Allegan Professional Health Services

Dear Parent,

Thank you for putting your trust in Allegan Professional Health Services to meet your healthcare needs. You have requested an appointment at: Gobles Medical Clinic, Otsego Medical Center, Fennville Medical Center, or Allegan Medical Clinic. As a parent you can help ensure that your child's first visit runs smoothly.

As soon as you receive this new patient packet, please complete and return all forms to our office so that we can request your child's records from their previous provider(s). (The patient handbook is yours to keep.) When we receive your child's information, we will contact you to schedule a new patient appointment. They will be scheduled for the first available appointment that works for your schedule. Often this can be four or more weeks out on our schedule. If you no show for your child's new patient appointment, your child may be denied as a new patient to this facility. If you need to cancel this new patient appointment for any reason, you must do so 24 hours prior to the appointment time or it will be considered a no show appointment.

It is essential that you review the patient handbook enclosed in this packet. The handbook contains our hours of operation, medication refill policy and procedures, patient rights & responsibilities, patient portal information, our late policy, as well as other resources available to our patients.

We look forward to meeting your family's needs and serving you now and in the future. If you have any questions, please contact our office at Gobles Medical Clinic (269) 628-2196, Otsego Medical Center (269) 694-9640, Fennville Medical Center (269) 561-8761, and Allegan Medical Clinic (269) 686-5800.

Thank you,

Allegan Professional Health Services Providers & Staff

Allegan Professional Health Services

Date: _____/_____/_____

New Patient (Birth to 1 year)

To maintain the accuracy of your records we may ask that you fill this form out once a year.

Parents: Please complete this form with your child's information. If you do not know the answer to a question, please skip and move to the next question.

Name: _____ Date of Birth: _____

Preferred Pharmacy: _____ Primary Language: _____

Race: Asian American Indian or Alaska Native African American Native Hawaiian
Other Pacific Islander White More than One Race Do Not Wish to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Do Not Wish to Report

Medical Allergies: _____ None

Birth History

Prenatal

Maternal Age:_____ Due Date:_____ Total # of pregnancies:_____ Total # of live births_____
Prenatal Care YES NO

Maternal blood type: A B O AB Rh Positive Negative Rhogam injection received? YES NO
GBS Negative Positive Received antibiotics prior to delivery? YES NO
Maternal Illness/Complications/Infections: NO YES Please explain: Diabetes High Blood Pressure
Other:_____
Any medications taken during pregnancy? If yes, please list: _____
_____

Used during pregnancy: Alcohol Tobacco Marijuana Other:_____

Delivery

Type of delivery: Vaginal (Natural) Vaginal (Vacuum or Forceps) Planned C/S Unplanned C/S
Reason for unplanned C/S_____
Bag of Water broke: On its own Had to be broken It was: Clear Baby had stool inside
Baby was: Small for gestational age Average for gestational age Large for gestational age

Time of delivery:_____ AM / PM APGAR scores: _____ @ 1 minute _____ @ 5 minutes
Hours in labor:_____ Gestational age @ birth: _____weeks _____ days
Weight:_____ pounds _____ ounces Length: _____ inches Head:_____ inches

After Delivery Care

Was Vitamin K injection given? YES NO Was Hepatitis B vaccine given? YES NO
Hearing test: PASSED FAILED Any jaundice noted: NO YES Treated with phototherapy: NO YES
Defects Noted: NONE Yes:_____
Was the baby under any distress after the birth: NO YES Please explain:_____
Was oxygen required? YES NO Did your baby go to the NICU? YES NO
Was your baby breastfed? YES NO If formula fed, type:_____
Discharge Date:_____

Nutrition

Does your child drink from: Breast Bottle Cup

Liquid:

Type	Ounces/day
Formula	
Milk	
Juice	
Water	
Other:	

Baby is Breastfed:
Length of each feeding:_____ minutes Frequency of feedings: Every _____ hours

Solids:
Age solids were introduced:
Fruits: _____ months old Veggies: _____months old
Cereals: _____months old Meats: _____months old

Elimination

Bladder: # Wet Diapers/day _____ No Concerns_____ Concerns:_____
Bowel: # Bowel Movements/day _____ No Concerns_____ Concerns:_____

Sleep

Uses pacifier? NO YES No Concerns_____ Concerns:_____# naps/day_____
#hours of sleep/day_____ Sleeps through night? YES NO Sleeps with parents? NO YES

Activity

No Concerns_____ Concerns_____

Family & Relationships

Parents are: Married Divorced Separated Live Together Never Together Friends
Father in Jail Mother in Jail
Child resides with: Mother _____% of the time Father_____% of the time
Occupations: Mother _____ Father_____
# of Siblings: _____ Brothers _____Sisters
Is your child cared for by someone else while you work? Center Daycare Homecare Babysitter Relative

Home Environment & Safety

Home Type: House Apartment Shelter Single Family Multi Family
Age of Home: <10 years 10-25 years >25 years
Is home safe? NO YES Heat type:_____
Water source: City Well Bottled Chlorinated? YES NO Fluoridated? YES NO

Car Restraints: Rear Facing_____ Front Facing_____
Lead in home? NO YES Known TB exposure? NO YES
Smoker in home? NO YES If someone smokes, do they smoke outside only? YES NO
Smoke detectors in home? YES NO Carbon monoxide detectors in home? YES NO
Radon in home? NO YES NEVER TESTED

Firearms in home? NO YES If yes, # in home_____ Are they locked up? YES NO
Is ammunition stored separately? YES NO
Used for: Recreation Hunting Occupation Protection

Do you have a pool or spa at home? NO YES
Animals in the home? NO YES Type:_____

Medical History

Does your child have any medical problems? Please list:_____
_____

Has your child ever been seen by a specialist? Please list: _____
_____

Surgical History

Has your child ever had surgery? If yes, please explain:

Surgery Type	Date

Family History:

	Who *(Mother, father, sister, brother, grandparent)*	**Age@ onset or death**	**Check if cause of death**		**Who** *(Mother, father, sister, brother, grandparent)*	**Age@ onset or death**	**Check if cause of death**
ADD/ADHD				Hearing Deficiency			
Alcoholism				High Cholesterol			
Allergies				Hypertension			
Alzheimer's Disease				Irritable Bowel Disease			
Asthma				Learning Disability			
Blood Disease				Mental Illness			
CAD				Migraines			
CAD Premature				Obesity			
Cancer				Osteoarthritis			
Type:				Osteoporosis			
CVA (Stroke)				PVD			
Depression				Renal Disease			
Developmental Delay				Seizure			
Diabetes				Other			
Eczema				Other			

Current Medications:

Medication Name	**Dose**	**Frequency**	**Original Prescriber**

Additional Comments:

Here at Allegan Professional Health Services, we have created a new patient process that assures we will have all the information necessary to better assist your child with his/her healthcare needs. This new patient appointment is scheduled so that you can establish care for your child with one of our providers. Please understand that this appointment is not the appropriate time to expect treatment for current issues. The provider will utilize this time to get to know you and your child and his/her healthcare needs and concerns. This appointment will allow time to collect the information needed to assure a positive relationship in this practice. If your child is having an issue please call our reception staff to schedule an acute care appointment. We look forward to caring for your family.

Thank you,
Allegan Professional Health Services Staff