Dear New Patient,

Thank you for choosing Benton Community Care Center!

To save time during your first appointment, feel free to print and fill out the following forms and bring with you to your appointment.

☐ Patient Information ☐ Patient History ☐ Patient Assessment
☐ Acknowledgement of Privacy Practices

Also, please remember to bring with you to the appointment:

- Your insurance cards and photo identification (preferably driver's license).
- Any prescription medicines you are taking (in the original packaging).
- Any over-the-counter supplements.

We look forward to meeting you. If you have any questions, please let us know!

Amber Thorne, FNP-BC
6468 State Highway 77
Benton, MO 63736
(573) 545-3700
www.missouridelta.com

MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON, MISSOURI

PATIENT INFORMATION
(to be completed by patient)

Date: ______________

Name: First ____________________ Middle ________ Last ____________________

Date of Birth	Age	Sex	Marital Status	Race	Religion
______	______	______	______	______	______

Social Security Number	Maiden/Other Name	Family Doctor
______	______	______

Patient Address ____

City/State/Zip ____________________ Home Phone ______________ Cell Phone ______________

Email Address ____

Patient Employer ____

Address: ____

City/State/Zip ____________________ Phone ______________

Preferred Pharmacy ____

Next of Kin

Spouse/Father/Mother Name ____________________ D.O.B. ______________

(Spouse or Parent if Patient is under 18 years of age)

S.S.N.# ____________________ Cell Phone Number ______________

Address if different from above ____

Spouse/Parent Employer ____

Address ____

City/State/Zip ____________________ Phone ______________

Closest Relative NOT Living With You

Name ____

Address ____

City/State/Zip ____________________ Phone ______________

Relationship to Patient ____

Person to Notify (other than Next of Kin)

Name ____

Address ____

City/State/Zip ____________________ Phone ______________

Relationship to Patient ____

MISSOURI DELTA PHYSICIAN SERVICES
SIKESTON MISSOURI
Patient Assessment

DATE:______________ NAME: _____________________________ DOB: ___________

Do you have an Advance Directive (i.e. Living Will, Power of Attorney, etc)? Yes No

If yes, which one and do we have a copy? ____

Please check any immunizations you've had:

Flu Vaccine □ **No** □ **Yes** If yes, when? __________________ Where? □ at MDMC □ other facility

HPV Vaccine □ **No** □ **Yes** If yes, when? ________________ Where? □ at MDMC □ other facility

Pneumonia Vaccine □ **No** □ **Yes** If yes, when? ___________ Where? □ at MDMC □ other facility

TDAP Vaccine □ **No** □ **Yes** If yes, when? _______________ Where? □ at MDMC □ other facility

□ Other: ____ Where? □ at MDMC □ other facility

Do you smoke? _______ **If yes, how long?** _________ **How many packs per day?** ________

Female
When was your last?
Mammogram? _____________________
Pap Smear? _______________________
Colonoscopy? _____________________

Male
When was your last?
PSA? ______________________
Colonoscopy? _____________________

If Diabetic:
When was your last?
Hgb A1C? _____________ Foot Exam? ______________ Eye Exam _____________

Have you had any visits to the Emergency Room or Hospital stay since your last office visit?

If yes, When? ______________________________ Why? ____________________________

Do you see other physicians/providers besides your Primary Care Physician?

If yes, Name of Provider/Specialty ______________________________

Reason? ____

Are you having any pain? Yes No Please circle the number that describes your pain.

Location: ________________________ 0 1 2 3 4 5 6 7 8 9 10

None mild mod severe very severe worse

Have you had any falls that have resulted in injury in the past year? ___________________

If yes, How Many? __________________ Type of injury? ____________________________

Do you have any of the following?

□ CAD (Coronary Artery Disease) □ Diabetes □ Hypertension

What level of education have you completed? ______________________________________

Missouri Delta Physician Services

BENTON COMMUNITY CARE CENTER
Health History Form

Patient Name________________________________ **Date of Birth**_________ **Today's Date**_________

Main reason for Today's visit: ____

Allergies to medication/food/latex:
Please provide name of allergy and reaction:
□ No allergies
____
____
____

Medications: Prescription & over-the-counter.
□ No current medications

Medication	**Dose**

*May use back to write additional medications or attach copy

Personal Medical History: Have you have had any of the following medical conditions.
__ High Blood Pressure
__ Heart Disease
__ Stroke
__ Asthma/COPD
__ Diabetes
__ High Cholesterol
__ Thyroid Problem
__ Kidney Disease
__ Cancer, Type: ____________________
__ Other: please describe: ________________

Surgical History: Please indicate whether you have had any of the following surgeries.
__ Tonsillectomy
__ Hysterectomy
__ Angioplasty
__ Appendectomy
__ Gallbladder
__ Other: please describe: ________________

Family History: Please indicate whether you have a blood relative with the following.
__ Heart disease
__ High blood pressure
__ Bleeding disorder
__ Mental illness
__ Stroke
__ Migraines
__ Diabetes
__ Cancer: type: ____________________
__ Other: Please describe: ________________

Social History: Please indicate whether you do the following.
__ Smoke Cigarettes:
if yes, packs per day_____ for how many years_____
__ Smokeless tobacco
if yes, how much per day_____ for how many years_____
__ Drink Alcohol
If yes, what and how often____________________
__ Recreational Drug Use
If yes, what and how often____________________

Missouri Delta
Physician Services

BENTON COMMUNITY CARE CENTER
Health History Form

Patient Name________________________________ Date of Birth_________ Today's Date_________

Current Problems: Please indicate if you are having or have had any of the following problems.

__ Fever
__ Fatigue/Extreme Tiredness
__ Night Sweats
__ Weight gain
__ Weight loss

__ Ear pain
__ Ear drainage
__ Hearing loss
__ Eye discharge
__ Eye pain
__ Visual changes
__ Nasal drainage
__ Sinus drainage
__ Sore throat

__ Food allergies
__ Seasonal allergies

__ Cough
__ Chronic cough
__ TB exposure
__ Shortness of breath
__ Wheezing

__ Chest pain
__ Swelling/edema
__ Heart Racing/Irregular heartbeat
__ History of blood clots

__ Abdominal pain
__ Blood in stools
__ Changes in stool
__ Constipation
__ Diarrhea
__ Heartburn
__ Loss of appetite
__ History of ulcers
__ Nausea
__ Vomiting

__ Burning with urination
__ Blood in urine
__ Urinary frequency
__ Slow urinary stream
__ Loss of bladder control
__ Urinary retention
__ Sexual dysfunction
__ Vaginal or penile discharge
__ Sexually transmitted disease

__ Heat/Cold intolerance
__ Increased thirst
__ Increased urination
__ Hair loss

__ Dizziness
__ Extremity weakness
__ Numbness/tingling
__ Trouble walking
__ Headache
__ Memory loss
__ Seizures

__ Anxiety
__ Depression
__ Insomnia

__ Itchy skin
__ Mole changes
__ Rash
__ Poor wound healing
__ Dry skin

__ Back pain
__ Neck pain
__ Joint pain
__ Muscle weakness

__ Easily bleed
__ Easy bruising
__ Swollen lymph nodes
__ Weakened immune system

MISSOURI DELTA MEDICAL CENTER

SIKESTON MISSOURI

ACKNOWLEDGMENT: RECEIPT OF PRIVACY PRACTICES NOTICE

I acknowledge that I have been provided with Missouri Delta Medical Center's Notice of Privacy Practices.

Patient or legal representative: ______________________________

Date:______________________________

□ Patient was unable /unwilling to sign acknowledgment.

Reason: ____

Staff initials: __________

Date: ______________

Time: ___________

Below is a list of people that may receive full disclosure of my medical information:

____

____

____

Copy of Notice was included in patient's Admission Information Packet