# KOKO PATIENT DEMOGRAPHICS FORM

Client's Name:
Last First Middle Initial

Birthday (MM/DD/YYY): ________

Gender: M F

Social Security Number:

Marital Status (circle):
Single Married Separated Divorced

Email Address:

Physical Address: Street City State Zip

Mailing Address: Street City State Zip

Home Phone: Message ok?: Cell Phone: Message ok?:

Ethnicity (circle): Hawaiian/Pt Hawaiian Caucasian Portuguese Hispanic Asian Other

Name of Employer:

Status (circle): Full Part

Name of Responsible Party if Not Patient:
Last First Middle
Initial

Home Phone:

Cell Phone:

Mailing Address of Responsible Party:
Street City State Zip

Employer of Responsible Party:

Phone Number:

Current Primary Care Provider:

Primary Insurance:

Subscriber's Name:

Insurance #:

Date of Birth:

Secondary Insurance:

Subscriber's Name:

Insurance #:

Date of Birth:

Emergency Contact:

Phone Number:

Relationship to Client:

Address:

I understand that Kīpuka o ke Ola (KOKO) participates with certain insurance plans, and as a courtesy will only ask for an estimated co-pay for each visit. If KOKO does not participate in my plan, I will be asked to pay the full amount at the time of service. In any case, I realize and agree that I am responsible for understanding my plan, benefits, and referral requirements, and that I am responsible for all charges.

Client or Guardian Signature:

Date:

# Kipuka o ke Ola

New Patient Information Form- Women's Health

**Patient Name:** ____________________ ____________________ ______
Last Name | First Name | Middle Initial

**Date of Birth:** ____________________ **Age** __________
**Occupation:** ____________________
**Primary Care Physician:** ____________________ **Referring Physician:** ____________________
**Preferred Pharmacy:** ____________________ **Pharmacy Location:** ____________________
**Chief Compliant:** ____________________
**Associated Symptoms:** ____________________

***ALLERGIES*** (medication, food, dye, latex, etc.): ◯ **NO KNOWN ALLERGIES**

| Allergies: | Reactions (anaphylaxis, hives, rash, etc.) |
|---|---|
| | |
| | |
| | |

***MEDICAL HISTORY*** (Check all the conditions you have or have has in the past): ◯ **NONE** (Healthy & Well)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Acid Reflux | | Congestive Heart Failure | | Heart Attack | | Pacemaker |
| | Anemia | | Colon Polyps | | Hepatitis/Cirrhosis | | Pancreatitis |
| | Anticoagulant Therapy | | COPD | | High Blood Pressure | | Positive Test for Blood in Stool |
| | Arthritis | | Chron's Disease | | High Cholesterol | | Radiation Therapy |
| | Artificial Implant | | Defibrillator | | HIV/AIDS | | Seizure/Epilepsy |
| | Artificial Valve | | Diabetes (type: | | Hyper/Hypothyroidism | | Sleep Apnea |
| | Asthma | | Diverticulosis/Diverticulitis | | Insomnia | | Stent |
| | Bleeding Disorder | | Emotional Conditions (Type): | | Irritable Bowel Syndrome | | Stroke/Paralysis |
| | Blood Clots/DVT | | Fatty Liver | | Irregular Heartbeat | | Tuberculosis/Positive TB Test Results |
| | Blood Transfusion | | Gallstones | | Kidney Failure/Dialysis | | Ulcerative Colitis |
| | Cancer (type): | | Gastric/Intestinal Ulcer | | Lactose Intolerance | | Use CPAP or Oxygen at home |
| | Chest Pain/Angina | | Glaucoma | | Mastectomy | | Other: |
| | Chronic Cough | | Gout | | Mitral Valve Prolapse/Murmur | | Other: |

***SURGICAL HISTORY:*** ◯ **NO SURGERIES**

| Surgery/Reason | When/Date | Where/Location: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***SOCIAL HISTORY:***

**Alcohol:** ☐ None ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly — Amount: ____________________
**Tobacco/Vape/Chew:** ☐ Yes ☐ No ☐ Former — Amount/Frequency: ____________________
**Street Drugs:** ☐ Yes ☐ No ☐ Former — Type/Frequency: ____________________
**Exercise:** ☐ Yes ☐ No ☐ Former — Type/Frequency: ____________________

*FAMILY HISTORY:* ◯ HEALTHY/WELL FAMILY ◯ ADPOTED ◯ UNKNOWN

| Family Member: | Alive/Deceased: | Age: | Medical Condition (ex: cancer, diabetes, gout, high blood pressure, high cholesterol, heart attack, lupus, Kidney disease, stroke, thyroid disease, etc.) |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Paternal Grandfather | | | |
| Paternal Grandmother | | | |
| Maternal Grandfather | | | |
| Maternal Grandmother | | | |
| Brother | | | |
| Sister | | | |
| Children | | | |
| Paternal Uncle | | | |
| Paternal Aunt | | | |
| Maternal Uncle | | | |
| Maternal Aunt | | | |

*MEDICATIONS (please include all over the counter and prescribed medication and supplements. You may attach a list):* ◯ NO MEDICATIONS

| Medication Name: | Dose | Frequency | Route (oral, Topical, Etc) | Reason for taking this Medication: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

*Previous Lab Work* (ex: CMP, CBC, Lipid Panel, A1C, UA, TSH, ESR, CRP, Wound culture, etc.) ◯ NO PREVIOUS LAB WORK

| Test: | When/Date: | Where/Location: |
|---|---|---|
| | | |
| | | |
| | | |

*Previous Imaging (ex: X-Ray, Ultrasound, DEXA/Bone Density, CT, MRI, Etc.)* ◯ NO PREVIOUS IMAGING

| Test: | When/Date: | Where Location: |
|---|---|---|
| | | |
| | | |
| | | |

Questions or concerns? ______________________________________________

______________________________________________

______________________________________________

______________________________________________

***REVIEW OF SYSTEMS:***
Are you currently having (check all that apply):

◯ NONE

**Constitutional**
- ☐ Fever
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss

**GYN**
- ☐ Pain with Intercourse
- ☐ Genital Sores
- ☐ Pelvic Pain
- ☐ Vaginal Pain
- ☐ Genital Itching

**Integumentary**
- ☐ Rash
- ☐ Itching
- ☐ Abnormal Moles

**Gastroenterology**
- ☐ Abdominal Pain
- ☐ Loss of Appetite
- ☐ Heartburn
- ☐ Blood in Stool
- ☐ Loss of control of stool
- ☐ Vomiting
- ☐ Bloating

**Eyes**
- ☐ Eye Pain
- ☐ Loss of Vision

**Cardiovascular**
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Swelling of Legs

**Breast**
- ☐ Nipple Discharge
- ☐ Breast Pain
- ☐ Breast Lump

**Genitourinary**
- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Painful Urination
- ☐ Urinary Incontinence
- ☐ Blood in Urine
- ☐ Incomplete Emptying
- ☐ Abnormal Urine Stream

**Respiratory**
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Wheezing

**Endocrine**
- ☐ Heat or Cold Intolerance
- ☐ Hot Flashes
- ☐ Abnormal Thirst

**Psychiatric**
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss

***PREGNANCY HISTORY:***

◯ **NO PREGNANCIES**

**Please list number of:** Pregnancies: ____________

**Please list number of:** Living Children: __________ Miscarriages: ________ Abortions: ________ Ectopic: __________

Still Born: ___________ Multiple Births (twins, etc.): _________ Number or Cesarean Deliveries __________

Date of Birth: __________ Type of Delivery: _______________ Epidural? ☐ Yes ☐ No Birth Weight: ________ ☐ M ☐ F

Date of Birth: __________ Type of Delivery: _______________ Epidural? ☐ Yes ☐ No Birth Weight: ________ ☐ M ☐ F

Date of Birth: __________ Type of Delivery: _______________ Epidural? ☐ Yes ☐ No Birth Weight: ________ ☐ M ☐ F

Date of Birth: __________ Type of Delivery: _______________ Epidural? ☐ Yes ☐ No Birth Weight: ________ ☐ M ☐ F

Date of Birth: __________ Type of Delivery: _______________ Epidural? ☐ Yes ☐ No Birth Weight: ________ ☐ M ☐ F

***Pregnancy History (continued):***
Additional Births:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

***GYNECOLOGICAL HISTORY:***
Have you had a Mammogram? ☐ Yes ☐ No If yes, please list when/where: ______________________
Date of last Pap smear: _______________ Where: ____________________ Was the results normal? ☐ Yes ☐ No
Have you had an abnormal Pap smear? ☐ Yes ☐ No
Have you had a DEXA bone scan? ☐ Yes ☐ No If yes, please list when/where: ______________________
Have you ever completed a Colonoscopy? ☐ Yes ☐ No If yes, please list when/where: ________________
Have you ever received the Gardasil Injection? ☐ Yes ☐ No
If yes, please list when/where and if you have received all three injections: ______________________

At what age did you start your period? _____ When was the first day of your last menstrual period? __________
Do you have your period monthly? ☐ Yes ☐ No How many days does your period last? __________
How many days between periods? ___________ Days

How many pads ______/ tampons ______ are used on your heaviest day?
Are your periods painful ☐ Yes ☐ No If yes how do you treat your pain? ____________________
Have you ever had sex? ☐ Yes ☐ No Are you currently sexually active? ☐ Yes ☐ No
Please indicate your sexual partners: ☐ Male ☐ Female ☐ Both
What do you use for birth control? ____________________

***Menopause:***
At what age did you start to experience menopause symptoms? ______ ◯ **NO SYMPTOMS**
Did you have a hysterectomy? ☐ Yes ☐ No
Did you have your ovaries removed? ☐ Yes ☐ No Did you remove one or both? ____________
Are you currently taking or previously taken hormones? ☐ Yes ☐ No
If yes, what type and how long have you used them? ____________________

***Additional Social History:***
Have you ever been sexually, physically, or emotionally abused? ☐ Yes ☐ No
Do you presently feel threatened by anyone? ☐ Yes ☐ No
Would you like counseling services? ☐ Yes ☐ No

What have you done for yourself in the past year? ____________________

The above information is accurate to the best of my knowledge.

Patient name *(print)*: ____________________

Patient Signature: ____________________ Date: __________

Parent/legal guardian name *(print)*: ____________________

Parent/legal guardian signature: ____________________ Date: __________

# Kīpuka o ke Ola

Physical Address: 64-1035 Māmalahoa Hwy, Suite F, Kamuela, HI 96743

Mailing Address: PO Box 818, Kamuela, HI 96743

Office: 808-885-5900 FAX 808-885-6900 www.kipukaokeola.com

## PHQ-9 SCREEN

**(Rev 1/29/18)**

**Name**__________________________________________ **Date** ________

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

| Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|
| 0 | 1 | 2 | 3 |

1. Little interest or pleasure in doing things _________

2. Feeling down, depressed, or hopeless _________

3. Trouble falling or staying asleep, or sleeping too much _________

4. Feeling tired or having little energy _________

5. Poor appetite or overeating _________

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down _________

7. Trouble concentrating on things, such as reading the newspaper or watching television _________

8. Moving or speaking so slowly that other people could have noticed? Or the opposite being so fidgety or restless that you have been moving around a lot more than usual? _________

9. Thoughts that you would be better off dead or of hurting yourself in some way _________

# Kīpuka o ke Ola

Physical Address: 64-1035 Māmalahoa Hwy, Suite F, Kamuela, HI 96743

Mailing Address: PO Box 818, Kamuela, HI 96743
Office: 808-885-5900 FAX 808-885-6900 www.kipukaokeola.com


## GAD-7 SCREEN

**(Rev 1/29/18)**

**Name:** ______________________________ **Date:** ____________

**Over the last 2 weeks, how often have you been bothered by the following problems?**

*Use "✔" to indicate your answer"*

0 = Not at all 1 = Several days 2 = More than half the days 3= Nearly every day

| | | | | |
|---|---|---|---|---|
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?