The Queen's Medical Center-West Oahu
Specialty Care Center
91-2135 Fort Weaver Road 3rd Floor
Ewa Beach, HI 96706

THE QUEEN'S MEDICAL CENTER

NEW PATIENT INFORMATION:

Name:____________________________________ PCP:______________________________________

Date of Birth:__________________ Age:________ Referring Physician: _________________________

Current complaint and symptoms: ____
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MEDICAL HISTORY: Check the conditions and symptoms that apply to you.

□ **NONE**

Constitutional:	□ Fever	□ Chills	□ Unexplained weight loss	
Eyes:	□ Visual disturbance	□ Glaucoma	□ Cataract	
Head, Ears, Nose, Throat:	□ Hearing Loss □ Nasal/Sinus Congestion	□ Ear Pain □ Difficulty Swallowing	□ Sore Throat □ Chronic Nose bleed	
Respiratory:	□ Asthma □ COPD □ COVID	□ Sleep apnea □ Use CPAP or oxygen at home	□ Wheezing □ Chronic cough	□ Tuberculosis □ Positive TB skin test □ Shortness of Breath
Endocrine	□ Diabetes	□ Thyroid - hypoactive	□ Thyroid - hyperactive	
Cardiovascular:	□ Hypertension □ Chest pain/angina □ Swelling/blood clot in legs □ High triglyceride	□ Irregular heartbeat □ Pacemaker □ Defibrillator □ High cholesterol	□ Congestive Heart Failure (CHF) □ Anticoagulant therapy	□ MVP/Murmur □ Artificial valve □ Stent
GI/Hepatic	□ Blood in stool □ Acid reflux □ Ulcer □ Nausea □ Abdominal Pain	□ Colon polyp(s) □ Colon cancer □ Ulcerative colitis □ Crohn's disease □ Vomiting	□ Irritable bowel syndrome □ Diverticulosis □ Lactose intolerance □ Diarrhea	□ Hepatitis or cirrhosis □ Fatty liver □ Gallstones □ Pancreatitis □ Constipation
Genitourinary	□ Blood in urine □ Enlarged Prostate □ Scrotal Pain	□ Difficulty urinating □ Frequent Urination □ Urinary Incontinence	□ Painful urination □ Incomplete Bladder emptying	□ Prostate Cancer □ Testicular pain
Neurology:	□ Seizure disorder □ Tremors	□ Stroke or paralysis □ Dizziness	□ Headache □ Weakness	□ Numbness/Tingling □ Paralysis
Endocrine:	□ Renal (kidney) failure	□ Dialysis	□ Diabetes	□ Thyroid Disease
Hematology/ Oncology :	□ Anemia □ Blood transfusion	□ Bleeding disorder (hemophilia)	□ Cancer; type: ____________________	□ Mastectomy □ Radiation therapy
Musculoskeletal:	□ Neck Pain	□ Back Pain	□ Joint Pain	□ Arthritis
Dermatologic:	□ Chronic Rash	□ Itching	□ Skin Lesion	□ Herpes
Other	□ HIV/AIDS	□ Anxiety/depression		

MEDICATIONS: (Including over the counter medications, Aspirin, Vitamins, Herbal Medications)
You can attach a list or bring in the medicine bottles for staff to enter into your medical record
Name of preferred pharmacy:____

Name of Medication	Dose	Frequency	Route (Oral, topical)	Reason for taking the medication

ALLERGIES: Please list all allergies and allergic reaction/sensitivities
(Aspirin, Iodine, X-ray Dye, Antibiotics, Other Medications)

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

SURGERIES:

Type of surgery	Part of Body (left, right, bilateral)	Date of Surgery

FAMILY HISTORY:

Mother	☐ Alive ☐Deceased (Age:___) Illness:______________	☐Diabetes ☐Hypertension ☐Heart Attack ☐Stroke ☐Glaucoma ☐GI ☐Kidney ☐Lungs ☐Thyroid ☐HIV/AIDS ☐Cancer Type:_________ ☐other:_____________
Father	☐ Alive ☐ Deceased (Age:___) Illness:______________	☐Diabetes ☐Hypertension ☐Heart Attack ☐Stroke ☐Glaucoma ☐GI ☐Kidney ☐Lungs ☐Thyroid ☐HIV/AIDS ☐Cancer Type:_________ ☐other:_____________
Sister	☐ Alive ☐ Deceased (Age:___) Illness:______________	☐Diabetes ☐Hypertension ☐Heart Attack ☐Stroke ☐Glaucoma ☐GI ☐Kidney ☐Lungs ☐Thyroid ☐HIV/AIDS ☐Cancer Type:_________ ☐other:_____________
Brother	☐ Alive ☐ Deceased (Age:___) Illness:______________	☐Diabetes ☐Hypertension ☐Heart Attack ☐Stroke ☐Glaucoma ☐GI ☐Kidney ☐Lungs ☐Thyroid ☐HIV/AIDS ☐Cancer Type:_________ ☐other:_____________
Daughter	☐ Alive ☐ Deceased (Age:___) Illness:______________	☐Diabetes ☐Hypertension ☐Heart Attack ☐Stroke ☐Glaucoma ☐GI ☐Kidney ☐Lungs ☐Thyroid ☐HIV/AIDS ☐Cancer Type:_________ ☐other:_____________
Son	☐ Alive ☐ Deceased (Age:___) Illness:______________	☐Diabetes ☐Hypertension ☐Heart Attack ☐Stroke ☐Glaucoma ☐GI ☐Kidney ☐Lungs ☐Thyroid ☐HIV/AIDS ☐Cancer Type:_________ ☐other:_____________

SOCIAL HISTORY:

Smoke: ☐ No ☐ Yes #pack(s)/day____, Started Smoking____ Quit: ☐ Yes ☐ No Last smoked ______________________
Vape: ☐ No ☐ Yes frequency: _________,
Alcohol: ☐ No ☐ Yes amount _________, Quit ☐ Yes ☐ No Last Drink ____
History of Illicit Drug Use? ____
Living situation (i.e. alone, with family, with friends): ____

REQUESTING A TRANSLATOR? ☐No ☐Yes Language:______________

Is the patient able to sign his/her own documents? ☐Yes ☐No

Does patient have a Durable Power of Attorney? ☐Yes (please bring a copy in for your records) ☐No

ANY QUESTIONS OR CONCERNS?

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