KAPOLEI FAMILY MEDICAL CENTER, INC

Initial Clinic History and Physical Form

Full Name:_____ **Preferred Name:**_____ **Pharmacy:**_____ **DOB**_____

List of Medication

Prescription/Non-prescription

Medication	Dose/Number per day

Past Surgical History

Date	Type of Surgery

Hospitalization:

Date	Reason

Past Medical History (Please check all that applies)

☐ None ☐ Anxiety ☐ High Cholesterol ☐ HIV

☐ Heart Disease ☐ Bleeding Difficulties ☐ Seizure ☐ High Blood Pressure

☐ Stroke/TIA ☐ Hepatitis A, B or C ☐ TB ☐ Loss of Consciousness

☐ Diabetes ☐ Asthma ☐ Hyperthyroid ☐ Hypothyroid

☐ Allergy: Food ☐ Allergies: Seasonal ☐ Arthritis ☐ Obstructive Sleep Apnea

☐ Emphysema ☐ Coronary Artery Disease

☐ Cancer: Type/Treatment _____

☐ Other (Specify): _____

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Drug Allergies/Type of Reaction

☐ No Known Drug Allergies ☐ Latex ☐ Tape (Adhesive)

Drug Allergy	Reaction

Family Medical History

Mother	☐ Living ☐ Deceased	Age:	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type:_____ ☐ Other: _____
Father	☐ Living ☐ Deceased		☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type:_____ ☐ Other: _____
Brothers	# Living _____ # Deceased _____		☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type:_____ ☐ Other: _____
Sisters	# Living ____ # Deceased _____		☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type:_____ ☐ Other: _____

For Females:

Are you Pregnant? _____ Are you Breastfeeding? _____ #of Pregnancies/Deliveries: _____

Type of Birth Control: _____ Last Menstrual Period: _____ Last Pap: _____

Last Mammogram: _____ Last Bone Density: _____

For Males:

Do you experience impotency? _____ Erectile Problems? _____

Social History: (please check all that applies)

Tobacco use	Alcohol Use	Drug Use	Exercise	Caffeine Use
☐ Never	☐ None	☐ None	☐ None	☐ None
☐ Quit/When?	☐ Socially	☐ Marijuana	☐ 1-2x/week	☐ Occasional
☐ Cigarettes/Pack Per day? _____	☐ Daily	☐ Amphetamines	☐ 3-4x/week	☐ Daily
☐ Pipe	☐ Heavy	☐ Other: _____	☐ 5-7x/week	
☐ Cigars				
☐ Chewing Tobacco				
How Many Years?	Have you ever been treated for alcoholism? _____ If yes, when? _____	Have you ever been tested for drug use? ☐ Yes ☐ No If yes, when? _____	Type of exercise:	How much caffeine?