient's Date of Birth

CONSENT TO OBTAIN MEDICATION INFORMATION/HISTORY (REQUIRED)

Consent for Obtaining Medication Information/History

I understand that this medication information/history may include: past and current prescriptions, prescription insurance eligibility, and prescription insurance claims history and prescription formulary files.

I give consent and understand that I can revoke this consent at any time by providing written notice, to my UnityPoint Clinic provider.

_____ _____

Signature of Patient/Guardian Today's Date

_____ _____

Printed Name of Patient Patient's Date of Birth

UnityPoint Clinic

Request of Information/Consent
Locations of Communication

The purpose of this form is to obtain guidance from you (the patient) about how we should communicate about you and to you.

Patient Information

Date of Request:_____/_____/_____

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

Patient Address: _____
City State Zip

SECTION 1: Communications to Family Members and Others Involved In My Healthcare

I give my permission to UnityPoint Clinic to communicate information concerning my medical condition and medical treatment to the person(s) listed below. **(*Note: If the patient is a minor, pursuant to Iowa and Illinois law, information generally will be given to both parents unless UnityPoint Clinic otherwise deems the communication inappropriate or if by court order one parent is not to be provided with information concerning the minor.)***

Name 1:_____ Relationship_____ Phone No._____

Name 2:_____ Relationship_____ Phone No._____

Name 3:_____ Relationship_____ Phone No._____

I understand that it is my responsibility to update the above information if I want it changed. This communication information will be used for all medical conditions and treatment obtained at UnityPoint Clinic or at the request of one of the physicians employed at UnityPoint Clinic.

I understand that mental health, substance abuse treatment and/or HIV information may **not** be disclosed pursuant to this form and that consent compliant with the Illinois Mental Health and Developmental Disabilities Confidentiality Act must be completed to disclose any mental health, substance abuse treatment and/or HIV information. Additionally, I understand that if there are exceptions to the communications permitted pursuant to this form, it is my responsibility to notify UnityPoint Clinic.

Note: This form does not provide the above-named person(s) with any authority, either implied or direct, over any treatment or direct care decisions. If you wish to designate a health care partner or representative, or if you wish to set up a living will, please discuss this with your primary healthcare physician or your attorney.

SECTION 2: Standard Methods to Communicate to Me (the patient)

Detailed information regarding my medical condition and medical treatment may be left on:

	Circle Yes or No		
My Home Answering Machine	Yes	No	Home Phone: _____
My Work Answering Machine	Yes	No	Work Phone: _____
My Cell Phone	Yes	No	Cell Phone: _____

Exceptions (types of information that cannot be left as messages): _____

_____

This form will be in effect until revoked, but I may be asked to confirm the information with a new dated signature on an annual basis.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Relationship (if not patient)