



THE QUEEN'S HEALTH CARE CENTERS

Downtown
550 S. Beretania St., #401
Honolulu, Hawaii 96813
Ph: (808) 691-7744
Fax: (808) 691-4005

Hawaii Kai
377 Keahole St.
Honolulu, Hawaii 96825
Ph: (808) 396-6675
Fax: (808) 395-2104

Kapolei
599 Farrington Hwy., #201
Kapolei, Hawaii 96707
Ph: (808) 691-7338
Fax: (808) 691-7360

Allergies Yes / No

Allergy	Reactions	How Severe?
		Low / Medium / High
		Low / Medium / High
		Low / Medium / High

Medical History

- | | | | |
|-------------------------|--|------------------------------|--|
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problem | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bladder Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Clotting Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bone Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Medical History | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bowel Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes Mellitus | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| GERD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemorrhoids | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Other: _____

Psychiatric History

- | | | | |
|------------------|--|-----------------------|--|
| ADHD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcohol Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Meth/Cocaine Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Mental Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Substance Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bipolar Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Schizophrenia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dementia | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Other: _____

Surgical History

- | | | | |
|---|--|---------------------------------|--|
| Abdominal Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back/Neck Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney/Bladder/Prostate Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brain Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | OB/GYN Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthopedic Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Rhythm Management Device (CRMD) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Surgeries | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thoracic Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cosmetic/Reconstructive Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vascular Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ENT Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Other: _____

Social History

What is your ethnicity?		Have you ever smoked or used nicotine?	YES NO
Are you married?	YES NO	If yes, what type? Cigarettes - Cigars - E-cigarettes - Pipe - Smokeless (chew or snuff)	
Number of children		Start Date:	Quit Date:
How many people in your household?		Packs / Day:	Years:
Your relationship with them		Do you drink alcohol? YES NO If yes, Beer, Liquor, or Wine? If yes, how much per week? _____	
Highest level of education		Do you use illicit drugs? YES NO If yes, what type? _____ How much per week? _____	
Employer and occupation		Are you on birth control? YES NO If yes, what type / name of birth control? _____	

Medications

Med Name	Dose	Taken How Often?	Took Today?
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No
		1x/day - 2x/day - 3x/day - 4x/day - Other	Yes / No

Family History

Relationship	Name	Status	Add Problem	Alcohol Abuse	Arthritis	Asthma	Birth Defects	Cancer	COPD	Depression	Diabetes Mellitus	Drug Abuse	Early Death	Hearing Loss	Heart Disease	High Cholesterol	Hypertension	Kidney Disease	Learning Disability	Mental Illness	Mental Retardation	Miscarriages/Stillbirths	Stroke	Vision Loss
Mother			+																					
Father			+																					
Sister			+																					
Brother			+																					
Daughter			+																					
			+																					
			+																					
Son			+																					
			+																					
			+																					
MGM			+																					
MGF			+																					
PGM			+																					
PGF			+																					

Other Problems:

Relationship	Problem	Relationship	Problem