

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.*

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**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: \_\_\_\_\_

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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

Liquid:

Type	Ounces/day
Milk	
Juice	
Soda Pop	
Water	
Other:	

Does your child drink from: Bottle Sippie Cup Cup

Solids:

Age solids were introduced: Baby Food \_\_\_\_\_ months old Table Food \_\_\_\_\_ months old

How many servings of:

Fruits: \_\_\_\_\_ Veggies: \_\_\_\_\_ Dairy/Calcium: \_\_\_\_\_ Proteins: \_\_\_\_\_

Supplements Given: \_\_\_\_\_

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

### Dental

Last Visit Date: \_\_\_\_\_ No Concerns Cavities Erosion Disease Uses Pacifier

### Elimination

Bladder: Toilet Trained? YES NO Day Only Age Trained: \_\_\_\_\_ Months

No Concerns \_\_\_\_\_ Concerns: \_\_\_\_\_

Bowel: Toilet Trained? YES NO # Bowel Movements/day \_\_\_\_\_

No Concerns \_\_\_\_\_ Concerns: \_\_\_\_\_

### Sleep

Sleeps with parents? NO YES Sleeps through night? YES NO >8 hours of sleep/night YES NO

Nightmares/Problems NO YES Explain: \_\_\_\_\_

### Education

School Name \_\_\_\_\_ Grade \_\_\_\_\_

Likes school? YES NO Cooperates at school? YES NO

### Activity

Hours of TV/computer games per day \_\_\_\_\_ TV in room? YES NO

### Exercise/Sports/Activity

Hours per week: \_\_\_\_\_ Type: \_\_\_\_\_

**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 \_\_\_\_\_ Birth Order \_\_\_\_\_  
 Cooperates with family/friends? YES NO Has friends? YES NO  
 Is your child cared for by someone other than parents? 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  
 Lead in home? NO YES  
 Car Restraints: Rear Facing \_\_\_\_\_ Front Facing \_\_\_\_\_ Booster \_\_\_\_\_  
 Uses bike helmet? YES NO  
 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:**

	<b>Who</b> (Mother, father, sister, brother, grandparent)	<b>Age@ onset or death</b>	<b>Check if cause of death</b>		<b>Who</b> (Mother, father, sister, brother, grandparent)	<b>Age@ onset or death</b>	<b>Check if cause of death</b>
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:**

<b>Medication Name</b>	<b>Dose</b>	<b>Frequency</b>	<b>Original Prescriber</b>

**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