PEDIATRIC HEALTH HISTORY FORM

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

Alpena Services	P.O. Box 857, Alpena, MI 49707	(989) 356-4049
Alpena High Health Center	3303 S Third Ave Suite D128 Alpena, MI 49707	(989)358-3935
Cheboygan Campus	740 S. Main St. Cheboygan, MI 48721	(231) 627-7118
Community 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 Health 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 Medical Clinic	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 Center?

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

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 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.

If you would like assistance filling out this form, please call our office and a Community Health Worker may be able to help.

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School/Teacher

Street Address	Mailing Address (PO Box)	City	Zip Code	Child Social Security #

Race (Optional) ❒ White ❒ Black ❒Asian ❒American Indian ❒ More Than One

Ethnicity (Optional) ❒ Non-Arabic/Non-Hispanic ❒Hispanic ❒Arabic

Mother/Parent Name	Mother/Parent Birth Date	Mother/Parent Social Security	Phone Number
Father/Parent Name	Father/Parent Birth Date	Father/Parent Social Security	Phone Number
Preferred Telephone Number	May We Leave a Message? ☐ Yes ☐ No	Best Time of Day to Be Contacted?	
Guardian Last Name (if different than mother/father)	Guardian First Name	Guardian Telephone Number	Relationship To Child

Name of Emergency Contact (other than parent/guardian)	Relationship	Telephone Number

HEALTH INSURANCE (Please complete all information)

❒ None (uninsured) Please contact me about help enrolling in MI Child/Healthy Kids health insurance for my child. ❒ Yes ❒ No

❒ Medicaid/Medicaid HMO Child's Card Number ______________________________________

❒ Blue Cross/Blue Shield
❒ Blue Care Network
❒ Priority Health
❒ TriCare
❒ Other:____

Name of Policy Holder ______________________________
Insurance Policy Number ____________________________
Insurance Group Number ____________________________
Birth Date of Policy Holder __________________________
Relationship of Policy Holder to child? __________________
Does your insurance pay for immunizations? ❒ Yes ❒ No

Please list ALL doctors, clinics, specialists, etc. who have treated your child in the past:

____

____

____

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 with reactions) Add a page, if necessary

____

____

PLEASE ANSWER THE FOLLOWING HEALTH-RELATED QUESTIONS

LABOR & DELIVERY

Please complete this section for patients under 3 years old or if there were pregnancy or birth complications.

Care during Pregnancy

Birth mother's age:_____ Marital status:___________

Expected Date of Delivery: ______________________

Lives with Father of Baby: ☐No ☐Yes

Number of Pregnancies:_____

Number of Births: ___Number of Living Children:_____

Was Prenatal Care Given?☐ No ☐Yes Where?

Mother's Blood Type:________ ☐Rh pos ☐Rh neg

Ultrasound: ☐Normal ☐Abnormal

Group B Strep Screen: ☐Neg ☐Pos

Mother's illness/complications (ex. Preeclampsia)

☐ No ☐Yes

Mother's Infections: ☐No ☐Yes

Medications during pregnancy:__________________

____

Check all use during pregnancy:

☐Pain Killers ☐Marijuana

☐Alcohol (if so how much?)__________________

☐Tobacco (if so how much?)_________________

☐Other drug use? ____________________________

Labor and Delivery

☐Vaginal ☐Induced ☐Cesarean

Time of birth:_______ Hours of labor: _____________

Gestational age at birth:___Wks ____ Days

☐Premature (<37 weeks)

Birth weight: _______lbs____oz Length:_____in

Head Circumference: _______cm or _______in

Multiple births? ☐No ☐Yes

Hospital Course

Place of delivery:_________________________

Vitamin K injection: ☐No ☐Yes

Hep B vaccine: ☐No ☐Yes

Hearing test: ☐Pass ☐Fail

Infant blood type:_____ ☐Rh pos ☐Rh neg

Jaundice: ☐No ☐Yes Phototherapy: ☐No ☐Yes

Sepsis evaluation: ☐No ☐Yes

Fetal distress: ☐No ☐Yes

Oxygen required? ☐No ☐Yes

Stayed in Neonatal Intensive Care Unit? ☐ No ☐Yes

Stayed in nursery? ☐No ☐Yes

Days:_________Reason:_____________

Birth Defects? ☐No ☐Yes

State screening done: ☐No ☐Yes

Medication given? ☐No ☐Yes

Umbilical cord blood test? ☐Normal ☐Abnormal

☐Turner syndrome ☐Down syndrome

Discharge

Feeding history: ☐Breast ☐Bottle ☐Both

Formula type:___________________________

Discharge date:__________________________

Discharge weight:________________________

Social services referral? ☐No ☐Yes

Males: Was patient circumcised? ☐No ☐Yes

FAMILY AND SOCIAL HISTORY

The following people live in the *same household* as your child: (example: Joe Jackson, 9, Maternal stepbrother)

NAME	AGE	RELATIONSHIP TO PATIENT

Does anyone in the household smoke? ☐Yes ☐No If yes, does that person smoke inside? ☐Yes ☐No

Does anyone vape? ☐Yes ☐No If yes, does that person vape inside? ☐Yes ☐No

For Patients over 12 Years Old: Does patient smoke? ☐Yes ☐No Does patient vape? ☐Yes ☐No

Child Care Provider:	Days/Week		Days/Week
☐Mother	______________	☐Daycare	________________
☐Father	______________	☐Sitter	________________
☐Grandparent	______________	☐Self	________________
☐Sibling	______________	☐Relative	________________
☐Nanny	______________	☐Neighbor	________________

Primary Residence

Patient Lives with:________________________________Time Spent:_________________________

Secondary Residence

Patient Lives with:________________________________ Time Spent:_________________________

Parents marital status:__________________

Siblings: How many?_______Birth Order_________Relationship with siblings:_____________________

Cooperates with family/friends: ☐No ☐Yes

Cooperates with teachers: ☐No ☐Yes

Has enough friends: ☐No ☐Yes

Has friends of all genders: ☐No ☐Yes

Any concerns about relationship with family/friends/others: ☐No ☐Yes

☐Right handed ☐Left handed ☐Ambidextrous

Home Environment:

Neighborhood: ☐urban ☐city ☐rural ☐country

Housing Status:

☐rent ☐own ☐lives with family/friends ☐homeless

Home Type: ☐house ☐apartment ☐trailer ☐other

Home Age:____________________

Home has adequate privacy: ☐No ☐Yes

Home has adequate safety: ☐No ☐Yes

Water source:☐ City ☐Well ☐Bottle

Is water chlorinated? ☐No ☐Yes

Is water fluoridated? ☐No ☐Yes

Is there lead in the home? ☐No ☐Yes ☐Removed

Safety:

Uses bike/skating helmet? ☐No ☐Yes

Car restraints: ☐Car seat: face rear ☐Booster ☐ None

Car seat: ☐ face front ☐Seatbelt

Carbon monoxide detector: ☐No ☐Yes

Smoke detectors: ☐No ☐Yes

Radon in home: ☐No ☐Yes ☐Treated ☐Untested

Pool/spa at home: ☐No ☐Yes

Pets/animals at home: ☐No ☐Yes Type:__________

Firearms in the home: ☐No ☐Yes

Are they locked/ kept in storage ☐No ☐Yes

MEDICAL HISTORY

1. Has your child ever been hospitalized? ☐No ☐Yes When, where and why?________________________

____

2. Has your child ever had a reaction to a medication or immunization? ☐No ☐Yes List:_______________

____

____

3. Check if the child has had any of the following health conditions:

❑ Seizures	❑ Asthma	❑ Heart Murmur
❑ Kidney or bladder infection	❑ Frequent Ear Infection	❑ Unusual bleeding
❑ Eczema	❑ Depression/Anxiety	❑ Frequent chest pain
❑ Sleeping difficulties	❑ Frequent abdominal pain	❑ Diabetes
❑ Arthritis	❑ Anemia	❑ Behavior Concerns
❑ Frequent headaches (describe)	❑ Broken Bones (Please list:)	❑ Other:

HEALTH MAINTENANCE

Your child's diet includes: (Please check all that apply)
☐Breast ☐Milk ☐Formula ☐Vegetables ☐Fruits ☐Meat ☐Milk ☐Juice ☐Soda ☐Pop ☐Beans, eggs & dairy
☐Cereals ☐Breads ☐Junk Food ☐"Fast Food" ☐Sweets

Does your Child see a dentist regularly? ☐No ☐Yes

Does your child have regular bowel movements? ☐No ☐Yes
Constipation? ☐No ☐Yes Frequent loose stools? ☐No ☐Yes
Does your child have normal urination? ☐No ☐Yes

FAMILY HISTORY/RELATIONSHIP TO PATIENT

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_____________________

FOR BEHAVIORAL HEALTH PROGRAMS ONLY:
What is the main reason(s) you are seeking support for your child? (Please include how long he/she has had these symptoms/concerns and any recent/past events contributing to these symptoms.) ________________________________

____

What are your hopes regarding your child's therapy?____

____

Please list any current or past behavioral health therapy your child/family has participated in. ________________

____

Has your child experienced any recent or past stressors? ☐Yes ☐No (e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's school changes, family moved, family financial problems, remarriage, sexual trauma, other losses?) If yes, please describe:____

____

We offer a Sliding Fee program to qualified patients that reduce the cost of medical care at our facility. Ask our staff for an application. We will need to know your annual income when determining eligibility for this program. You can be sure we will hold this information in the strictest of confidence!

We ask that you to provide us with your approximate family income. This information 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. Approximate Family Income $___________

PATIENT CENTERED MEDICAL HOME - PCMH

ALCONA HEALTH CENTER IS A PATIENT CENTERED MEDICAL HOME. We are focused on your child's wellness. We have created a wide range of services and resources designed to:

- Track and monitor the care received from all of health care providers
- Help your child meet health-related goals and grow into healthy adults
- Offer your child extended access to our health care team

Welcome to Alcona Health Center. We are honored to be part of your child's healthcare management. We're committed to providing your child with the best care possible.

It is our expectation that you will help guide your child in adopting a healthy lifestyle which is so important to your child's well-being.

We will be discussing some important steps you can help your child with to maintain or achieve good health. Your cooperation is very important.

It will give our staff and providers great pleasure to work with you on these goals, answer questions, provide education, and offer referrals to other health professionals as needed. Everyone who joins our practice should start by having a complete physical exam followed by periodic check-ups that may include health assessments and education.

We look forward to working with you as your family healthcare provider. Please contact us whenever you'd like to talk about anything you think may be affecting your child's health. It's our hope that we can have a relationship where the lines of communication are open, and communication goes both ways. We will help you remember when your child is due for wellness exams and/or immunizations.

Self-management is a series of small steps you can take to help your child work toward health care goals. We will support you and assist you in identifying action steps, to achieve those goals.