Eagle View Community Health System
"with an eye on your health"

Oquawka Site
PO Box 198
Oquawka, IL 61469
309-867-2770
877-350-2385 (toll-free)
309-867-3205 (fax)

Stronghurst Site
PO Box 240
Stronghurst, IL 61480
309-924-2424
866-346-1337 (toll-free)
309-924-1389 (fax)

NAME: _____ DATE: _____
ADDRESS _____ CITY _____ STATE _____
ZIP CODE _____ PHONE _____ BIRTHDATE_____EMAIL_____
SOCIAL SECURITY NUMBER_____

MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

GENDER: ❑ MALE ❑ FEMALE ❑UNDIFFERENTIATED
PLEASE LIST PREFERRED PRONOUNS _____

GENDER IDENTITY: ❑ MALE ❑ FEMALE ❑ MALE TO FEMALE
❑ FEMALE TO MALE ❑ OTHER (PLEASE SPECIFY): _____

SEXUAL ORIENTATION: ❑ BISEXUAL ❑ LESBIAN, GAY, OR HOMOSEXUAL
❑ CHOOSE NOT TO DISCLOSE ❑ DON'T KNOW ❑ STRAIGHT OR HETEROSEXUAL ❑OTHER (PLEASE DESCRIBE)
_____

RACE/ETHNICITY: ☐ WHITE(not Hispanic or Latino) ☐ BLACK/AFRICAN AMERICAN (not Hispanic or Latino) ☐ HISPANIC OF LATINO (all races) ☐ AMERICAN INDIAN/ALASKAN NATIVE ☐ ASIAN ☐ NATIVE HAWAIIN ☐ OTHER PACIFIC ISLANDER

EMPLOYED BY:_____ BUSINESS PHONE _____
EMPLOYER'S ADDRESS _____ OCCUPATION _____
METHOD OF PAYMENT ❑ INSURANCE ❑ SELF ❑MEDICAID ❑ MEDICARE
NAME AND GROUP # OF INSURANC: _____
PERSON RESPONSIBLE FOR ACCOUNT _____ ADDRESS _____
INSURED'S SOCIAL SECURITY _____

ALLERGIES: _____
_____

ROUTINE MEDICATIONS: _____
_____

PAST HISTORY: Have you ever had or do you now have any of the following:

Check each item	Yes	No	Check each item	Yes	No
Alcohol use			Meningitis		
Anemia or other blood disease			Menstrual difficulties		

Revision Date: 2/20/19

Anorexia			Mononucleosis		
Appendicitis, acute or chronic			Nervous or mental disease		
Arthritis			Pneumonia		
Asthma			Poliomyelitis		
Back problems			Pregnancies		
Binge eating			Rheumatic fever		
Bronchitis			Hernia		
Cancer			Sexually transmitted diseases		
Cardiovascular disease			Sinus disease		
Chickenpox			Skin disease		
Diabetes			Smoker		
Ear infections, disease, mastoid, etc.			Street drug use		
Epilepsy or convulsive disorder			Thyroid trouble		
Gallbladder disease			Tonsillitis		
Hay fever			Ulcer, stomach or duodenal		
Headache			Vertigo (dizziness) or fainting spells		
Hepatitis			Vomiting or losing weight		
HIV infection			Whooping cough		
Hypertension					
Injuries (serious)					
Kidney disease					
Liver disease					

If yes, explain: _____
_____

Surgeries (Check all that apply):
Appendectomy ❑ Tonsillectomy ❑ Adenoidectomy ❑ Hysterectomy ❑ Cholecystectomy (gallbladder) ❑
Caesarean Section ❑ Other (please explain) _____

PEDIATRIC HISTORY - FILL OUT UP TO AGE 5

PARENTS	SIBLINGS	AGE	SEX	HEALTH	MISCARRIAGES	MONTH	CAUSE
Mother _____							

Father _____							

DEVELOPMENTAL HISTORY

Held up head _____
Sat aided _____
Sat alone _____
Stood aided _____
Stood alone _____
Crept _____
Walked _____
Said words _____
Sentences _____
First teeth _____
Other _____

BIRTH HISTORY

Term _____
Prem. at ____ Months _____
Pregnancy number _____
Delivery type _____
Instruments _____
Labor length _____
Other _____

(CONDITION AT BIRTH)

Weight _____ Height_____
Apgar score _____
Jaundice _____
Convulsions _____
Deformities _____
Other _____

FEEDING HISTORY

Breast _____
Formula _____
Vitamin supp. _____
Soft foods added _____
_____
Appetite _____
Stools_____
Allergies _____

(HABITS)

Sleep _____
Naps _____
Play _____
Other _____
_____

FAMILY HISTORY

Do any of your blood relatives have a history of any of the following:

		Yes	No	Relationship		Yes	No	Relationship
1.	Cancer	__	__	_____	9. Diabetes	__	__	_____
2.	Heart disease	__	__	_____	10. Nervous or mental disease	__	__	_____
3.	High blood Pressure	__	__	_____	11. Asthma or Hay fever	__	__	_____
4.	Liver disease	__	__	_____	12. Convulsions	__	__	_____
5.	Stroke	__	__	_____	13. Stomach disease	__	__	_____
6.	Tuberculosis	__	__	_____				
7.	Lung disease	__	__	_____	14. Alcohol or Drug use	__	__	_____
8.	Kidney disease	__	__	_____				

AGREEMENT & CONSENT

The undersigned may voluntarily seek medical and/or surgical treatment or diagnosis from the health care providers at EVCHS, and hereby authorizes and gives consent to laboratory tests, X-rays, EKGs, and other routine medical treatment and diagnostic procedures as may be necessary at any given time. The undersigned consents to and authorizes all treatments, the performance of minor operations and the administration of local anesthetics, and any or all other technical procedures which in the judgement of the health care provider may be considered necessary or advisable for diagnosis and/or treatment.

Date _____

Signature of patient_____

Signature of parent/guardian _____
(must be signed by parent/guardian if under 18 years of age)