



ADULT HEALTH HISTORY FORM

Welcome to Alcona Health Centers! Listed below are our locations:

Alpena Services	P.O. Box 857, Alpena, MI 49707	(989) 356-4049
Cheboygan Campus	740 S. Main St. Cheboygan, MI 48721 Suite 2A Suite 2B Suite 2C Suite 2D	(231) 627-7118 (231) 627-7118 (231) 627-7118 (231) 627-3002
Health Center of Northern Michigan	3434 M-119, Harbor Springs 49740	(231)348-9900
Harrisville Services	205 N. State, P.O. Box 130, Harrisville 48740	(989) 724-5655
Indian River Campus	6135 Cressy St, Indian River, MI 49749	(231) 238-8908
Lincoln Services	177 N. Barlow Road, P.O. Box 279, Lincoln, MI 48742	(989) 736-8157
Long Rapids Plaza	346 Long Rapids Plaza Alpena, MI 49707	(989) 358-3500
Oscoda Services	208 S. State Street, Second Floor, Oscoda, MI 48750	(989) 739-2550
OWL Extension, Richardson Elementary	3630 E. River Road, Oscoda, MI 48750	(989)569-6002
Ossineke Services	11745 US-23, PO Box 83 Ossineke, MI 49766	(989) 471-2156
Pellston Services	421 Stimpson Dr. Unit 102, Pellston, MI 49769	(231) 844-3051
Petoskey Child Health Associates	2390 Mitchell Park Dr. , Petoskey, MI 49770	(231) 487-2250
Pickford Campus	416 M-129, Pickford, MI 49774	(906) 647-2217
Tiger Health Extension, Alcona Elementary School	181 N. Barlow Road, Lincoln, MI 48742	(989)736-8716
Wildcat Health Extension, Lincoln Elementary School	309 W. Lake St, Alpena, MI 49707	(989) 358-3998

****Please note that registered sex offenders are not allowed on the premises at the school-based clinics.**

We offer Dental services at our offices in Alpena and Oscoda. We also offer cleaning and oral screenings at our Lincoln and Cheboygan sites.

How do I become established with Alcona Health Centers?

Call one of our many offices, and **simply request to become an established patient of Alcona Health Centers.**

Our staff will schedule you for an appointment so that we may determine if we can meet your healthcare needs. Please note that this initial appointment does not establish you as a patient of Alcona Health Centers. Upon completion of your initial appointment, one of our healthcare providers will make the determination whether we can meet your needs.

It is important that you return this form to our office, preferably at least a week before your appointment.

This information is very helpful to our providers when addressing all of your important healthcare issues. Your initial appointment is usually 30-45 minutes long. If you find you cannot keep this appointment; notify us as soon as possible to cancel or reschedule.

Patient Name: _____ Today's date ____/____/____
Address _____ City _____ Zip code: _____
Date of Birth ____/____/____ Gender: _____ Gender Identity: _____ Sexual Orientation: _____
Race: _____ Marital Status: _____ Maiden Name: _____
Telephone Number: Home: () _____ cell: _____ email: _____
Drivers License Number _____ Soc. Sec. Number _____
Insurance Company: _____ Subscriber _____
Guardian: _____ Telephone: _____ Address: _____

DO YOU HAVE A PREFERENCE OF THE PROVIDER WITH WHOM YOU'D LIKE TO SEE? _____

May we contact you to schedule appointments? Yes No Leave messages on your answering machine? Yes No

Is there a number we can call in an emergency situation? _____

No Telephone? We can call to leave a message for you at (name) _____ Phone: (____)____-_____

We have a Patient Portal that allows you to access key aspects of your medical records. Would you like to register for access to the Portal? Yes No

We will be requesting a copy of a picture ID.

Please list ALL doctors, clinics, specialists, etc. who have treated you in the past 3 years. Have you ever been discharged from a physician's office? If so, why? Attach a page if needed.

ALCONA HEALTH CENTERS IS A PATIENT-CENTERED MEDICAL HOME.

We are focused on you. How is this beneficial to you? It means we have created a wide range of services and resources designed to:

- Coordinate and monitor the care you receive from all of your health care providers
- Help you plan and achieve health care goals that are important to you and manage chronic conditions
- Offer you extended access to our health care team

We are honored to be your healthcare provider and are committed to providing you with excellent care that is in keeping with your needs and beliefs. We seek to develop a trusting relationship focused on your wellbeing.

As a Patient Centered Medical Home, it is important to us that you understand the benefit of this to you. If you have questions, ask us anytime.

It is our expectation that you'll take responsibility for working toward the healthy lifestyle that is so important to your well-being. It's important to be actively involved in your healthcare, whether it be medical, behavioral, or dental health. You may include others (family/friends) to be present to support you in your healthcare. We may ask you to sign a release of information form in these instances, when appropriate.

We will be encouraging you to do things that positively impact your health. Let us know if any advice we offer conflicts with your values, beliefs, or ability to do. We can consider alternative plans.

While we offer the expertise and clinical advice, we understand your understanding and cooperation is vital. We believe patients can achieve great things in improving their health. Our staff are trained to help you develop self-management goals, a series of specific measurable steps to help you get to where you want to be, whether it be weight loss or getting more mobile, only to name a few goals.

We expect all patients to have an annual health exam. This will allow us to screen for preventative health concerns such as obesity, chronic disease, cancers, behavioral health, dental health, and decline in health status. Please plan for this by scheduling one a year in advance. We'll call to remind you of your appointment a few days prior.

As your Patient Centered Medical Home (PCMH), we are prepared to guide all aspects of your healthcare. Contact us whenever you have concerns. Before going to the ER, unless it's a dire emergency, call us first. Perhaps we can save you the trip by offering you advice over the phone. We have a medical provider on call anytime the clinic is closed. **We prefer our patients NOT use the ER for things we can take care of in the office or by phone.**

We offer PLANNED VISIT to address a chronic health conditions. At these visits, usually only one or two health concerns are addressed and we focus efforts on your current state of health, discuss the plan of care, offer education, and discuss self-management goals.

PLEASE ANSWER THE FOLLOWING GENERAL HEALTH-RELATED QUESTIONS

LIST CURRENT MEDICATIONS (Include over-the-counter meds, vitamins, etc.) Add a page, if needed.

Name of Medication	Strength	Dose

ALLERGIES (Include medications, food and environmental allergies) Add a page, if necessary

Are you prescribed and taking a controlled medication? ___ Yes ___ No The State of Michigan *requires* that we obtain a report from them that lists every controlled medication script you've filled over the past few years. We may also require you to submit to drug testing and to sign and abide by a controlled substance agreement. If you hold a current medical marijuana card, we will need to have a copy of it to put in our records.

PREVIOUS SURGERY (including dates if known)

Angioplasty _____
 Appendectomy _____
 Arthroscopy _____
 Back Surgery _____
 Blood Transfusion _____
 CABG _____
 Cardiac Pacemaker _____

Carpal tunnel release _____
 Cataract Extraction _____
 Cholecystectomy _____
 Electroconvulsive Therapy _____
 Gastric bypass _____
 Hernia Repair _____
 Hip Replacement _____

Hysterectomy _____
 Knee replacement, total _____
 ORIF _____
 Thyroidectomy _____
 Tonsillectomy _____
 Other _____

Have YOU or any BLOOD RELATIVE ever had:	Check if You	Check if a Relative	Relationship to you
ADD/ADHD			
Alcoholism			
Allergies			
Alzheimer's disease			
Arthritis			
Asthma			
Cancer (specify type and age diagnosed)			
Cardiovascular Disease			
Coronary Artery Disease			
Depression			
Developmental delay			
Diabetes (type I or type II)			
Eczema			
Elevated Lipids			
Genetic Disease			
Hearing Deficiency			
Hypertension			
Irritable bowel syndrome			
Learning Disability			
Mental Illness			
Migraines			
Obesity			
Osteoporosis			
Peripheral vascular disease			
Renal disease			
Seizure disorder			
Stroke			
Thyroid Disorder			
HIV/AIDS			
Hepatitis A__ B__ C__			
Pain (Chronic)			
Sexually Transmitted Infections			
Other			

General Health Questions

	Yes	No
Tobacco Use? If yes, Amount _____ Type _____ How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol Use? If yes, Amount _____ Type _____ How often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine Use? If yes, Type _____ How Much? _____	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Sleep Patterns?	<input type="checkbox"/>	<input type="checkbox"/>
Trouble Falling Asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Staying Asleep?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent waking episodes at night? If yes, how often? _____	<input type="checkbox"/>	<input type="checkbox"/>
Disrupted breathing, gasping, gagging or choking for air during sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a CPAP?	<input type="checkbox"/>	<input type="checkbox"/>

Social HistoryHand dominance: Right Left Ambidextrous

Current or Previous Employment _____

Military Experience _____

Highest Level of Education _____

Previously Widowed? _____ Previously Divorced? _____ Children? _____ # of Daughters _____ # of Sons _____

Do you exercise? _____ If yes, what type? _____ How often? _____

Hobbies or Activities? _____

Special Diet? _____

Do you wear a seatbelt? Yes NoSmoke Detectors in the home? Yes NoCarbon monoxide detectors in home? Yes NoRadon in home? Yes NoPool/Spa at home? Yes No

Recent travel out of state or country? _____

Women's Health History:

Age at first period: _____ Avg. days of Flow: _____

Do you perform self-breast exams? Yes NoHave you ever had a mammogram: Yes No If yes, where and when? _____

Is there a history of breast cancer with you or family member (related by blood)? _____

Previous breast augmentation? Yes NoPrevious PAP Smear: Where? _____ When? _____ Have you had a hysterectomy? Yes No

Is there a history of ovarian or cervical cancer with you or a family member (related by blood)? _____

Have you ever been Pregnant? Yes No If so, number of live births: _____ number of miscarriages: _____Have you ever been on hormone replacement therapy? Yes NoAre you currently sexually active? Yes No Are you on birth control? Yes No**Men's Health History:**Any problems urinating (More frequent than usual? Small Amounts? Weak stream? Painful?) Yes NoHave you ever been diagnosed with a problem with your prostate? Yes NoIs there any history of testicular cancer in you or your family (blood relatives)? Yes NoDo you check your testicles for lumps monthly? Yes No Noticed any pain in your testicles? Yes NoHave you had a vasectomy? Yes No Any questions about birth control? Yes No

PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Somedays	Most Days	Nearly Everyday
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or the opposite -being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very Difficult
- Extremely Difficult

Drug Abuse Screening Test

Have you used drugs other than those required for medical reasons? Yes No

Have you abused prescription drugs? Yes No

Our clinic offers a ‘Sliding Fee’ Program to qualified patients that reduce the cost of your medical care received at our facility. Ask our staff for an application! We will ask you to tell us your approximate family income. This is used solely for organization-wide demographic data; for sliding fee consideration and *not for any other purposes*. It is not shared with anyone except in aggregate and no one is mentioned by name in reports.

Advance Directive: An Advance Directive, also known as a ‘living will’ or ‘Five Wishes’ is a document that you complete PRIOR to a medical emergency so that your family and doctors will know what kind of medical services you would or would not want if you were unable to make those medical decisions yourself. We have these forms available upon request.

Do you have an Advance Directive? ___Yes ___No **If so, we need a copy.**

Do you want information about creating an Advance Directive? ___Yes ___No

We will try to review the Advance Directive with you yearly to assure it still reflects your wishes. If you make a change your Advance Directive, give us a revised copy for our records. We may provide a copy to specialists to whom we have referred you and to the ER if you’re ever transported there from our clinic.

Respect. We do not tolerate discrimination of anyone based upon race, gender identification/sexual orientation, religion, national origin, physical disability, or age. This same respect is mutually requested for our staff. Inform us of your preferences and inform us if we have failed to provide this courtesy.

Alcona Health Centers is participating in a Medicare Shared Savings Program Accountable Care Organization. ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give you high quality care at the right time in the right setting. If you have questions, you can talk with Alcona Health Centers at any time. You can also visit www.medicare.gov/acos.html or call 1800-MEDICARE (TTY users should call 1-877-486-2048).

Controlled Medication Management:

Opioid abuse is a serious public health issue. Drug overdose deaths are the leading cause of injury death in the United States and it affects almost every community and family in some way. Each year, drug abuse causes millions of serious illnesses or injuries among Americans. If you take a medicine in a way that is different from what the doctor prescribed, it is called prescription drug abuse. Abusing some prescription drugs—including narcotics, sedatives, tranquilizers, and stimulants—can lead to use disorder. We abide by State of Michigan and federal guidelines when prescribing controlled medications to patients of all ages.

We will obtain a report that is provided to us by the State of Michigan that lists every controlled medication prescribed to you (what, when, amount, provider, pharmacy). We assess your pain regularly and request you to cooperate with urine drug testing. We do investigate tips received about misuse. We maintain the right to notify law enforcement about misuse/diversion of controlled medications. **We maintain the right NOT to prescribe controlled substances whenever we believe it to be in the patient’s best interest.** We may require behavioral health consultation, specialty referral, and/or physical therapy in lieu of or along with prescribing of controlled medications.

We have policies and procedures to guide the prescribing of controlled medications. You may view them upon request. We generally do not prescribe controlled medications at the first appointment and will want to see records from previous providers/test results to validate the need for controlled medications. We don’t replace lost or medications reported as stolen. We do not provide prescriptions for controlled medications on weekends or after-hours. We share a copy of your signed controlled substance contract to specialists to whom we have referred you to for care.