

Hope Medical Clinic Minor Patient Profile

Patient's First Name <small>Print</small>		MI	Patient's Last Name		Patient's Date of Birth <small>MM/DD/YYYY</small>	Today's Date <small>MM/DD/YYYY</small>
Parent/Guardian's First Name		MI	Parent/Guardian's Last Name		Parent/Guardian's Employer	
Parent/Guardian's Address						
<small>Number</small> _____		<small>Street</small> _____		<small>Lot/Apt</small> _____	<small>City</small> _____	<small>State</small> _____ <small>Zip</small> _____
Home Phone -- --		Cell Phone -- --		Work Phone -- --		Patient's SSN/Visa/Green Card (circle type); if none, year arrived in USA
<small>Area Code</small> _____		<small>Area Code</small> _____		<small>Area Code</small> _____		
<input type="checkbox"/> male	<u>Patient's Ethnicity (mark 1)</u>	<input type="checkbox"/> Am Indian/Alaska Native	<input type="checkbox"/> Black/African	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Unknown	
<input type="checkbox"/> female		<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Other	<input type="checkbox"/> White non-Hispanic	
Patient's Primary Language Spoken:			Parent/Guardian's Marital Status:			
			<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed			
Emergency Contact Number (if different than above) <small>Name</small>			Relationship to Patient		Contact's Phone --- <small>Area Code</small> <small>Number</small> <small>Ext</small>	
PATIENT'S RELIGION/CHURCH:						
Does the patient have Healthy Kids, MI Child, or other health coverage? <input type="checkbox"/> no <input type="checkbox"/> yes		Has a parent/guardian applied for any of these on the patient's behalf? <input type="checkbox"/> no <input type="checkbox"/> yes		Is a parent/guardian a veteran? <input type="checkbox"/> no <input type="checkbox"/> yes		Has the patient received healthcare elsewhere in the last two years? <input type="checkbox"/> no <input type="checkbox"/> yes
CURRENT MEDICATIONS: List all medications the patient is currently taking, for what condition, and for how long:						
Medication name		Condition			Approximate start date	
ALLERGIES: <input type="checkbox"/> Check here if the patient does not have any known allergies. If the patient has known allergies, use the spaces below to list medications and substances he/she is allergic to or has a bad reaction to:						
Medication/substance name		Describe Reaction		Medication/substance name		Describe Reaction
SURGERIES AND HOSPITALIZATIONS: List the approximate date and reason for each surgery and hospitalization						
Date					Date	
PATIENT'S HEALTH HABITS						
Does the patient ever smoke or chewed tobacco? <input type="checkbox"/> no <input type="checkbox"/> yes		How many cigarettes a day?	At what age did he/she start?		When did he/she quit?	Would he/she like to quit? <input type="checkbox"/> no <input type="checkbox"/> yes
Does the patient use recreational drugs? <input type="checkbox"/> no <input type="checkbox"/> yes		What kind?			How often? Per day/week	Would he/she like to quit? <input type="checkbox"/> no <input type="checkbox"/> yes
Does the patient use alcohol? <input type="checkbox"/> no <input type="checkbox"/> yes		What kind?	How often? Per day/week		Would he/she like to quit? <input type="checkbox"/> no <input type="checkbox"/> yes	Average amount of TV patient watches daily:
Is the patient concerned about HIV/AIDS or STD exposure? <input type="checkbox"/> no <input type="checkbox"/> yes		Number of meals the patient eats daily:	Number of times the patient exercises weekly:		Average amount the patient sleeps daily:	Does the patient use seatbelts? <input type="checkbox"/> no <input type="checkbox"/> yes

Please turn over and complete back

PATIENT'S HEALTH HISTORY: Check the box for each condition experienced by the patient or his/her family members											
	Patient	Mother	Father	Siblings	Grandparents		Patient	Mother	Father	Siblings	Grandparents
Alcoholism/substance abuse						Kidney disease					
Arthritis/joint disease						Learning disabilities (ADD/ADHD/other)					
Asthma/hay fever/emphysema/lung disease						Liver disease/hepatitis					
Birth defects or injuries						Mental Health (depression/anxiety/other)					
Blood disorders						Menstrual problems					
Bowel/bladder problems						Positive PPD/TB					
Cancer (specify types below)						Rheumatic Fever					
Dental problems						Seizures/epilepsy					
Diabetes						Sexually transmitted disease					
Eczema or frequent rashes						Sickle cell anemia					
Frequent colds, sore throat, earaches (4 or more per year)						Speech problems					
Hearing problems						Stroke					
Heart disease/chest pain/heart attack						Thyroid					
High blood pressure						Vision problems					

Please explain any problems specified above, or list any other chronic disorders the patient may have: _____

PATIENT'S EARLY CHILDHOOD DEVELOPMENT: For patients aged four years or younger, or if the information is important, please list the approximate age at which the patient reached each developmental level			
Activity	Age	Activity	Age
Smile		Talk	
Hold head up without support		Talk in sentences	
Sit up without support		Toilet trained: Day	
Crawl		Toilet trained: Night	
Walk without support		Read	

Please list and explain any difficulties involved in the patient's prenatal development, delivery, or post-delivery period: _____

Has the patient ever had measles, mumps, or chicken pox? _____

PATIENT'S IMMUNIZATION HISTORY: Please list the last known date the patient received each of the following vaccines			
Vaccine	Date	Vaccine	Date
Diphtheria		Polio	
Hepatitis A		TB	
Hepatitis B		Tetanus	
MMR		Varicella	
Other:		Other:	

Note: The Hope Medical Clinic cannot provide immunizations or determine immunization status. These services are available from your local health department.

Signature of parent or guardian

Printed name of parent or guardian

Legal relationship of responsible party to patient