Kona NPs LLC **New Patient Questionnaire**

Name_____ DOB:_____ Today's Date:_____
Address:_____ City:_____State:____ Zip:_____
Phone: (____) ____-_____ Cell: (____) ____-_____ E-mail: _____
Primary Insurance:_____Policy #:_____ Subscriber: ☐Self ☐Other____ _____DOB:__/__/____
Secondary Insurance:_____Policy #:_____☐ Self ☐Other_____ DOB:__/__/____
EMERGENCY CONTACT INFORMATION Able to release your health care information to them?
Name:_____ Phone: (____) ____-_____ Relationship:_____☐ Yes ☐No
Name:_____ Phone: (____) ____-_____ Relationship:_____☐ Yes ☐No
How did you learn about us? ☐ Advertisement ☐ Newspaper ☐Mailer ☐Friend ☐Referral ☐Other

CURRENT MEDICAL PROBLEM
What problem brought you here?
_____
_____
What symptoms are you having?
_____
_____
When did your symptoms start? _____
Has your appetite changed in the last six months? ☐ Decreased ☐ Increased ☐ Stayed the same
Current Height ____ Weight lbs____ Has your weight changed in the last six months? ☐ No ☐ Yes
If yes, ☐ Gained lbs ☐ Lost lbs How much?_____
Has your overall energy / pep level changed? ☐Decreased ☐ Increased ☐Stayed the same
Do you take naps during the day? ☐No ☐Yes If yes, how many and how long? _____
PAST MEDICAL / SURGICAL HISTORY
Have you had any difficulty with anesthesia in the past? ☐ No ☐ Yes If yes, explain:_____
Have you had any problems with bleeding during or after surgery in the past?☐ No ☐Yes
If yes, explain:_____
Please list any medical problems (e.g., diabetes, high blood pressure, cancer, etc)
1._____ 3._____ 5. _____ 7._____ 9. _____
2. _____ 4. _____ 6. _____ 8._____10._____
Females: Number of: pregnancies:____ live births:____ miscarriages:____ abortions: ____
Age when you started your period: _____ Age at menopause: ____Hormone replacement: ☐No ☐Yes
Please list any previous operations or procedures, include date
1._____ 3._____ 5. _____ 7._____ 9. _____
2. _____ 4. _____ 6. _____ 8._____10._____
FAMILY HISTORY
Are there any diseases that run in your family? ☐No☐Yes If so, explain: Disease Family member affected
Mother_____ Father_____ Kids _____
Grandfather _____ Grandmother_____
MEDICATIONS
List all medications, vitamins, supplements, and over-the-counter medications below.
Medicine or pill name Dose (e.g., 50 mg) How many times per day? Why do you take this?
1._____ 3._____ 5. _____ 7._____ 9. _____
2. _____ 4. _____ 6. _____ 8._____10._____
Are you allergic to any medications, pills, food, etc.? ☐No☐ Yes. Please list below & explain your reaction.
1._____ 3._____ 5._____
2._____ 4._____ 6._____
Allergic to shellfish?☐ No☐ Yes ☐ Don't Know To contrast /medical test dye?☐No ☐Yes ☐Don't Know
VACCINATIONS
Have you had a pneumonia vaccine < 5 years? No☐ Yes,☐date:_____ Don't Know ☐
Have you a flu vaccine this flu season? No ☐ Yes ☐date:_____Don't Know ☐
SOCIAL HISTORY
Single ☐Married ☐ Separated☐ Divorced ☐Widowed ☐What kind of work do you do?_____
Have you smoked? ☐Never ☐No ☐ Yes Quit?☐ No☐ Yes How much per day?_____packs/day

Do you drink alcohol? ☐Never ☐ No ☐ Quit ☐ Yes How much of what per day?_____
Do you use street drugs? ☐ Never ☐ No ☐ Quit ☐ Yes, type:_____
Do you have any problems taking care of your daily activities of living (e.g., bathing, walking)?
☐ No (Independent) ☐ Need some help / assistance ☐ Need constant help (Dependent)
Do you have difficulty falling asleep? ☐ No ☐ Yes Or staying asleep at night? ☐ No ☐ Yes
Do your legs bother you at night? ☐ No ☐ Yes Do you kick during sleep? ☐ No ☐ Yes ☐ N/A
Do you have an advance directive (living will, durable power of attorney)? ☐ No ☐ Yes, please provide copy.
Do you have any religious or cultural beliefs that impact your healthcare? ☐ No ☐ Yes Explain:_____
How do you learn best? ☐ Pictures ☐ Books ☐ Pamphlets ☐ Video ☐ Talking to others ☐ Computer
Do you have problems with transportation? ☐ No ☐ Yes Do you have financial concerns? ☐ No ☐ Yes

Do you currently have or have you had any of the following?

CONSTITUTIONAL
Fever ☐ No ☐ Yes Chills ☐ No ☐ Yes Loss of appetite ☐ No ☐ Yes Pain ☐ No ☐ Yes, location:_____
How bad is your pain? (circle one) 0 1 2 3 4 5 6 7 8 9 10 (no pain.....worst pain ever)
Type: ☐ Burning ☐ Stabbing ☐ Tingling ☐ Dull ☐ Throbbing ☐ Constant ☐ Radiating ☐ Cramping ☐ Intermittent

EYES / ENT
Blurred or double vision ☐ No ☐ Yes Hard of hearing ☐ No ☐ Yes Nose bleeds ☐ No ☐ Yes

CARDIOVASCULAR
Shortness of breath ☐ No ☐ With activity ☐ At rest High blood pressure ☐ No ☐ Yes Chest pain/angina ☐ No ☐ Yes
Have you been treated for this in the past 30 days? ☐ No ☐ Yes Heart murmur ☐ No ☐ Yes
Irregular heart beat ☐ No ☐ Yes Ankles / feet swelling ☐ No ☐ Yes High cholesterol ☐ No ☐ Yes
Congestive heart failure ☐ No ☐ Yes Have you been treated for this in the past 30 days? ☐ No ☐ Yes
Heart attack or myocardial infarct (MI) ☐ No ☐ Yes Have you been treated for this in the past 6 months? ☐ No ☐ Yes

PULMONARY
Asthma ☐ No ☐ Yes Wheezing / trouble breathing ☐ No ☐ Yes Emphysema / COPD ☐ No ☐ Yes
Have you ever been treated for this? ☐ No ☐ Yes Cough ☐ No ☐ Yes, ☐ wet ☐ dry Coughing blood ☐ No ☐ Yes
Tuberculosis (TB) ☐ No ☐ Yes Other:_____

HEMATOLOGY
Anemia ☐ No ☐ Yes Bleeding disease ☐ No ☐ Yes Clotting disease ☐ No ☐ Yes HIV positive ☐ No ☐ Yes
Do you bruise easily? ☐ No ☐ Yes Swollen glands / lumps ☐ No ☐ Yes

MUSCULOSKELETAL
Joint pain ☐ No ☐ Yes Back pain ☐ No ☐ Yes Arm numbness / weakness ☐ No ☐ Yes
Leg numbness / weakness ☐ No ☐ Yes

NEUROLOGY
Stroke ☐ No ☐ Yes, date:_____If yes, did you have any problems afterwards? ☐ No ☐ Yes Explain:_____
"Mini stroke" or TIA ☐ No ☐ Yes, date:_____ Seizure ☐ No ☐ Yes, date:_____
Other:_____

GASTROENTEROLOGY
Stomach pain ☐ No ☐ Yes Nausea / vomiting ☐ No ☐ Yes Vomiting blood ☐ No ☐ Yes
Difficulty swallowing ☐ No ☐ Yes Heartburn ☐ No ☐ Yes Diarrhea ☐ No ☐ Yes
Bloody stool or black stool ☐ No ☐ Yes Constipation ☐ No ☐ Yes Change in bowel habits ☐ No ☐ Yes
Gallbladder disease ☐ No ☐ Yes Hernia ☐ No ☐ Yes, type:_____

GENITOURINARY
Painful urination ☐ No ☐ Yes Frequent urination ☐ No ☐ Yes Incontinence ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes Venereal disease ☐ No ☐ Yes Other:_____

IMMUNE SYSTEM / NUTRITIONAL / OTHER
Cancer ☐ No ☐ Yes, date:_____ Type(s):_____ Has it spread to other locations? ☐ No ☐ Yes
If yes, where:_____ Chemotherapy ☐ No ☐ Yes In last 30 days? ☐ No ☐ Yes
Radiation ☐ No ☐ Yes In last 90 days? ☐ No ☐ Yes Thyroid problems ☐ No ☐ Yes Anxiety ☐ No ☐ Yes
Open wounds ☐ No ☐ Yes, where:_____ Depression ☐ No ☐ Yes
Unusually thirsty AND frequent urination ☐ No ☐ Yes

Insurance Authorization-Please Read and Sign
I hereby authorize my doctor to furnish information to insurance carriers or government agencies concerning illness and treatments. I hereby assign them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance. I agree to pay a $35.00 fee for less than 24 hour cancellation notice for missed appointments. If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____(patient signature) ___/___/_____(today's date)