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: ______________________ Gender: (M) (F) (T) Attending MD: Scott Moon

PCP:_________________________________ Referring MD: ______________________________

Physical Address:______________________________ City: __________ State: ____ ZIP: _______

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_____________________________

Patient Name: ______________________________ **DOB:** _______________ **Date:** ______________

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#:_________________________

DOS: ______________________________

NAME:_____________________________

DOB:______________________________

Radiation Oncology

HIPPA Approved Contacts

Please list the individual(s) you give permission to have access to and discuss your protected health information:

Name	DOB	Phone Number	Relationship

Additional Comments:

____

____

____

____

This form will remain in effect until written request is received to change or an updated form is filled out by patient.

Print Patient Name or Legal Representative	Signature	Date	Time	AM PM
If Legal Representative Relationship to Patient	**Interpreter**	**Date**	**Time**	**AM PM**

The above person signed this consent in my presence and confirmed to me that he/she understood what they were signing

Print Witness	Signature	Date	Time	AM PM

Patient Name: ______________________________ **DOB:** _______________ **Date:** _____________

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:_______

Patient Name: ______________________________ **DOB:** _______________ **Date:** ____________

MEDICAL HISTORY ** 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: _________________________

When: _______ Type: _______________________________ Facility: _________________________

When: _______ Type: _______________________________ Facility: _________________________

Hospitalizations: (Y) (N)

When: _______ Type: _______________________________ Facility: _________________________

When: _______ Type: _______________________________ Facility: _________________________

When: _______ Type: _______________________________ Facility: _________________________

When: _______ Type: _______________________________ Facility: _________________________

Injuries: (Y) (N)

When: _______ Type: _______________________________ Facility: _________________________

When: _______ Type: _______________________________ Facility: _________________________

Medical Illnesses: (Y) (N)

When Diagnosed: ______ Type: _______________________ Physician: _________________________

When Diagnosed: ______ Type: _______________________ Physician: _________________________

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: _________ If no: Last menstrual period _________________________

List all:

Age at first birth: _________ Number (#) of pregnancies: ___________________________

# of births: _________ # of miscarriages _______ # of 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: _______________ Date: _____________

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) ****Please state Family member's Age at time of Cancer Diagnosis *****

Father: ____

Mother: ____

Siblings: ____

**Cancer History in family: ____

Other: ____

SOCIAL HISTORY

Exercise: ____

Work Hazards/Occupational Exposures: ____

Alcohol Use: Type of drinks: _______________

Recreational Drug Use: ____

Tobacco Use: Type:____ ex. Cigarettes, cigar, chewing

How many packs a day:__________ How many years: _______When quit: __________________

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	Purpose/Comments

* **Form:** tablet, capsule **Dose**: 20 mg **Frequency:** daily, at bedtime **Route**: Oral **Comments:** directions/purpose

REVIEW OF SYSTEMS

Kona Community Hospital, Radiation Oncology Clinic

NAME: ____ **DOB:** ________________________

DATE: ____________

Please indicate if you have experienced any of these problems frequently or if they have worsened in the last 6 to 12 months.

GENERAL SYMPTOMS

Fevers/Chills	Y	N
Night Sweats	Y	N
Weight Loss	Y	N

EYES

New Trouble Seeing	Y	N
Double Vision	Y	N
Pain	Y	N

EAR/NOSE/MOUTH/THROAT

Pain	Y	N
Nasal Obstruction	Y	N
Bleeding from Nose	Y	N

HEART & ARTERIES

Chest Pain	Y	N
Palpitations	Y	N
Calf Pain with Walking	Y	N

LUNGS

Shortness of Breath	Y	N
Increase in Coughing	Y	N
Increase in Wheezing	Y	N
Coughing up Blood	Y	N

STOMACH & INTESTINES

Difficulty Swallowing	Y	N
Indigestion/Heartburn	Y	N
Abdominal Pain	Y	N
Nausea/Vomiting	Y	N
Change in Bowel Movements	Y	N
Blood in or Black Stool	Y	N

SKIN

Rash	Y	N
Itching	Y	N

MUSCULOSKELETAL

New Bone Pain	Y	N
Focal Weakness	Y	N

Where:________________

GENITOURINARY

Painful Urination	Y	N
Blood in Urine	Y	N
Urinary Leakage	Y	N
Urinary Frequency	Y	N
Trouble Emptying Bladder	Y	N

MALE

Trouble Having Erection	Y	N

FEMALE

New Blood from Vagina	Y	N
Heavy Blood from Vagina	Y	N

Last Mammogram_____________

Last Pelvic Exam _____________

BLOOD/LYMPHATICS

Easy Bruising/Bleeding	Y	N
New or Swollen Nodes	Y	N

NEUROLOGICAL

New Headaches	Y	N
Dizzy Spells	Y	N
Numbness/Weakness	Y	N

PSYCHOLOGICAL

Anxiety	Y	N
Depression	Y	N
Thoughts of Hurting Self	Y	N

PHYSICIAN SIG:_____________________________