KONA
COMMUNITY HOSPITAL

Providing and Enhancing Accessible Comprehensive Healthcare Services

Date: _____

Name: _____ DOB: _____
Last First MI

_____ Physicians are not employees of Kona Community Hospital, therefore all physician's charge will be separate from the hospital's billing statement

Social Security Number: _____ Sex: (M) (F)

Local (Physical) Address: _____
Street Apt #

_____
City State Zip

Local (Mailing) Address: _____
Street Apt #

_____
City State Zip

Home Phone: _____ Cell Number:_____

Alternate Number:_____Email:_____

Place of Birth: _____ Religion:_____

(Full Time) (Part Time) Retired-As of: _____

Place of Employment: _____

Employer Address: _____

Phone Number: _____

Have you assigned anyone Durable Power of Attorney for your medical care? (Y) (N)

Durable Power of Attorney Name: _____

Relationship: _____

Attorney's Address: _____

Primary Phone Number: _____ Alternate Number: _____

Do you have a medical Living Will? (Y) (N)

Marital Status (Check One): S _____Single M _____Married D _____Divorced

W _____Widowed X _____Separated

Number of Children and Ages: _____

_____

Spouse's Name: _____ DOB: _____

Spouses Social Security Number If Insurance Guarantor: _____

Spouse's Address: _____

Spouse's Employer: _____

Phone Number: _____ Work Number_____

Primary

In Case of Emergency, contact: _____

Relationship: _____

Contact's Address: _____

Primary Phone Number: _____ Alternate Number: _____

Secondary

In Case of Emergency, contact: _____

Relationship: _____

Contact's Address: _____

Primary Phone Number: _____ Alternate Number: _____

BLACK LUNG QUESTIONAIRE

Are you receiving Black Lung (BL) Benefits? If yes, what date did benefits begin: _____	(Y)	(N)
Are services to be paid by the government research program?	(Y)	(N)
Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?	(Y)	(N)
Was this illness the result of a work-related accident/condition?	(Y)	(N)
Was this illness the result of a non-work-related accident? If yes, on what date did the accident occur: _____	(Y)	(N)
Is no-fault insurance available?	(Y)	(N)
Is liability insurance available?	(Y)	(N)

MEDICAL HISTORY

Prior Radiation Therapy: (Y) (N) If so, when and where?_____

_____

Prior Chemotherapy: (Y) (N) If so, when and where? _____

_____

List all:

Surgeries: _____

_____

Medical Illnesses: _____

_____

Injuries: _____

_____

Hospitalizations: _____

_____

FAMILY HISTORY (List all health related issues)

Father: _____

Mother: _____

Siblings: _____

Previous Cancer History:_____

SOCIAL HISTORY

Exercise: _____

Work Hazards/Occupational Exposures: _____

Alcohol Use: _____

Drug Use: _____

Tobacco Use: _____

Medications

Patient Name:_____ DOB:_____

Drug Allergies & Reactions: (None Known)

_____

_____

_____

Food Allergies & Reactions (None Known)

_____

_____

_____

Latex, Iodine, soaps, etc. and Reactions (None Known)

_____

Current Medications, Supplements, OTCs, and Herbals

Drug Name	Dose	Frequency	Route	Date	Date	Date

Legend: (D)= discontinued, (C)=Changed (dose or time), (A)=Added

Patient Name:_____ DOB:_____

Office Use Only Below

VITALS

Tobacco Use: (Y) (N) Is Patient interested in Smoking cessation program: (Y) (N) Was Info Given: (Y) (N)

Has Patient had a Flu shot: (Y) (N) If so when?_____

HT _____ WT _____ T _____

R _____ B/P _____/_____ HR _____

SpO2 % _____ Pain Scale (0-10) 0 1 2 3 4 5 6 7 8 9 10

Is Patient having pain: (Y) (N) If so, where and what type:_____

_____

Physcians Pain Management Plan: _____

_____

Notes: _____

_____

_____

_____

CHIEF COMPLAINT

Reason for today's consultation: _____ ICD-9: _____

History of present illness: _____

_____

_____

_____

_____

PHYSICAL EXAMINATION

Constitution: _____

Eyes: _____

Ears, Nose, Throat & Mouth: _____

Respiratory and Chest: _____

Cardiovascular: _____

GI and Abdomen: _____

GU-Pelvic, Rectal: _____

Skin and/or Breasts: _____

Musculoskeletal: _____

Neurological: _____

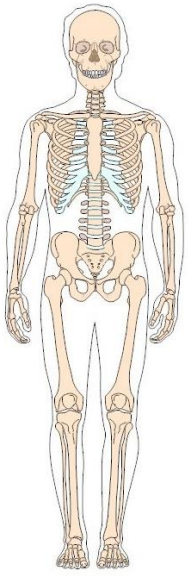
Psychiatric: _____

Hematologic/Lymphatic: _____

PERFORMANCE STATUS

ECOG: 0 1 2 3 4 5 KPS: 100 90 80 70 60 50 40 30 20 10 0

DIAGRAMS



NOTES

_____

_____

_____

_____

_____

_____

REVIEW OF IMAGING AND LAB

X-RAY, CT, MRI: _____

_____

_____

NUCLEAR MEDICINE: _____

LABORATORY: _____

_____

PATHOLOGY: _____

I spent over _____ minutes working exclusively on the patient's behalf including but not limited to; performing history and physical examination, reviewing the medical records, pathology reports, laboratory reports and imaging studies, discussing the diagnosis and prognosis and counseling patient regarding management.

Dictations to:

Referring Physician: _____ Physicians: _____

Physicians: _____ Physicians:_____

Physicians: _____Physicians:_____