COVENANT HealthCare

HEALTH HISTORY/ADOLESCENT
12 YEARS OF AGE THRU 17 YEARS OF AGE
(PHYSICIAN OFFICE)

Date _____

Name _____ Age _____ Gender _____ Date of Birth _____

FAMILY HISTORY

Mother's name _____ Age _____ Living at home? ☐ Yes ☐ No
Mother's health _____ Occupation _____

Father's name _____ Age _____ Living at home? ☐ Yes ☐ No
Father's health _____ Occupation _____

Brothers & Sisters Names _____ Birthdates _____

_____ _____

_____ _____

Has any blood relative had any of the following:

	Yes	Relationship	No
Asthma	☐	_____	☐
Tuberculosis	☐	_____	☐
Diabetes	☐	_____	☐
Stroke	☐	_____	☐
Heart Disease	☐	_____	☐

	Yes	Relationship	No
Allergies	☐	_____	☐
Depression	☐	_____	☐
Eczema	☐	_____	☐
Seizures	☐	_____	☐
Alcoholism	☐	_____	☐

	Yes	Relationship	No
Arthritis	☐	_____	☐
High Cholesterol	☐	_____	☐
High Blood Pressure	☐	_____	☐
Blood Disease	☐	_____	☐
Cancer	☐	_____	☐

PATIENT PAST ILLNESSES

	Yes	No
Asthma	☐	☐
Emphysema	☐	☐
Depression	☐	☐
High Cholesterol	☐	☐
Cancer	☐	☐
Bowel Trouble	☐	☐
Gall Stones	☐	☐
Drug Problem	☐	☐
High Blood Pressure	☐	☐

	Yes	No
Allergies	☐	☐
Tuberculosis	☐	☐
Heart Disease	☐	☐
Diabetes	☐	☐
Blood Disorder	☐	☐
Back Trouble	☐	☐
Liver Problems	☐	☐
Hearing Loss	☐	☐
Sexually Transmitted Disease	☐	☐

	Yes	No
Skin Problems	☐	☐
Anxiety	☐	☐
Kidney Problems	☐	☐
Stroke	☐	☐
Thyroid Disease	☐	☐
Glaucoma	☐	☐
Alcohol Problem	☐	☐

PLEASE COMPLETE IF FEMALE WITH ABDOMINAL PAIN

Age at 1st menstrual period _____
Have you ever had sex? _____
If the answer is "yes", please answer these questions:
Number of times pregnant _____
Number of living children _____
Date of last Pap smear _____

What type of birth control do you use? _____

	Yes	No
Have you had any sexually transmitted diseases?	☐	☐
Have you had an AIDS risk assessment?	☐	☐
Do you practice safe sex (use condoms)?	☐	☐

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HOSPITALIZATIONS

Date	Reason

PREVIOUS SURGERIES

Date	Type

MEDICINES

List all medications you are taking, including prescriptions and over-the-counter medicines.

Medication & Dosage	Reason	Ordering Physician

ALLERGIES

Please check any allergies you have and the reaction

	Reaction
☐ Penicillin	
☐ Amoxicillin	
☐ Sulfa	
☐ Aspirin	
☐ Codeine	
☐ Insect Sting	
☐ Food	
☐ Other (List)	

☐ No Known Allergies

IMMUNIZATIONS / TB TESTS

Please check any immunizations you have had and the approximate year.

	Date	Date	Date	Date	Date
☐ DPT/DT					
☐ Polio					
☐ MMR					
☐ Hib					
☐ Hep B					
☐ Varicella					
☐ TB Skin Test					

SAFETY

	Yes	No
Do you always wear a seat belt?	☐	☐
Do you wear a helmet when riding a bicycle, motorcycle or skating?	☐	☐
Does anyone smoke at home?	☐	☐
Do you have a smoke detector?	☐	☐

NUTRITION

	Yes	No
Do you get regular dental check-ups?	☐	☐
Do you limit sweets, fats and junk food in your diet?	☐	☐
Are you on a special diet?	☐	☐

What type? _____

SOCIAL HISTORY

	Yes	No
Do you exercise at least 3 times a week?	☐	☐
Do you smoke cigarettes?	☐	☐
Do you chew tobacco?	☐	☐
Do you use drugs?	☐	☐
Have you ever taken steroids?	☐	☐
Do you ever use alcohol?	☐	☐
Have your grades gone down in the last year?	☐	☐
Have you ever been physically or sexually abused?	☐	☐

PERSONAL HISTORY

Below are some common concerns of teenagers. Please check "yes" or "no" if you have any of these concerns or not.

	Yes	No
Feeling down or depressed?	☐	☐
Trouble sleeping?	☐	☐
Tired during the day?	☐	☐
Dizzy spells?	☐	☐
Frequent headaches?	☐	☐
Worried about school?	☐	☐
Worried about weight?	☐	☐

Other (List) _____

_____

_____

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

PF08203 (R 12/04)

ACKNOWLEDGMENT/ RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT I.D.

I acknowledge, by signing below, that I have received a copy of the Covenant HealthCare **Notice of Privacy Practices**.

_____

Name

_____

Signature

Date:____/____/____

Covenant HealthCare Staff Use Only

Acknowledgment Received:_____/_____/_____

Reason Acknowledgment **was not** Received:

☐ I have previously received the Notice of Privacy Practices.

☐ Other, explain:

_____

_____

_____

Covenant HealthCare Staff _____

(Signature)

COVENANT HealthCare

Covenant HealthCare
1447 North Harrison
Saginaw, MI 48602

CONSENT/PATIENT INFORMATION

PF02996 (2/11)

PATIENT I.D. _____

Patient Full Legal Name: _____ Photo ID: y/n _____

Date of Birth: _____ Soc Sec #: _____ Patient Sex: _____ Male _____ Female

Address: _____ Marital Status: S / M / D / W

City, State, Zip: _____ Ethnicity: _____

Telephone: _____ Preferred Language: _____

Cell Phone#:(_____) _____ Race: White / Black / Hispanic / Asian / Other

Email Address: _____

Contact Person Other than Home: _____ Telephone #: (_____) _____ - _____

Patient Employer: _____ Employer Telephone: _____

Employer Address: _____ Date of Retirement: _____

Student:Full Time: _____ Part Time: _____ Parent/Guardian: _____

Family Doctor: _____ ReferringDoctor: _____

Pharmacy _____ Location: _____

BILL TO:Self___Parent/Guardian____Work comp____Auto____Insured Name & Date of Birth _____

Primary Insurance: _____ Secondary Insurance: _____

Spouse Name: _____ Spouse Employer: _____

Spouse Date of Birth: _____ Employer Address: _____

Spouse Soc. Sec. #: _____ - _____ - _____ Date of Retirement: _____

AUTHORIZATION FOR MEDICAL INSURANCE BENEFITS

1) I assign payment to be made on my behalf to Covenant Healthcare.
2) I also authorize Covenant Healthcare to furnish information necessary for claims processing to any insurance carrier concerning my illness and treatments.
3) A universal claim form will be completed to help expedite insurance carrier payment.
4) I understand that all professional services will be charged to the patient for insurance other than our participating carriers.
5) Payment of the account is the patientís direct responsibility and I am responsible for any non-paid services.
6) Payment for services are due when rendered unless other arrangements have been made in advance with our billing staff.

_____ _____

Date Patient Signature/Guardian

COVENANT PEDIATRIC NEUROLOGY
BIRTH HISTORY

Vaginal Delivery_____ C-Section_____

Gestational Age_____

Complicatiions_____

_____

DEVELOPMENTAL HISTORY

Age when first sat up_____

Age when first able to walk_____

Age when first able to stand_____

Grade_____

Special ED ? _____