KONA
COMMUNITY HOSPITAL
Care You Can Count On
Medical Oncology
79-1019 Haukapila Street • Kealakekua, HI 96750
808-322-6910 • 808-322-6918 (fax)

NEW PATIENT VISIT: **DOS:**

Name: _____ **Date of Birth:** _____ **Age:** _____

Male: ☐ **Female:** ☐ **Marital Status:** Single ☐ Married ☐ Divorced ☐ **Occupation:** _____

Primary Care Provider: _____ **Phone:** _____

Who referred you to this office: _____

Reason for today's visit: _____

Your medical history:

Condition	Yes	No	Condition	Yes	No	Condition	NA	Yes	No
Fever			Cough						
Weight loss			With sputum			Prostate issues			
Weight gain			With blood			Urination at night			
Amount of change			Wheezing			How many times:			
Poor appetite			Difficulty breathing			Joint/muscle pain			
Night sweats			Nausea			Where:			
Chills			Vomiting			Back pain			
Fatigue			Diarrhea			Swollen joints			
Blurred vision			Constipation			Arthralgia's (joint pain)			
Double vision			Heartburn			Myalgia's (muscle pain)			
Cataracts			Indigestion			Skin itching			
Glaucoma			Hemorrhoids			Rash			
Spots/floaters in the eyes			Bleeding			Sores			
Poor hearing			Black stools			General weakness			
Ringing in the ears			Abdominal pain			Headaches			
Dizziness			Burning on urination			Numbness/tingling			
Nasal congestion			Dark or bloody urine			Where:			
Nose bleeds			Urinary urgency			Pain			
Sore throat			Urinary frequency			Where:			
Dental problems				**NA**		How long have you had it:			
Chest pain			Irregular periods			What makes it better:			
Palpitations			Missed periods			What makes it worse:			
Pounding heart			Pregnant			Anxiety			
Irregular pulse			Hot flashes			Tearful			
Swollen feet			Date of last PAP smear			Depressed			
High blood pressure			Date of last mammogram			Change in sleep pattern			

FOR OFFICE USE- BP: **P:** **R:** **T:** **%O2:** **Wt:** **HT:**

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Patient: _____ **Date of Birth:** _____

Tell us about your other medical problems and past surgeries:

Date	Condition or Surgery	Date	Condition or Surgery

Have you had any of the following tests performed?

Test	Yes	No	Date	Where?	Ordered by?
Recent Blood work					
Bone scan					
PET scan					
Recent CT scan					
Recent MRI					
Recent Sonogram (ultrasound)					

Family History:

Relationship	Age	Alive or Deceased	Any medical issues and cause of death if applicable
Mother			
Father			
Sister(s)			
Brother(s)			
Daughter(s)			
Son(s)			

Social History:

Do you smoke: ☐No ☐Quit ☐Yes- How much? _____ since what age: _____

How much alcohol do you drink (include beer & wine): _____ How Often?_____

Do you have a: Living Will: ☐No ☐Yes Power of Atty for healthcare: ☐No ☐Yes Who: _____

Do you follow a special diet: ☐No ☐Yes Explain:_____

Do you exercise regularly: ☐No ☐Yes Explain: _____

Highest level of Education: _____ Past Occupation: _____

Are you exposed to any health hazards: ☐No ☐Yes Explain: _____

_____ _____

Patient/Guardian Signature **Date**

Reviewed by: _____ **Date:** _____