Mālama Pono
HEALTH CARE, LLC
Claudia Christman, M.D.

Patient Registration

Name:_____
Last First Middle

Social Security Number:_____-_____-_____

Gender: Male Female Birthdate:_____ Age: _____

Marital Status: Single Married Divorced Widowed Long-Term Partner

Home Address: _____

_____

Phone: Home: _____ Work:_____

Cell: _____ Email:_____

Local Address: _____
(If different
from above) _____

Local Phone: _____
(If different from above)

How did you hear about Malama Pono Health Care? _____

Employer: _____ Job title/position:_____

Address: _____ Phone:_____

Emergency Contact:_____ Relationship: _____ Phone: _____

Person/Party Responsible for Bill:_____

Address: _____ Phone: _____

Signature _____ Today's Date _____

Mālama Pono
HEALTH CARE, LLC
Claudia Christman, M.D.

Medical History Questionnaire

Name _____ Today's Date _____
Birthdate _____ Age _____

What medications are you presently and/or regularly taking? (Include over-the-counter medications, herbal supplements, vitamins, etc.) _____
_____
_____

Are you allergic to any medications? (If yes, please list) _____
_____
_____

Do you have any other allergies? (If yes, please list) _____
_____
_____

List any surgeries and/or hospitalizations (include the type of surgery/injury and hospitalization, including dates):
_____
_____

Are you currently being treated by any other health care providers? (This may include other physicians, specialists, mental health care providers, acupuncture/chiropractic, etc.) If yes, please list the provider, type of care provided, and purpose (Example: Dr. X, podiatrist, for foot pain).
_____
_____

Immunizations (please provide dates)

Tetanus	_____	MMR	_____
Flu	_____	Pneumococcal	_____
Hepatitis A	_____	Hepatitis B	_____
Other:	_____	Polio	_____

Social History:

1. Do you currently or have you in the past smoked cigarettes, pipe, or cigars? _____ YES _____ NO
   If yes, number of packs per day _____ x _____ number of years
   Age started _____ If you quit, age when you quit _____

2. Do you currently or have you in the past chewed tobacco? _____ YES _____ NO
   If yes, Age started _____ If you quit, age when you quit _____

3. Do you consume caffeinated beverages? _____ YES _____ NO
   If yes, types and quantity (how much?)
   _____
   _____

Patient Name _____

4. Do you consume alcohol? _____ YES _____ NO
If yes, how many drinks per day/week? (type of alcohol and quantity)

_____

_____

5. Do you use non-prescribed drugs? _____ YES _____ NO
If yes, type, date started, and frequency (how often)? _____

_____

_____

6. Do you have a history of substance abuse or substance dependence, and/or treatment for substance abuse (including drugs, alcohol, abuse of pain medications, etc.)

_____

_____

7. Are you currently employed? _____ YES _____ NO
If so, on a scale of 1-10 how stressful is your job? _____

8. Are you currently involved in a significant relationship? Are there any issues related to your relationship (for example, relational stress, STD, physical or emotional abuse or concerns, etc.)? If so, describe:

_____

_____

9. How often do you exercise? _____

10. Women and Men: Do you conduct regular self breast exams? _____

11. Men Only: Do you conduct regular self-testicular exams? _____

12. Do you wear your seatbelt and/or (for bicycle/motorcycle/moped riders) wear a helmet?
_____ YES _____ NO

Family History

In your family, is there any history of the following (please circle):

Heart Disease / High Blood Pressure / Diabetes / Stroke / Cancer / Alcoholism / Psychiatric Disorder / Substance Abuse / Domestic Violence / Other:

If you circled any of the above, please indicate the relationship of the person in your family (mother, father, sister, etc.), what illness, and what age they were when diagnosed. _____

_____

_____

_____

_____

Patient Name _____

TO THE BEST OF YOUR KNOWLEDGE HAVE YOU EVER HAD OR BEEN TOLD YOU HAD (place a checkmark for "Yes" or "No"):

	Yes	No	Explain any "Yes" Answers
A. Epilepsy, seizures, concussions, loss of consciousness, fainting spells, migraines, dizziness, stroke, paralysis, or any disease or abnormality of the brain or nervous system			
B. Heart attack, murmur, palpitation (racing heart or skipped beats), high blood pressure, chest pain, varicose veins, or any disease or abnormality of the heart, blood, or blood vessels?			
C. Tuberculosis, asthma, shortness of breath, coughing up blood, wheezing, swelling of the feet or ankles, or any abnormality of the lungs, or respiratory system?			
D. Ulcer, indigestion, difficulty swallowing, colitis, abdominal pain, blood in stool, gall stones, hernia, or any disease or abnormality of the stomach, intestines, rectum, gall bladder, pancreas, or liver?			
E. Urinary problems, sexually transmitted diseases, abnormal pap smears, irregular periods, prostate problems, or any disease or abnormality of the breast kidneys, prostate or genital system?			
F. Diabetes, gout, high cholesterol, or any disease or abnormality of the thyroid or other glands?			
G. Arthritis, rheumatic fever, back problems, or any disease or abnormality of the joints, muscles, or bones?			
H. Visual problems, decreased hearing, ear infections, sinus problems, or any abnormality of the eyes, ears, nose, or throat? Do you wear glasses, contact lenses, or hearing aids?			
I. Problems with skin?			
J. Cancer or tumor?			
K. Any physical deformity or defect?			
L. Pregnancies? Past or current? (Include miscarriages/abortions)			
M. Weight or nutritional problems, dietary restrictions, or history of eating disorders?			
N. Sleep Difficulties (difficulty falling/staying asleep, sleep apnea, snoring, etc.)			
O. Depression, anxiety, stress, or other mental health concerns?			
P. Have you ever been exposed to any chemicals, toxins, poisons, smoke, fumes, asbestos, or radioactive materials at home or at work?			
Q. Have you had any blood transfusions, unprotected sex, or intravenous drug use that may increase your risk for HIV/STDs?			

_____ _____

Your Signature Today's Date