

Aloha Nui Family Practice

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How were you referred to us? (circle one)

family	coworker
friend	print ad
medical professional	internet
medical organization	radio
medical insurance	social media

Client Demographics:

Last Name: _____ First Name: _____ MI: _____
Nickname or name you prefer: _____
DOB: _____ Gender: M/F/ TG Sexuality: HET/LBGT Single/Married/Partner/Divorced/Widow
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Physical Address: _____ City: _____ State: _____ Zip Code: _____
Contact phone: _____ (mobile) _____ (Home)
Email: _____ ***will never be used for solicitation**
Emergency contact: _____ Relationship: _____ Phone #: _____

Medical Records:

Who may access your medical records? *remains in effect until changed by client

Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____
Name: _____ Relationship: _____ Phone #: _____

Medical History:

Allergies: Penicillin / Sulfa drugs / bee stings / Others: _____

Chronic Medical Conditions *Circle all that apply

Hypertension Obesity Hyperlipidemia Diabetes Kidney disease Hepatitis / Liver Disease
HIV / AIDS Anemia Thyroid disease Birth Defects Irritable Bowel Asthma / COPD / Emphysema
Depression Anxiety Bipolar disorder Suicidal Arthritis Stroke / Aneurysm
Cancer (Type?) – Breast / Colon / Skin / Prostate / Lung / Bone / Brain / Lymphoma / Leukemia / Others: _____

Alcohol use

How often? Never / Socially / Daily Is alcohol use an addiction? Y / N Are you or have you been in rehab? Y / N

Tobacco use

How many packs per day? 1 / 2 / 3/+ What age did you start? _____ Have you ever tried to quit? Y / N

Drug use

Drugs abused? MJ / Cocaine / Methamphetamine / Heroin / Opioids / Ecstasy / Others: _____ Completed rehab? Y / N

Surgical History

Appendectomy / Cholecystectomy / Lithotripsy / Coronary artery bypass / Back / Knee / Shoulder / C-section / Breast Augmentation
Others: _____