Pearl City Medical Associates, Inc.

98-1079 Moanalua Road / Suite 500 / Aiea, Hawaii 96701-4794

Welcome to Pearl City Medical Associates, Inc. Please fill out this form to the best of your knowledge. Thank you.

Patient Name:	Date of Birth:	Today's Date:

Sex:	Last Menstrual Period:	Year of menopause:

MEDICAL HISTORY

ILLNESSES					
Conditions			Date of onset	Conditions	Date of onset
Hypertension	☐ Yes	☐ No		Other:	
Heart Disease	☐ Yes	☐ No		Other:	
High Cholesterol	☐ Yes	☐ No		Other:	
Stroke	☐ Yes	☐ No		Other:	
Diabetes	☐ Yes	☐ No		Other:	
Asthma	☐ Yes	☐ No		Other:	
Other:				Other:	
Other:				Other:	
Other:				Other:	
Other:				Other:	
Other:				Other:	

HOSPITALIZATIONS / OPERATIONS			
Reason for hospitalization	Date	Type of operation / surgeon	Date
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	

INJURIES / TREATMENT		
Injury type	Treatment	Date of injury
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Patient Name: _____ Today's Date: _____

ALLERGY LIST	
Allergies	Type of reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	

MEDICATION LIST			
Prescription medications, dose, frequency, and route	Date started	Herbals, supplements, and over-the-counter drugs	Date Started
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	

FAMILY HISTORY

Use a check mark (✓) to indicate positive history

	Father	Mother	Sisters	Brothers	Daughters	Sons	Maternal grand-parents	Paternal grand-parents	Other
Deceased	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon or rectal cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐

Patient Name: _____ Today's Date: _____

SOCIAL HISTORY

Tobacco: ☐ Never used ☐ Current-Type:_____ Freq:_____ ☐ 2nd hand ☐ Prior use - Quit date:_____

Alcohol: ☐ Never used ☐ Occasional use ☐ Daily Drinks per day/week:_____
History of alcohol (describe):

Drug abuse: ☐ Never used ☐ Occasional use ☐ Daily ☐ Prior use - Quit date:_____
History of drug abuse (describe):

Occupation (or prior):

Home environment: ☐ Private home ☐ Assisted living ☐ Other (describe):
Others in household:

NUTRITION / DIET

Describe:

PHYSICAL ACTIVITIES

Type of activity	Total minutes in one session	Number of times per week
1.		
2.		
3.		
4.		
5.		
6.		
7.		

OTHER TREATING PHYSICIANS AND PROVIDER OF CARE

(Please include eye doctors and dentists)
This documentation not required for IPPE

Name	Specialty / type of care	Date discontinued
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		