University Of Michigan Health-Sparrow School-Based Health Center New Patient Health History Questionnaire	Name: Birthdate: School: Grade:

PERSONAL INFORMATION

Patient's Legal Name: _____ Preferred Name (if applies): _____

Date of Birth: _____ Age: _____ SSN#: _____

Primary Address: _____

_____

City/State/Zip: _____ Who does the patient live with? _____

Email (if applicable): _____ Preferred Phone #: _____

PARENT/GUARDIAN INFORMATION (if under 18):

1st Parent/Guardian Name: _____ Date of Birth: _____

Relationship to patient: _____ Same household as patient: ☐ Yes | ☐ No

Address: _____City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____

Preferred method of contact during the day: ☐ Home Phone | ☐ Cell Phone | ☐ Work Phone |

Primary language: _____ Needs Interpreter: ☐ Yes | ☐ No

2nd Parent/Guardian Name: _____ Date of Birth: _____

Relationship to patient: _____ Same household as patient: ☐ Yes | ☐ No

Address: _____City/State/Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____

Preferred method of contact during the day: ☐ Home Phone | ☐ Cell Phone | ☐ Work Phone |

Primary language: _____ Needs Interpreter: ☐ Yes | ☐ No

EMERGENCY CONTACT INFORMATION (please list in order of who we should contact first):

1st Emergency Contact Name: _____ Relationship to patient: _____

Preferred Language: _____Interpreter Needed? ☐ Yes ☐ No

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Name: _____ DOB: _____ Today's Date: _____

2nd Emergency Contact Name: _____ Relationship to patient: _____

Preferred Language: _____Interpreter Needed? ☐ Yes ☐ No

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION (*Please provide a copy of the insurance card)

Primary Insurance: _____ Coverage Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Relationship to Patient: _____ Member/Subscriber ID: _____

Group/Policy #: _____ Subscriber Is Covered Through: ☐ Current Employment | ☐ COBRA / Continuation of benefits ☐ Retirement ☐ Other (please specify): _____

Employer: _____Occupation: _____

Employer Size: ☐ 1 – 9 ☐ 20 – 99 ☐ 100+ ☐ Unknown

Secondary Insurance: _____ Coverage Effective Date: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Relationship to Patient: _____ Member/Subscriber ID: _____

University of Michigan Health-Sparrow offers financial assistance for uninsured and under-insured patients. Financial Counselors are available to assist patients in applying for programs such as Medicaid, ACA Marketplace coverage, and other programs designed to help cover and/or offset medical costs. If you need help paying for medical care, or have questions regarding financial assistance, please contact the Sparrow Financial Counseling Department at 517-364-6060 or Toll-Free 833-227-7664, to discuss options.

☐ I/We would like more information about Sparrow's Financial Assistance Program | ☐ I/We would like help signing up for Medicaid | ☐ I/We do not need financial assistance at this time

Does the patient have a current primary care provider/pediatrician? ☐ Yes | ☐ No

Primary Care Physician & Location: _____

Preferred Pharmacy & Location: _____

***Legal Sex:** ☐ Male | ☐ Female| ☐ X | ☐ Unknown (*Used for legal and administrative purposes)

Sex Assigned at Birth: ☐ Female | ☐ Male | ☐ Intersex or Uncertain | ☐ Not recorded on birth certificate | ☐ Choose not to disclose

Gender Identity: ☐ Male | ☐ Female | ☐ Transgender Male | ☐ Transgender Female | ☐ Non-Binary | ☐ Not Listed | ☐ Unknown | ☐ Choose not to disclose

Patient's Name: _____ DOB: _____ Today's Date: _____

Sexual Orientation: ☐ Bisexual | ☐ Lesbian/Gay | ☐ Straight | ☐ Unknown |☐ Choose not to disclose |☐ Other _____

Pronouns: ☐ He/Him/His | ☐ She/Her/Hers | ☐ They/Them/Theirs |☐ Other _____

Race: ☐ Asian | ☐ American Indian & Alaska Native | ☐ Black or African American | ☐ Native Hawaiian or Other Pacific Islander | ☐ White | ☐ Other (please specify): _____

Ethnicity: ☐ Arab | ☐ Hispanic or Latino | ☐ Not Hispanic or Latino | ☐ Choose not to disclose | ☐ Other (please specify): _____

Religion: ☐ Agnostic | ☐ Atheist | ☐ Buddhist | ☐ Catholic | ☐ Christian | ☐ Muslim |☐ Jewish | ☐Hindu | ☐ Jehovah's Witness | ☐ No Preference | ☐ Choose not to disclose | ☐ Other (Please specify) :_____ **Marital Status:** ☐ Single | ☐ Married | ☐ Other (please specify): _____

Primary language (spoken at home): _____ Needs Interpreter: ☐ Yes | ☐ No

ALLERGIES- Please list all allergies (including; medications, latex, food, seasonal, etc. Please also include reaction type and any emergency medications required). Attach additional sheet if needed.

Allergy	Reaction	Requires Emergency Medication?
Ex: Tree Nuts	Anaphylaxis, Hives	Yes. Epi-pen

MEDICATION(S)- please list all current medications (including prescriptions, over-the-counter medications, supplements, vitamins, topicals, etc.). Attach additional sheet if needed.

Name of Medication	Dose	Amount Taken	Frequency (how often)	Prescribed by
Ex: Vitamin D3	2,000 IU's	1 capsule	Daily	PCP- Dr. Health

Patient's Name: _____ DOB: _____ Today's Date: _____

Personal Medical History- Do you currently have or have you previously had any of the following?

Allergies	Yes	No	Diabetes	Yes	No	Meningitis	Yes	No
Anemia	Yes	No	GERD (Reflux)	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Headaches	Yes	No	Sickle Cell Anemia	Yes	No
Arthritis	Yes	No	Heart Disease	Yes	No	Substance Abuse	Yes	No
Asthma	Yes	No	Heart Murmur	Yes	No	Suicide attempt	Yes	No
Blood Transfusions	Yes	No	HIV / AIDS	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Joint Disorder	Yes	No	Tuberculosis	Yes	No
Clotting Disorder	Yes	No	Kidney Disease	Yes	No	Ulcers	Yes	No
Depression	Yes	No	Nerve/Muscle Disorder	Yes	No	Vision/Hearing issues	Yes	No

Other Past Medical History: _____

Surgical History

Appendectomy (Appendix removal)	Yes	No	Eye Surgery	Yes	No	Spine/Back Surgery	Yes	No
Brain Surgery	Yes	No	Fracture Surgery	Yes	No	Tonsils or Adenoids removed	Yes	No
Cholecystectomy (Gallbladder removal)	Yes	No	Heart Surgery	Yes	No	Tympanostomy (ear) tubes	Yes	No
Cosmetic Surgery	Yes	No	Hernia Repair	Yes	No			

Other Surgical History: _____

Family History: If family history is unknown, check here ☐ Adopted ☐

Relationship	Medical / Health Problems	Age	Status (Living/Deceased)	Cause Of Death
Mother			L / D	
Father			L / D	
Sister			L / D	
Brother			L / D	
Son			L / D	
Daughter			L / D	
Maternal Grandmother			L / D	
Maternal Grandfather			L / D	
Paternal Grandmother			L / D	
Paternal Grandfather			L / D	

Other Relevant Family History: _____