

		Morr	is Hos	pital and Heal	thcare Cente	rs Reg	istra	tion	Form	
	Last Name:		First N	ame:		M.I.:	M	aiden	Previous Name	(if applicable):
	Mailing Address:			Apt/Unit #:	City/State/Zip	<u>:</u>				
	Primary Contact Numb	er:		Secondary Cont	act Number:		Work	Num	ber:	Ext.:
	Preferred Phone Numb	er for Appo	ointme	nt Reminders: \Box	Primary Number	er 🗆 Sed	conda	ry Nu	mber Other:	L
	Preferred Delivery Met	hod for Ap	pointm	ent Reminders:	☐ Voice Messag	е 🗆 Те	ext Me	essage		
	Primary Care Physician	:		Referring Physic	ian:			Patie	nts Date of Birth	:
_	Sex: □ Male □ Female	Marital Sta	tus: 🗆	Married □ Divo	rced \square Partner	Socia	ıl Secu	ırity N	lumber:	
atio	☐ Transgender			☐ Widowed ☐ L				-		
Patient Information	Employer Name:			Employer Addr					Employer Phon	e #:
intl	Employment Status:	Full-Time [Part-	 Time □ Not Empl	loved □ Self-En	nploved	I □ R	etired	☐ Other:	
atie	Student Status:				Email Address	•				
В	☐ Full-Time ☐ Part-Tim	ne 🗆 Not a	Stude	nt						
	Race (please select):	American	Indian	or Alaska Native	Asian 🗆 Nati	ve Haw	/aiian	or Oth	ner Pacific Island	er
		Black or A	African A	American 🗆 Whi	ite 🗆 Decline to	Specify	y 🗆	Other		
	Ethnicity (please select	Ethnicity (please select one):			Preferred Language (please sele					
	☐ Hispanic/Latino ☐ N	ot Hispanic	or Lati	no 🗆 English 🛭	□ Spanish □ De	ecline to	Spec	ify	=	is needed, one will be
	☐ Decline to Specify			☐ Other: _			=		provided.	
	Preferred Pharmacy Na	me and Lo	cation:	(please include a	nny mail order p	harmad	cy)			
	Advanced Directives: (/)	f yes, please	e provid	de the office with	a copy for your	record)				
	☐ Medical Power of Att	torney 🗆 🏻	Do Not	Resuscitate 🗆 Liv	ving Will 🗆 Not	Applica	able 🗆	□ Non	e	
	e following Parent Section		-	-		-		_	f 18). Please not	e that any individuals
an #1	Parent/Legal Guardian	#1 First and	d Last N	lame:	Birt	hdate:				Relationship:
gal Guardi	Mailing Address: (Same	as Patient	□ Yes)		Apt	/Unit #	:	City	/State/Zip:	
Parent/Legal Guardian #1	Main Contact Number:	☐ Same a	s Patie	nt	Sec	ondary	Numl	oer (if	applicable):	
an #2	Parent/Legal Guardian	#2 First and	d Last N	lame:	Birt	hdate:				Relationship:
Parent/Legal Guardian #2	Mailing Address: (Same	as Patient	☐ Yes)		Apt	/Unit #	•	City	/State/Zip:	
Parent/Leg	Main Contact Number:	☐ Same a	s Patie	nt	Sec	ondary	Numb	oer (if	applicable):	
	Parent/Legal Guardia	an Marital S	Status:	☐ Married ☐ Di	vorced \square Partn	er 🗆 U	nmarr	ied 🗆] Widowed □ Lo	egally Separated



	***Responsible be listed as th		•			•	_	•						•	
	Is the responsib														
t,	Last Name:			First	First Name:			M.I.:	Previo	us N	ame (if	applicable)	ı		
Responsible Party	Date of Birth: Social Security Number:			Prin	Primary Phone: Email:				Gender: ☐ Male ☐ Female ☐ Transgender			emale			
espon	Mailing Addres	SS:		•	Apt	/Unit#	: City/State/Zip Code:								
E	Employer Nam	e:			Emp	oloyer	Address:								
	Work Phone: Ext.: Okay to Lo					ige at W	/ork:	Responsible	Party'	's Re	lation t	o Patient:			
	Is the emergen	cy contact a pa	tient with	the N	/lorris	Hosp	ital Healtho	are Cen	ters?	P □ Yes □ N	lo				
Emergency Contact	Relation to Pat	ient:	Las	st Nam	ne:				First	: Name:				Date of Birt	th:
rgency	Main Contact Number: Work Phone:							•					Ext.:		
Eme	Mailing Addres	s: (Same as Pat	ient 🗆 Ye	s)		Apt/U	nit #:	City/S	State	/Zip:					
	Primary Insura	nce Company:					Primary In	surance	Add	ress:	Pho	one I	Numbe	r:	
	Subscriber Nun	nber:					Group Nur	nber:					Copay	(s):	
surance	Policy Holders Name: Same as Patient Is this person a patient with the Healthcare Centers? Yes						No								
Primary Insurance	Date of Birth:		Social Sec	curity	Numl	ber:	Primary Co	ntact N	lumb	er:					
Prin	E-mail:		1	Ge	nder	: 🗆 Ma	ale 🗆 Fema	ale Mail	ing A	ddress:					
					1_		ansgender								1_
	Employer Name	e:			Emp	loyer'	s Address:				Wo	ork P	hone:		Ext.:
	Secondary Insu	rance Compan	y:			9	Secondary I	nsurano	ce Ad	dress:	Pho	ne N	umber	:	I
, e	Subscriber Nun	nber:					Group Nur	nber:					Copay	(s):	
Secondary Insurance	Policy Holders I	Name: 🗆 San	ne as Patie	ent			Is this person a patient with the Healthcare Centers? ☐ Yes ☐ No								
ndary I	Date of Birth:		Social Sec	curity	Numl	ber:	Primary Co	ntact N	lumb	er:					
Seco	Email:		•		Gen		☐ Male ☐ F☐ Transgen		Mail	ing Address:					
	Employer Name	e:			Emp	loyer'	s Address:				Wo	ork P	hone:		Ext.:



Initials:	
I understand that it is the policy of the Healthcare Centers of Morris Hospital to be given at leas	t 24 hour notice when
canceling an appointment. I understand that more than 3 failures to cancel appointments without proper r	otice may result in being
discharged from the practice.	
This Healthcare Center is a lab drawing station for Morris Hospital and all labs will be processed	by the Morris Hospital
laboratory. I am aware that my insurance may prefer or require an outside lab to be used for lab processin	g and that I am responsible
for the charges that my insurance does not pay.	
I have read and been offered a current copy of the Notice of Privacy Practices.	
I have read and been offered a current copy of the Patient Rights and Responsibilities.	
I understand that my medication history will be verified electronically for treatment purposes.	
I understand that my immunization records will be sent electronically to the State of Illinois Imm	nunization Registry.
Patient or Parent/Guardian Signature Date	

^{*}By signing I attest to all information provided is true to the best of my knowledge.



MEDICAL & FAMILY HISTORY FORM Name: Today's Date: Date Of Birth: Last Medical Examination: **Other Medical Providers** Specialty Phone # / Location **MEDICATIONS** Please list all of your current prescription <u>and</u> non-prescription medications, vitamins and supplements: ☐ None When did you start Medication Strength Frequency medication? **PAST MEDICAL HISTORY: Birth History: (**Pediatric patients only**)** Birth weight: ______ Delivering Physician/Hospital: _____ ☐ Vaginal ☐ C-Section due to _____ □Full-Term (>38 weeks) □ Premature (<38 weeks) # weeks ☐ Forceps ☐ Vacuum Pregnancy Concerns: _____ ☐ None

☐ None

MH#1464B 8/2019 Page **4** of **1**



PAST MEDICAL HISTOR	Y:				
□ None					
☐ Acid reflux ☐	Coronary Artery	☐ Heart Attack		☐ Milk intolerance	☐ Sciatica
☐ Alcohol abuse	Disease /CAD	☐ Heart murmur		☐ Multiple Sclerosis	☐ Scoliosis
□ ADHD □	Cirrhosis	☐ Hemorrhoids		□ Mumps	☐ Seizures
☐ Anemia ☐	Colon Polyps	☐ Hepatitis		☐ MRSA	☐ Sexual problems
☐ Anxiety ☐	Constipation	□ Hernia		☐ Osteoporosis	☐ Sinusitis
☐ Arthritis ☐	Crohn's disease	☐ Herpes		☐ Ovarian cyst	☐ Sleep apnea
☐ Asthma ☐	Congestive Heart	☐ High Blood Pre	ssure	☐ Overweight	☐ Strep throat,
☐ Autism	failure/ CHF	☐ High Cholester	ol	☐ Pancreatitis	multiple
☐ Bedwetting ☐	Depression	☐ High triglyceric	les	☐ Parkinsons Disease	☐ Stomach ulcer
☐ Bi-pap/C-pap use ☐] Diabetes	☐ HIV or AIDS		☐ Peptic Ulcer	☐ Stroke or paralysis
□ Blood Clots □	Diverticulitis	☐ Irregular Heart	Beat	Peripheral Vascular	☐ TB – Tuberculosis
☐ Blood Transfusion ☐	Drug Abuse	☐ Irritable Bowe		Disease /PVD	\square TB skin test positive
☐ Breast problem ☐	Ear infections,	Syndrome		☐ Phlebitis	☐ Thyroid disease
☐ Cancer,	multiple	☐ Kidney Disease	!	☐ Pneumonia	☐ Ulcerative colitis
· y p c ·] Emphysema	/failure		☐ Polio	☐ Urinary reflux
☐ Chest] Eczema	☐ Lung Disease		☐ Psoriasis	☐ Varicose veins
Pain/Angina 🗆 🗆	Fatty liver	☐ Lupus		☐ Pyloric stenosis	☐ Venereal disease
☐ Chicken pox ☐	Gallstones	☐ Measles		☐ Radiation therapy	☐ Other
☐ Cough ☐] Glaucoma	\square Memory probl	ems	☐ Rheumatic fever	
] Gout	☐ Migraines		□ RSV	
ALLERGIES (List all known a	allergies, including medica	tion, food, animals	, season	al, etc.)	
☐ None					
Do you have a latex alle	ergy? 🗆 Yes 🗆 No				
Allergy			Read	ction	
CLIDGEDIES /DDOCEDLID	NEC .				
SURGERIES/PROCEDUR					
□ None			<u> </u>		По
☐ Appendectomy	☐ Ear tubes		Hiata		Ovary
□ Duccet	☐ Ear tubes ☐ EGD		☐ Hyste	erectomy	Prostate
☐ Breast	☐ Ear tubes ☐ EGD ☐ ERCP		□ Hyste □ Joint	erectomy replacement	☐ Prostate ☐ Stomach
Colon surgery	☐ Ear tubes ☐ EGD ☐ ERCP ☐ Gallbladder		□ Hyste □ Joint □ Kidne	erectomy replacement ey	☐ Prostate ☐ Stomach ☐ Thyroid
☐ Colon surgery ☐ Colonoscopy	☐ Ear tubes ☐ EGD ☐ ERCP ☐ Gallbladder ☐ Groin hernia		☐ Hyste☐ Joint☐ Kidne☐ Mast	erectomy replacement ey ectomy	☐ Prostate ☐ Stomach ☐ Thyroid ☐ Tonsillectomy
☐ Colon surgery ☐ Colonoscopy ☐ Colostomy	☐ Ear tubes ☐ EGD ☐ ERCP ☐ Gallbladder ☐ Groin hernia ☐ Heart bypass		☐ Hyste☐ Joint☐ Kidne☐ Mast☐ Liver	erectomy replacement ey ectomy biopsy	☐ Prostate ☐ Stomach ☐ Thyroid ☐ Tonsillectomy ☐ Tubal ligation
☐ Colon surgery ☐ Colonoscopy	☐ Ear tubes ☐ EGD ☐ ERCP ☐ Gallbladder ☐ Groin hernia		☐ Hyste☐ Joint☐ Kidne☐ Mast☐ Liver☐ Obes	erectomy replacement ey ectomy biopsy	☐ Prostate ☐ Stomach ☐ Thyroid ☐ Tonsillectomy

MH#1464B 8/2019 Page **5** of **1**



			of MORI	RIS HOSPITAL			
REVIOUS	HOSPITALIZAT	IONS OR SERI	OUS INJURIES				
	None						
Hospital	lization or Injury					Date	
I							
<u> </u>							
MMUNIZ	ATIONS						
			nmunization histo	ory Immuniza	ation records ava	ilahle	
				•		iidbic	
dult Imm	unizations/Vacci	nation Records	unknow	N Immunization his	story		
Check if	Vaccination /	Immunizatio	n			Date Received	
received	Influenza /Flu						
	Pneumonia						
	Tetanus						
	Shingles						
	Other -						
	Other -						
					·		
AMILY H	STORY (Check th	e appropriate bo	x to indicate whi	ch relative has had	the following di	seases)	
		.					
Parents ,	/ Grandparents	Father	Mother	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
		□Alive	□Alive	□Alive	□Alive	□Alive	□Alive
		□Deceased	□Deceased	□Deceased	□Deceased	□Deceased	□Deceased
		Age:	Age:	Age:	Age:	Age:	Age:
Diabetes							
	d Pressure		-				
Heart Dise Cancer	ease						
Caricer		Type:	Type:	Type:	Туре:	Type:	Type:
Arthritis		турс.	турс.	турс.	турс.	турс.	турс.
Endometr	riosis						
Heart Atta							
High Chal	octorol						

Lupus
Osteoporosis
Thyroid Disease

Lung Bowel Gallbladder

ISSUES

Other: please specify Unknown history NO KNOWN HEALTH



Brothers / Sisters	□Brother □Sister	□Brother □Sister	□Brother □Sister	□Brother □Sister	□Brother □Sister	□Brother □Sister
	□Alive	□Alive	□Alive	□Alive	□Alive	□Alive
	□Deceased	□Deceased	□Deceased	Deceased	Deceased	Deceased
	Age:	Age:	Age:	Age:	Age:	Age:
Diabetes						
High Blood Pressure						
Heart Disease						
Cancer						
	Type:	Type:	Type:	Type:	Type:	Type:
Arthritis						
Endometriosis						
Heart Attack						
High Cholesterol						
Lupus						
Osteoporosis						
Thyroid Disease						
Lung						
Bowel						
Gallbladder						
Other: please specify						
Unknown history						
NO KNOWN HEALTH						
ISSUES						
				•		•
# Sons	□Son	□Son	□Son	□Son	□Son	□Son
# Daughters	□Daughter	□Daughter	□Daughter	□Daughter	□Daughter	□Daughter
	□Alive	□Alive	□Alive	□Alive	□Alive	□Alive
	□Deceased	□Deceased	Deceased		□Deceased	□Deceased
				□□Deceased		□ □ Deceased
				☐Deceased Age:		
Diabetes	Age:	Age:	Age:	Age:	Age:	Age:
Diabetes High Blood Pressure						
High Blood Pressure						
High Blood Pressure Heart Disease						
High Blood Pressure	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer						
High Blood Pressure Heart Disease Cancer Arthritis	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus Osteoporosis	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus Osteoporosis Thyroid Disease	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus Osteoporosis Thyroid Disease Lung	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus Osteoporosis Thyroid Disease Lung Bowel	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus Osteoporosis Thyroid Disease Lung Bowel Gallbladder	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus Osteoporosis Thyroid Disease Lung Bowel Gallbladder Other: please specify	Age:	Age:	Age:	Age:	Age:	Age:
High Blood Pressure Heart Disease Cancer Arthritis Endometriosis Heart Attack High Cholesterol Lupus Osteoporosis Thyroid Disease Lung Bowel Gallbladder	Age:	Age:	Age:	Age:	Age:	Age:



SOCIAL HISTORY	
Daycare and Activities:	Daycare: ☐ At Home ☐ Day Care ☐ Elder Day Care ☐ Caretaker Activities: ☐ Sports ☐ Dance ☐ Band ☐ Scouts ☐ Other ☐
Education Level:	Highest grade level completed: ☐ Pre-School ☐ Grade School ☐ Home School ☐ High School ☐ College
Do you have smoke/carbon monoxide detectors in your home?	□ No □ Yes
Exercise:	How many days a week do you exercise? Type of exercise: Duration: Less than 30 minutes each time
Living with:	☐ Alone ☐ Spouse ☐ Children ☐ Siblings ☐ Parents ☐ Mother ☐ Father ☐ Step-Parents ☐ Caretaker ☐ Other
Marital Status:	☐ Married – How long? ☐ Single ☐ Divorced ☐ Widowed
Occupation:	□ Unemployed □ Retired
Pets:	□ No □ Yes - Type:
Recreational Drug Use:	□ No □ Yes; Specify drug(s) and amount(s):
Tobacco Use Screening:	☐ Never ☐ Former Smoker ☐ Current, Daily Smoker ☐ Current, Some Days Smoker
	If former, how long has it been since you smoked? \square < a month \square 1-3 months \square 3-6 months \square 6-12 months \square 1-5 yrs \square 5-10 yrs \square >10 yrs
	If current daily smoker, how many cigarettes a day? \Box 5 or less \Box 6-10 \Box 11-20 \Box 21-30 \Box 31 or more
	If current daily smoker, how soon after you wake? ☐ within 5 min ☐ 6-30 min ☐ 31-60 min ☐ after 60 min
	If current daily smoker, are you interested in quitting? ☐ Ready to Quit ☐ Thinking About Quitting ☐ Not Ready to Quit
Alcohol Use Screening:	Did you have a drink containing alcohol in the past year? \square No \square Yes
	If yes, how often did you have a drink containing alcohol in the past year? Monthly or Less 2-4 Times a Month 2-3 Times Per Week 4 or More Times a Week
	If yes, how many drinks did you have on a typical day when you were drinking in the past year? \square 1 or 2 \square 3 or 4 \square 5 or 6 \square 7 to 9 \square 10 or more
	If yes, how often did you have six or more drinks on one occasion in the past year? ☐ Never ☐ Less Than Monthly ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily
Caffeine:	□ No □ Yes - How much? How often?
Guns (Optional):	Do you have guns in your home?
Abuse:	History of physical, mental or sexual abuse? ☐ No ☐ Yes
Special Considerations (Notes):	Any other special considerations pertaining to medical care? No Yes If yes, explain

MH#1464B 1/2018 Page **8** of **1**



ALLERGY HISTORY:	
Reason for your visit today:	
Were you referred by a physician to see an allonumber:	ergist? If yes, please provide the Providers name, office phone and fax
PRIOR ALLERGY HISTORY:	
Have you been evaluated by an allergist in the	e past? □ yes □ no
Have you ever been diagnosed with allergic rifindings:	hinitis (environmental allergies)? If yes, please explain any important
Have you had prior allergy skin testing perform	med? If yes, please explain any important findings:
Have you received allergy injections in the pas If yes, when and how long were you treated w	
Have you been diagnosed with any food allerg	gies? ☐ yes ☐ no
If yes, please list all foods and the reactions yo	ou have experienced?
Food:	Reaction:
Food:	Reaction:
Food:	
Do you avoid any foods? \square yes \square no <i>If yes,</i>	please list any foods you are avoiding:

MH#1464B 1/2 Page 9 of 19



ENVIRONMENTAL HISTORY:
How long have you lived in your residence? \square < 1 year \square 1-5 years \square 6-10 years \square > 10 years
Type of home? □ townhouse □ single family home □ apartment
Age of home, townhome or apartment unit? \square < 1 year \square 1-5 years \square 6-10 years \square 10-20 years \square > 20 years
Location of home? □ city □ rural area □ suburbs
Do you have a basement? □ yes (<i>check all that apply</i>) □ no
\square crawl space \square finished \square unfinished \square seepage or leak \square wet or musty
Past flooding in the home? ☐ yes ☐ no
Type of heating in home? □ central forced air □ radiator (steam) □ solar □ space/electric heater
Type of air-conditioning? □ none □ central A/C □ window unit
How often do you change air filters? □ every month □ every 3 months □ every 6 months □ once a year
Type of air filters? ☐ HEPA ☐ 3M ☐ 2M ☐ unknown
Do you keep your windows open in warmer months? □ yes □ no
Type of home ventilation? □ air purifier □ ceiling fans □ dehumidifier □ HEPA filters □ humidifier
☐ wood/coal stove or fire place
Do you have pets at home? If yes, indicate number of each pet(s) you have: cats dogs birds
guinea pigs hamsters rabbits
Do pets sleep in your bedroom? □ yes □ no
Are there any tobacco smokers in the home? ☐ yes ☐ no
Do you use feather pillows or comforter? □ yes □ no
Do you have carpeting in the bedroom? □ yes □ no <i>If yes, how old in the carpet?</i> years
PRIOR LAB WORK, TESTING OR CONSULTATIONS:
Have you had any prior autoimmune workup checking for rheumatologic conditions in the past? ☐ yes ☐ no
Have you had any prior testing/imaging: \square yes (check all that apply) \square no
\square chest x-ray \square CT of chest \square CT of head \square CT of neck \square CT of sinuses \square GI endoscopy with biopsy
\square MRI of the ear \square MRI of head \square MRI of sinuses \square prior sinus surgeries \square rhinoscope by ENT \square skin biopsy
Have you had any prior consultations: □ yes (check all that apply) □ no
☐ ENT ☐ dermatology ☐ gastroenterology ☐ pulmonary ☐ rheumatology

MH#1464B 1/2018 Page 10 of 19



Please describe all important lab, imaging and consultation findings from previous page:
NASAL OR SINUS CONCERNS (if no concerns please SKIP to next section):
Do you have the following nasal or sinus symptoms consistently? □ yes (<i>check all that apply</i>) □ no
□ burning in mouth □ clear, thin/think or white/yellow/green mucous □ congestion □ dark circles under ey
☐ dry mouth ☐ dry gritty eyes ☐ ear pain ☐ ear plugging ☐ ear ringing ☐ hay fever ☐ headache
☐ hoarseness ☐itchy mouth or lips ☐ migraines ☐ nasal polyps ☐ nasal/sinus pressure ☐ pain in throat
\square postnasal drip \square runny nose \square recurrent sinus infections \square red eyes \square scratchy throat \square sneezing
□ sores in mouth □ watery eyes
How long have you been having symptoms?
What triggers your nasal symptoms? (please list any outdoor, indoor, irritant/chemical triggers)
Please list the name of all the prescription and over the counter and prescription allergy and sinus medications you have tried and if they worked:
ASTHMA OR BREATHING CONCERNS (if no concerns please SKIP to next section):
At what age were you first diagnosed with asthma?
How was the asthma diagnosed?
Do you have the following breathing issues or asthma like symptoms consistently? \Box yes (check all that apply) \Box
\square anxiety \square burning in chest \square chest pain with exhalation \square chest pain with inhalation \square chest tightness
\square cold hands and feet \square not getting oxygen \square dry cough \square productive cough \square fatigue from coughing
\square hyperventilation \square mucous production \square nervousness \square pain in back
\square rib pain \square pain in shoulder \square shortness of breath \square persistent wheezing
☐ any other symptoms

MH#1464B 1/2018 Page 11 of 19



Describe all that apply to the pattern and duration of your asthma or breathing problems:
\square no pattern found \square rare and mild \square getting worse \square occurs at rest \square exercise/exertion \square morning
\square afternoon \square evening \square throughout the day \square intermittent \square 1-2 times a week
\square more than twice a week \square few times a month \square wakes me up at least once a week at night \square spring
□ summer □ fall □ winter □ year round
List all the allergens, chemical, products or irritants that make your breathing worse?
How many times a year do the following infections make your asthma or breathing worse?
☐ # of sinus bronchitis ☐ # of pneumonias ☐ # of recurrent URIs
☐ # of sinus infections
How many urgent care/ER visits have you had for asthma or breathing trouble in the past year?
How many oral or IV steroid courses for asthma in past year?
Were the symptoms alleviated with steroids? \square yes \square no
Number of days missed from work or school in past year due to breathing issues or asthma?
When was your last PFT or spirometry?
When was your last Chest X-ray or CT of chest?
How many time a week do you use your albuterol inhaler?
Please List name of ALL inhalers and dosage you have been prescribed in the past 2-3 years?
ALLERGIC REACTION, SWELLING, AND SKIN RASHES (if no concerns please SKIP to next section):
Are you having any of the current skin problems or reactions? ☐ yes ☐ no
\square anaphylactic/severe allergic reaction \square chronic itching \square eczema/atopic dermatitis \square hives \square rash
□ swelling
Describe the characteristics of the current skin reaction(s) or rash:

MH#1464B 1/2018 Page 12 of 19



Where is the skin rash or allergic reaction occurring? (check all that apply)
\square abdomen \square arms \square around eyes \square back \square chest \square eyebrow/eyelids \square face \square feet
☐ fingers ☐ groin ☐ hands/wrist ☐ legs ☐ lips ☐ neck ☐ thighs
Describe the pattern of the allergic reaction (check all that apply):
\square no pattern found \square getting worse \square getting better \square intermittent \square lasts less than 12 hours
☐ lasts less than 24 hours ☐ lasts more than 24 hours ☐ occurring in evening or night ☐ occurring in the mornin
\square occurring once a day \square present all the time \square sporadic \square spreading everywhere
Does avoiding any foods alleviate skin condition? \square yes \square no <i>If yes, please list foods being avoided:</i>
Have you ever been stung by an insect? ☐ yes (check all that apply) ☐ no
□ bee □ fire ant □ hornet □ mosquito □ spider □ wasp □ yellow jacket □ unknown
List any important details about the stinging insect reactions you have experienced:
What triggers your skin condition (check only those that are effecting you skin)?
\square acrylic nails \square adhesives \square alcohol based body/facial products \square anti-aging products \square bleach/chlorine
\square body soap/wash \square cosmetics \square deodorants \square dishwashing soap \square dry ventilation \square dry-cleaned garments
\square dust \square eye cream \square fabric softener/sheets \square fabric dye/new clothing \square feather pillows/bedding \square fertilizer
\Box food dye/coloring \Box fragrance \Box hair dyes \Box household cleaners \Box insecticide \Box jewelry \Box latex
☐ laundry detergent ☐ leather belt ☐ lotions ☐ mold exposure ☐ mouthwash ☐ nail polish ☐ newspaper prints
\square nickel \square nylon \square outdoor pollen (airborne) \square paint fumes \square paper boxes \square perfumes \square pets (cats/dog)
□ polyester □ rubber □ sawdust □ spandex □ shampoo/conditioner □ stainless steel
\square tight clothing/ elastic undergarment \square toothpaste \square wool
☐ List any other skin irritants:
Do any of the non-allergic triggers below effect your skin (check only those that effect your skin)?
\square anger \square cold air \square cold object \square cold water \square cooking fumes/odors \square direct sun light
\Box dry air \Box emotional stress \Box exercise \Box going from hot to cold temperature \Box heat \Box hot beverage/foods
\square hot water/shower \square humidity \square prolonged pressure to skin \square rubbing or friction to skin
\square submersion in water \square sleeping on back \square spicy foods \square sweating \square tobacco smoke \square vibration to skin

MH#1464B 1/2018 Page 13 of 19



How many ER/urgent care visits have you had for skin rash or allergic reactions in the past 6 months?								
Any new medications you have been started on within the past year of the skin condition starting? □ yes □ no								
If yes, please list name of medications and dosage taken:								
Do you think a particular medication(s) may be causing your symptoms? ☐ yes ☐ no								
If yes, list medication(s):								
Please list all medications that have been tried for your ongoing skin condition:								
Have you been prescribed an Epipen for any allergic reaction? If yes, please describe for what reason you were prescribed this medication:								
FOOD REACTION (if no concerns please SKIP to next section):								
List ALL confirmed food allergies OR list ANY foods you have experienced reactions to? Please describe in detail.								
Do you have the following symptoms from food ingestion consistently? \square yes (<i>check all that apply</i>) \square no								
\square abdominal pain \square anaphylaxis \square bloating \square blood in stool \square burning in mouth \square chest tightness								
\square constipation \square coughing \square diarrhea \square diffuse hives \square dizziness \square eczema/atopic dermatitis \square flushing								
\square gas \square headaches \square itchy mouth/lips \square itchy skin \square localized hives \square loose stools \square loss of consciousness								
\square migraines \square nausea \square numbness/tingling \square rashes \square runny nose \square shortness of breath \square sneezing								
☐ sores in mouth ☐ swelling ☐ vomiting ☐ watery/itchy eyes ☐ wheezing								
How often do these reactions occur?								

MH#1464B 1/2018 Page 14 of 19



Did avoidance of certain foods above alleviate yours s	symptoms? ☐ yes ☐ no ☐ unsure
Have you been diagnosed with a food intolerance (suctive diagnosed?	ch as lactose intolerance)? If yes, list which foods and how were
Have you ever been prescribed an Epipen for a food re	eaction? If yes, when was it last used?
Are there any other important details that you think v	we should know about your concerns with foods?
I have provided all accurate information regarding my for my visit to the Allergist.	current symptoms and medical health to the best of my ability
Patient Signature:	Date:

MH#1464B 1/2018 Page 15 of 19



Beta Blocker Screening Form

The medications listed below are "beta blockers", commonly used to treat high blood pressure, angina (chest pain), irregular heart rhythms, and migraine headaches.

Please place a check mark if you are currently taking any of the medications listed below:

Oral Medications					
Betapace (Sotalol)	Timolide (Timolol)				
Blocadren (Timolol)	Toprol3XL, Toprol (Metoprolol)				
Bystolic (Nebivolol)	Trandate (Labetalol)				
Cartrol (Carteolol)	Visken (Pindolol)				
Coreg (Carvedilol)	Zebeta (Bisoprolol)				
Corzide, Corgard (Nadolol)	Ziac (Bisoprolol)				
Inderal, Innopran XL (Propranolol)	Breviloc (Esmolol) – IV use				
Inderide (Propranolol)	Eye Drop Section				
Kerlone (Betaxolol)	Betopic (Betaxolol)				
Levalol (Penbutolol)	Betagan (Levobunolol)				
Lopressor (Metoprolol)	Betimol (Timolol)				
Normodyne, Normozide (Labetalol)	Corsopt (Timolol)				
Sectral (Acebutolol)	Istalol (Timolol)				
Tenoretic (Atenolol)	Ocupress (Carteolol)				
Tenormin (Atenolol)	Optipranolol (Metipranolol)				
Other:	Timoptic (Timolol)				
If you should be started on any new medication(s) by your physician in our office of any changes. I am currently on the medication(s) listed above I am currently NOT on any medication(s) list above	physician, please notify either our allergy nurse or				
Patient Name:	Date:				
Signature:					

MORRIS HOSPITAL and HEALTHCARE CENTERS CONSENT FORM and AGREEMENT



	Acct#
1.	CONSENT TO TREATMENT
	I,, believing I have a condition requiring medical care, hereby voluntarily consent to
	such care at Morris Hospital & Healthcare Centers("MHHC"). I consent to diagnosis, medical care and treatment that I
	have agreed to receive and that is considered necessary or recommended by my physicians(s) and other healthcare
	providers (collectively, "practitioners"). This consent includes, but is not limited to, the administration of fluids, blood

I understand that I am seeking services during a pandemic and that entering any facility in which you have contact with other individuals increases the risk of potential exposure to the COVID – 19 virus.

Pt Initials ______

2. GENERAL CONSENTS and ACKNOWLEDGEMENTS:

- A. I understand that the practice of medicine and surgery is not an exact science. I acknowledge no guarantees have been made to me as to the diagnosis or result of examination or treatment at MHHC. If I am pregnant, I understand that all the provisions in this agreement apply to my newborn child/children for their medical care and treatment.
- B. I understand the following regarding the practitioners involved in my care:

and/or blood products/components, medication and any radiology procedures.

- i. Employed practitioners:— S.Ahmed, F.Aijaz, J. Allen, C. Albinson, H.Amin, S. Analytis, P.Analytis, D.Anjum, L.Anubrolu, M.Aranas, M. Bialas, I.Best, A.Blough, S.Bojak, J.Bolden, B.Bunton, E.Cacello, N.Chalisa, A.Chen, S.Ciechna, C.Comfort, M.Connolly, S.Davis, J.DeLind, J.Frye, M.Gordon, J.Greggain, O. Hla, H.Hedayati, S. Henline, M.Hill, D. Howd, C. Jaegle, S.Johnson, J. Jones, Y.Kagalwalla, C. Kao, C.Kelly, R. Kohlman, B. Lawton, H.Lugo, , I.Mezo, C. Miller, L.Moy, E.Muraskas, A.Nomani, V.Ochoa, M.Passerman, J.Pendergast, C.Pierard, A.Piper, F.Rahman, D.Raval, P.Roumeliotis, A.Saeed, B.Said, R.Saleem, N. Seplak, L.Setrini-Best, A. Staker, H.Suleiman, J.Thomas, A.Todd, D.Toussaint, K. Ulivi, L.Verchimak, S Whitmer, and D.Zuelke are employed by MHHC.
- ii. Non-Employed practitioners- all practitioners, other than those listed in B.i, including those who provide remote monitoring during surgeries or provide "virtual" services, are not employees or agents of MHHC. Instead, these are independent practitioners who have been permitted to use MHHC facilities and to exercise their independent medical judgement in the care and treatment of their patients.
- iii. I acknowledge that the employment status of the practitioners who treat me is not relevant to my selection of MHHC for my medical care and treatment. MHHC does not control or direct any practitioner's care of his or her patients.

**I have read and understand Section B.1, 2 & 3

als
ais

- C. I understand that I have a right to express a concern or grievance regarding any quality of care issue either informally or formally through the patient grievance mechanism established by MHHC.
- D. I agree that all telephone numbers and email addresses I provide to MHHC may be used by MHHC or those acting on its behalf to communicate with me by telephone (including cell phone), text, or any automated or prerecorded messages.
- E. I acknowledge and agree that money, jewelry and other valuables should not be brought into any MHHC facility; but if I do bring them into a MHHC facility, I agree they should be deposited with the facility's cashier or sent home by me with a responsible person. I agree that I will not hold MHHC liable for the loss or damage to any money, jewelry, glasses dentures, documents, fur coats, or other articles, goods or property of any kind that I bring into the facility. I agree to inform the nursing staff of any valuables in my possession.

3. MY HEALTH INFORMATION

- A. I authorize MHHC to retain, preserve and use for scientific or teaching purposes or to dispose of any specimen or tissue taken from my body during my hospitalization.
- B. In the event I am (or my child is)transferred/referred to another health care facility, I authorize MHHC to release information and/or copies of my medical record or portions thereof to such other health care facility and/or practitioner in the event of such transfer/referral. I further authorize the facility and any practitioners to which I am (or my child is)transferred/referred to provide information to MHHC upon request regarding the care, condition and treatment of myself (and/or my child).
- C. I authorize the use of my medical records for quality assurance and/or risk management purposes. I further authorize any practitioners involved in my care to provide information to MHHC upon request concerning my care, condition, and treatment.
- D. In the event a practitioner or other individual involved in my care sustains exposure to my blood or body fluids, I understand MHHC may test my blood for infectious disease of any nature and description.
- E. I agree that MHHC can use and disclose my health information for treatment payment and operations purposes, and as otherwise described in the MHHC Notice of Privacy Practices.
 - If I am an obstetrical patient, I understand that MHHC may use and release my health information for the care and treatment of my newborn child/children, for related payment and MHHC operations. I understand that my health information will be included in my newborn child/children's records.

MORRIS HOSPITAL and HEALTHCARE CENTERS CONSENT FORM and AGREEMENT

4. FINANCIAL CONSENT AND ACKNOWLEDGEMENTS:

- A. I authorize MHHC to release and/or send any medical information deemed by it to be necessary for the processing and payment of my bills for services rendered by MHHC and its employed or contracted practitioners for which it is authorized to bill to any insurance company or other third party payor who is or may be responsible for paying any part of my medical treatment.
- B. I understand this information may include the diagnosis of and treatment for mental illness, substance abuse disorder, human immunodeficiency virus, and genetic testing.
- C. I understand that, whether a consent is signed as patient, agent or as guarantor, I am directly responsible and will pay for the services rendered by MHHC and those for whom it is authorized to bill and is not paid by insurance.
- D. I acknowledge that I may receive a separate bill for services from each of the independent practitioners providing services at MHHC for the services provided. I am solely responsible for the payment of any bills received from these independent practitioners. These independent practitioners may or may not participate in managed care contracts and it is my responsibility to confirm their participation in any particular managed care plan or insurance.
- E. I understand this authorization is furnished to enable MHHC, the practitioners for whom it is authorized to bill, and also independent practitioners who bill on their own behalf, and me, to obtain or attempt to obtain proceeds, benefits or amounts due to me or to members of my family from insurance companies or third party payors due to my treatment and hospitalization. In consideration of MHHC's cooperation in securing or attempting to secure said amount on my behalf, I release MHHC, its agents, servants, employees and attorneys from all responsibilities and/or liabilities incidental to their release of my medical records and other information.
- F. I further authorize MHHC to release and/or send copies of my records or portions thereof to my practitioners and to practitioners on MHHC medical staff or those of other hospitals who were consulted in regard to my treatment, for the purpose of billing and collection amounts due to them for services rendered. This release includes the results of any blood test performed to determine the presence of the Human Immunodeficiency Virus (causative agent of AIDS).
- G. In the event I am entitled to benefits arising out of any policy insuring me, I hereby assign those benefits to MHHC for application on my bill.
- H. MHHC may obtain a consumer report on me from any Consumer Reporting Agency. Should my account be referred for collection, I (patient, agent, or guarantor) shall pay all reasonable costs of collection including but not limited to, attorneys' fees incurred because of any suit or claim that may be filed or asserted in connection therewith.
- I. If I do not have health insurance or have difficulty paying my MHHC bill, MHHC provides financial assistance options, including free care, discounted care or interest-free payment plans. Information about MHHC's financial assistance program, qualification criteria and whether or not my practitioner or other practitioners offer financial assistance is available from MHHC patient accounts department.

5. OTHER ACKNOWLEDGEMENTS AND CONSENTS

- A. Important Message from Medicare: my signature acknowledges my receipts from MHHC of the Important Message from Medicare.
- B. I have been informed of my patient rights and responsibilities.
- C. By signing below, I acknowledge that I have received a copy of MHHC's Notice of Privacy Practices.D. I understand that MHHC's authorized nursing and allied health students accompany and sometimes participate with practitioners and MHHC staff in the delivery of, as well as the observation of care.

Pt Initials

- E. I understand that I may cancel or revoke any authorization or consent I have given by notifying MHHC's Privacy Officer in writing at any time. I can reach the Privacy Officer by writing to Morris Hospital, 150 W. High St. Morris, IL 60450, Attn. Privacy Officer or by fax at 815-942-3203.
- F. I certify I have read the Consent Form and Agreement and I am the patient or I am duly authorized to execute this acknowledgement on behalf of the patient. I accept the terms of this agreement.
- G. This consent form and agreement will expire upon the earlier of the cessation of treatment at MHHC or one (1) year from the date hereof. Please note: Healthcare Center consents are valid unless revoked.

Patient, legal representative Signatur	DATE:	TIME:		
X				
Relationship of Above to Patient		Witness Si	gnature	
DD	Interpreter (if applicable)			



HEALTHCARE CENTERS of MORRIS HOSPITAL CONSENT FOR VERBAL RELEASE OF INFORMATION

Patient Name:					Date Of Birth:									
Please list your preferred numbers		Type (please circle)		Leave Message to call the office		ge	Leave Detailed message regarding instructions		T	Leave detailed message with Lab/Test results				
Primary: ()	-	Home	Work	Cell	YF	ES	NO		YES	NC)	YES	S	NO
Secondary: ()	-	Home	Work	Cell	YE	ES	NO		YES	NC)	YES	S	NO
❖ Answering machines and voice mail must have an identifying message to confirm these are your numbers. For Example: "You have reached John Doe"														
Please list any person with whom we MAY share details about your healthcare. Indicate below whether this may include appointments, messages, test results or instructions, billing information, and sensitive health information (SHI) such as mental health, developmental disabilities, AIDS/HIV or other STD treatments and/or diagnosis, Drug/alcohol abuse diagnosis, treatment and or referral and genetic testing. (Minors 12 and over have certain rights to treatment and confidentiality of sensitive information. They may exercise these rights to restrict information in specific situations).														
Name	Relationship	Phone Number		May make or cancel message to call the off		age to	normal test results or			release ling nation	May release Sensitive Health Information			
					YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
					YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
					YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
I understand that this consent is valid, until it is revoked by me, and applies to information about me obtained through Morris Hospital and Healthcare Centers. I understand that I may revoke this consent at any time by giving written notice to Morris Hospital and Healthcare Centers of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to Morris Hospital and Healthcare Centers.											se my			
Signature:			I	Oate:_										
Printed Name:														
Relationship to Patient: _														