

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



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

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
Group Beta Strep 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
Bag of Water broke: On its own Had to be broken It was: Clear Baby had a BM 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 initiated? YES NO
Hearing test: PASSED FAILED Any jaundice noted: NO YES Treated
Newborn Screening Test: COMPLETED REFUSED Circumcision: COMPLETED REFUSED N/A

After Delivery Care (Continued)

Defects Noted: NONE Yes: _____

Were you under any distress after the birth: NO YES Please explain: _____

Was oxygen required? YES NO

Were you breastfed? YES NO If formula fed, type: _____

Discharge Date: _____

Were you adopted? YES NO

Hand dominance: RIGHT LEFT AMBIDEXTROUS

Nutrition

Type of Diet: _____ Supplements: _____

Excess junk food/snacks: Candy Chips Cookies Fast Food Fried Food Ice Cream Snacks

Excess soda: Diet w/Caffeine Regular w/Caffeine Decaf Diet Decaf Regular Amount/Day: _____

Caffeine: Chocolate Coffee/Tea Energy Drinks Soda Tablets

Have you ever used tobacco? NO YES

Smoking Tobacco: Cigarettes Cigarillos/Cigars Pipe E-Cigarettes

Non-Smoking Tobacco: Chew Smokeless Snuff

Uses daily? NO YES # _____/day Age Started? _____

Body Image: No Concerns Distorted Body Image: NO YES Self Conscious: NO YES

Dental

Last Visit Date: _____ No Concerns Cavities Erosion Disease Uses Pacifier

Elimination

Bladder: No Concerns _____ Concerns: _____

Bowel: No Concerns _____ Concerns: _____

Sleep

Concerns: NO YES _____ Changes in sleep pattern NO YES

Education

High School Graduate? YES NO

School Name _____ Current Level _____

Goals: GED Diploma Associates Bachelors Masters PhD Other _____

Employment

Military Experience? YES NO Current Status: _____

Employed? NO Where: _____ Hours/week _____

Activity

Hours of TV/computer games per day _____ Hours of Internet/day _____
 Activity Level: Moderate Sedentary Vigorous

Exercise

Hours per week: _____ Type: _____

Religion

Affiliation? YES NO Type: _____ Practicing? YES NO
 Agrees to blood transfusions if necessary to sustain life? YES NO
 Do you have an advanced directive? None Do Not Resuscitate Living Will Durable Power of Attorney

Family & Relationships

Resides with: Lives Alone Spouse Mother Father Both Parents Other _____
 Support from: None Mother Father Siblings Relatives Spouse Significant Other
 Marital Status: _____ Do you have children? NO YES
 Parents are: Married Divorced Separated Live Together Never Together Friends
 Father in Jail Mother in Jail
 # of Siblings: _____ Brothers _____ Sisters Birth Order _____
 Cooperates with family/friends? YES NO Has friends? YES NO Friends of both sexes? YES NO

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
 Lead in home? NO YES REMOVED UNKNOWN
 Car Restraints: Seatbelt _____ NONE _____
 Uses bike helmet? YES NO
 Known TB exposure? NO YES
 Smoker in home? NO YES Smoked 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: _____

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

<u>Additional Comments:</u>

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