KONA
COMMUNITY HOSPITAL

Providing and Enhancing Accessible Comprehensive Healthcare Services

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

Date: _____

Name: _____ **DOB:** _____
Last **First** **MI**

Social Security Number: _____ Sex: (M) (F) Attending MD: Scott Moon

PCP:_____ Referring MD: _____

Local (Physical) Address: _____ City: _____ State: ____ ZIP: _____

Local (Mailing) Address: _____ City: _____State:____ ZIP: _____

Home Phone: _____ Cell Number: _____

Alternate Number: _____ Email:_____

Place of Birth: _____ Ethnicity: _____

Preferred Language: _____ Interpreter: _____

Religion: _____ Part Hawaiian: (Y) (N) Citizen of Country: (Y) (N) Veteran: (Y) (N)

Patients Employment History

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

Employer Name: _____

Employer Address: _____ City: _____ State:_____ ZIP:_____

Work# _____

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

Durable Power of Attorney Name: _____

Relationship: _____

Attorney's Address: _____ City: _____ State:_____ ZIP: _____

Primary Phone Number: _____ Alternate Number: _____

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

Marital Status (Check One): ___Single ___Married ___Divorced ___Widowed ___Separated

Spouse's Name: _____ DOB: _____

Spouse's Address: _____ City: _____ State: _____ ZIP:_____

Phone Number: _____ Work Number:_____

Emergency contacts

Primary

In Case of Emergency, contact:_____

Relationship: _____ Home: _____ Work: _____ Cell: _____

Contact's Address: _____ City:_____ State:_____ ZIP:_____

Secondary

In Case of Emergency, contact:_____

Relationship: _____ Home: _____ Work: _____ Cell:_____

Contact's Address: _____ City:_____ State:_____ ZIP:_____

INSURANCE

Spouse's Employment History If Insurance Guarantor

Spouses Social Security Number If Insurance Guarantor: _____

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

Employer Name: _____

Employer Address: _____City:_____ State: ____ ZIP:_____

Home: _____ Work: _____ Cell: _____

Primary Insurance

Payer Plan: _____ Phone#: _____

Subscriber #:_____ Group#: _____

Secondary Insurance

Payer Plan: _____ Phone#: _____

Subscriber #:_____ Group#:_____

BLACK LUNG QUESTIONAIRE

Are you receiving Black Lung (BL) Benefits? (Y) (N)

If yes, what date did benefits begin: _____
Black Lung ID #: _____

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? (Y) (N)
If yes, on what date did the accident occur: _____
Is no-fault insurance available? (Y) (N)
Is liability insurance available? (Y) (N)

Patient entitled to Medicare because of disability (Y) (N)

END RENAL DISEASE QUESTIONAIRE

Patient entitled to Medicare because of End Stage Renal Disease (Y) (N)
Date Dialysis Began?_____
In 30 month coordination period? (Y) (N)
Receiving training for self-dialysis? (Y) (N)
Date self-dialysis training started? _____
Initial entitlement to Medicare based on ESRD? (Y) (N)
Date Part A effective? _____
Had Transplant (Y) (N)

If yes, on what date: _____

PUBLIC HEALTH SERVICE OR RESEARCH QUESTIONAIRE

Are services covered by a Public Health Service of Research Program? (Y) (N)

Start Date: _____

End Date: _____

Program Name: _____

Address: _____City:_____State:_____ZIP:_____

MEDICAL HISTORY

Patient Name: _____ **DOB:** _____ **DOS:** _____

List all:

Prior Radiation Therapy: (Y) (N)

When: _____ Area Treated: _____ Facility: _____

Prior Chemotherapy: (Y) (N)

When: _____ For What Diagnosis: _____ Facility: _____

Surgeries: (Y) (N)

When: _____ Type: _____ Facility: _____

When: _____ Type: _____ Facility: _____

Hospitalizations: (Y) (N)

When: _____ Type: _____ Facility: _____

When: _____ Type: _____ Facility: _____

Injuries: (Y) (N)

When: _____ Type: _____ Facility: _____

Medical Illnesses: (Y) (N)

When Diagnosed: _____ Type: _____ Physician: _____

When Diagnosed: _____ Type: _____ Physician: _____

Connective tissue disease: (Y) (N) Ex: Scleroderma and/or Lupus

Type: _____ Type: _____

Women Only

Menarche (age at first period) When: _____

Menopause (Y) (N) When: _____ In no: Last menstrual period: _____

List all:

Age at first birth: _____ Number of pregnancies: _____

Number of births: _____ Number of miscarriages or elective abortions: _____

Plans for more children: (Y) (N) Breastfed: (Y) (N)

BCP (Birth Control Pills) (Y) (N) How long: _____ Type: _____

HRT (Hormone Replacement Treatment) (Y) (N) How long: _____ Type: _____

Other Comments: _____

Patient Name: _____ **DOB:** _____ **DOS:** _____

Heart

Implanted pacemaker or defibrillator: (Y) (N) When: _____ Type: _____

Cardiologist's name: _____ Phone Number: _____

Family History: _____

Other: _____

Dental

Dentist: _____ Phone Number: _____

Problems: _____

Recent dental work: _____

Scheduled dental work: _____

FAMILY HISTORY (List all health related issues)

Father: _____

Mother: _____

Siblings: _____

Cancer History in family: _____

Other: _____

SOCIAL HISTORY

Exercise: _____

Work Hazards/Occupational Exposures: _____

Alcohol Use: _____

Drug Use: _____

Tobacco Use: _____

Other: _____

Medications

Patient Name: _____ DOB: _____

Drug Allergies & Reactions:

_____

_____

Food Allergies & Reactions

_____

_____

Latex, Iodine, soaps, etc. and Reactions

_____

_____

Pharmacy of choice

_____

Current Medications, Supplements, OTCs, and Herbals

Drug Name	Form	Dose	Frequency	Route	Date start	Date finished

Form ex: Capsule, spray Dose ex: 200 mg Frequency ex: 2 x day Route ex: By Mouth

VITALS

Patient Name: _____ **DOB:** _____ **DOS:** _____

Referring Physician: _____PCP:_____

Tobacco Use: (Y) (N) 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 _____

Sp02 % _____ Take Face Photo (Y) (N)

Upper Extremity Circumference

	10cm Proximal	10cm Distal
Right		
Left		

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10 Where: _____Type: _____

Physicians Pain Management Plan: _____

Notes: _____

CHIEF COMPLAINT

Reason for today's consultation: _____ ICD-10:_____

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: _____

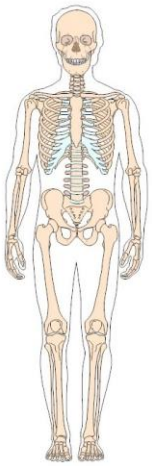
Neurological: _____

Psychiatric: _____

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: _____