Allegan Professional Health Services

Dear New Patient,

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 new patient you can help ensure that your 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 records from your previous provider(s). (The patient handbook is yours to keep.) When we receive your information, we will contact you to schedule your new patient appointment. You 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 new patient appointment, you will 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 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

New Patient Questionnaire (Adult)

Date: _____/_____/_____

To maintain the accuracy of your records we 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

Advanced Directive: Do you have any legal documentation stating who will be making medical decisions for you, if you are unable to make them for yourself? Yes (Please include a copy for your records) No

Current Medications: ☐ **No Current Medications**

Medication Name	Dose	Frequency	Original Prescriber

Medical Allergies:_____ None

Past Medical History (Check all that apply): ☐ **No Past Medical History**

Allergies - Seasonal		Blood Clots		Gallbladder Disease		Osteoarthritis	
Allergies - Food		Cancer, if yes-type		GERD		Renal Disease	
Anemia				Headaches/Migraines		Seizure Disorder	
Angina		Cardiac Arrhythmia		Heart Disease		Thyroid Disease	
Anxiety		COPD		Heart Valve Disorder			
Arthritis		Coronary Artery Disease		Hepatitis/Liver Disease		Other:	
Asthma		Depression		Hypertension			
Atrial Fibrillation		Diabetes		Irritable Bowel Disease			
Benign Prostatic Hypertrophy		Elevated Cholesterol		Myocardial Infarction			

Additional Comments:

Surgical History, (Check all that apply, and year surgery performed): ☐ **No Past Surgical History**

Surgery		Year	Surgery		Year	Surgery		Year	Other:
Angioplasty			Cataract Extraction			Thyroidectomy			
Angioplasty w/Stent			Cholecystectomy			Tonsillectomy			
Appendectomy			Colectomy						
Arthroscopy			Colostomy			Other:			
Back Surgery			Gastric Bypass			Hysterectomy			
Blood Transfusion			Hernia Repair			Vasectomy			
CABG			Hip Replacement						
Carpal Tunnel Release			Knee Replacement						
Cardiac Pacemaker			LASIK						

Family History: ☐ **Unknown**

	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				Elevated Cholesterol			
Alcoholism				Genetic Disorder			
Allergies				Hearing Deficiency			
Alzheimer's Disease				Hypertension			
Arthritis				Irritable Bowel			
Asthma				Learning Disability			
Blood Disease				Mental Illness			
CAD				Migraines			
CAD Premature				Obesity			
Cancer				Osteoporosis			
Type:				PVD			
CVA (Stroke)				Renal Disease			
Depression				Seizure			
Developmental Delay				Thyroid Disease			
Diabetes				Other			
Eczema				Other			

Hand Dominance: Right Left Ambidextrous

Education:

Grade Completed:_____

Degree Obtained: GED Diploma Associates Bachelors Masters PhD Other

Employment:

Military Experience? YES NO Current Status:_____

Employed? YES NO Where:_____ Hours/week_____

Social Status:

Marital Status: Single Married Divorced/Widowed
Do you have children?: YES NO # Sons:_____ # Daughters_____
Housing status: Stable Temporary Unstable Patient Lives With:_____
Support Person(s): NONE Spouse Children Parent(s) Significant Other

Tobacco:

Do you use tobacco? YES NO Type: Cigarettes Chewing Tobacco Cigars
Age Started:_____ years old How often: _____ day / week / month
Previous Smoker: YES NO Ever tried to quit: YES NO Year Quit:_____ Longest time stopped:_____
Have you ever had passive smoke exposure? NO YES Where? Home Car Other_____
Level of exposure: Mild Moderate Severe

Alcohol/Drugs:

Do you use alcohol? YES NO Age Started:_____ years Sought treatment for abuse YES NO
How often:_____ day / week / month Have you had withdrawal or blackouts from alcohol? YES NO
Type: Beer Wine Liquor Other:_____
Do you use recreational drugs? YES NO Type:_____
How often:_____ day / week / month / year
Do you consume caffeine? YES NO How often:_____ day / week / month
Type of caffeine consumed**:** Coffee/Tea Soda Pop Energy Drinks Other:_____

Sleep

Any changes in sleep pattern? YES NO Average # of hrs/night _____
Trouble falling asleep? NO YES Difficulty staying asleep? NO YES
Frequent waking episodes at night? NO YES Disruptive breathing or choking during sleep? NO YES

Lifestyle

Activity: Moderate Sedentary Vigorous
Type of exercise: (Swimming, jogging, sports, ect.)_____
Frequency of exercise:_____ Hours per Week
Diet: Junk Food Vegetarian Well-balanced Gluten-Free Other_____

Do you have pets in the home? NO YES Type:_____

Home Environment/Safety

Smoke detectors in home? YES NO Carbon monoxide detectors in home? YES NO
Any falls in the past year? NO YES Did it result in injury? NO YES Details_____
Radon in home? NO YES UNKNOWN Pool/Spa at home? NO YES
Type of home heat: Electric Gas Oil Solar Wood
Firearms in home? NO YES #_____ Locked for storage? YES NO Safety On? YES NO
Ammunition stored separate? YES NO Stored unloaded? YES NO
Kept for: Recreation Hunting Occupation Protection

Recent Travel: Exposure to_____ Country_____

High Risk Behaviors

Psychological History:

Do you have a history of suicidal/homicidal thoughts? NO YES When?_____
History of Psychological problems? NO YES Explain:_____

Abuse/Violence:

History of child abuse? NO YES Perpetrator:_____ Type: Physical Sexual Verbal
Were you ever placed in a foster home as a child? NO YES

History of domestic violence? NO YES When?_____
Is the perpetrator in the home? NO YES Restraining order in place? YES NO

Have you ever been convicted of a sexual offense? NO YES

Have you ever been incarcerated? NO YES Crime convicted of:_____
Dates of incarceration:_____ to _____ Type: Juvenile or Adult
Probation status: Cleared Court-Mandated Active Probation

Sexual Behaviors:

Sexual Preference: Heterosexual Homosexual Bisexual Unsure
Are you currently sexually active? YES NO Current # of partners_____
Do you practice safe sex? YES NO Birth control method:_____
# of life partners?_____ HIV tested? NO YES: Negative Positive
History of sexually transmitted infections? NO YES Type:_____

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 you with your healthcare needs. Your new patient intake appointment is scheduled so that your provider will have all the information available to better care for you. One of our intake providers will utilize this time to input your history, medications and concerns into our electronic health record. If referrals to specialists are necessary (example: pain management clinic, psychiatric services), these may be placed at this intake appointment. Another appointment will be scheduled for you to meet your new provider after you have completed your intake appointment. **If you do not show for this intake appointment (and do not call at least 24 hours prior to the appointment to cancel), you may be declined as a new patient to this practice.** Please understand that this appointment is not the appropriate time to expect treatment for multiple issues. If the provider was able to address one of your concerns, which issue would you like to have addressed (if time allows)?

Thank you,
Allegan Professional Health Services Staff