

PATIENT INFORMATION				
Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth
Legal Sex (Please check one)* <input type="checkbox"/> Male <input type="checkbox"/> Female *Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.	Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male/Female-to-Male <input type="checkbox"/> Transgender Female/Male-to-Female <input type="checkbox"/> Other <input type="checkbox"/> Chose not to disclose	Sexual Orientation <input type="checkbox"/> Lesbian, gay or homosexual <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Chose not to disclose		
Home Address		City	State	Zip Code
Mailing Address		City	State	Zip Code
Please complete and indicate your preferred contact method by checking one of the boxes below: <input type="checkbox"/> Home Phone () () () <input type="checkbox"/> Cell Phone () () () <input type="checkbox"/> Day Phone () () () <input type="checkbox"/> Email Address				
Housing Status: <input type="checkbox"/> Not Homeless <input type="checkbox"/> Doubling Up <input type="checkbox"/> Homeless <input type="checkbox"/> Street, Beach, etc. <input type="checkbox"/> Shelter <input type="checkbox"/> Unreported <input type="checkbox"/> Transitional				
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	Do You Need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other:	
Race (pick one below that best describes you):				
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> African American/Black	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Chinese	
<input type="checkbox"/> Chuukese	<input type="checkbox"/> Filipino	<input type="checkbox"/> Guamanian	<input type="checkbox"/> Japanese	
<input type="checkbox"/> Korean	<input type="checkbox"/> Laotian	<input type="checkbox"/> Marshallese	<input type="checkbox"/> Micronesian	
<input type="checkbox"/> Native American	<input type="checkbox"/> Portuguese	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Samoan	
<input type="checkbox"/> Tongan	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Other Asian	<input type="checkbox"/> Other Pacific Islander	
<input type="checkbox"/> All Other (Specify):				
PARENT OR LEGAL GUARDIAN INFORMATION				
Relationship of Guarantor to Patient (Check One): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:				
Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth
Home Address		City	State	Zip Code
Mailing Address		City	State	Zip Code
Please complete and indicate your preferred contact method by checking one of the boxes below: <input type="checkbox"/> Home Phone () () () <input type="checkbox"/> Cell Phone () () () <input type="checkbox"/> Day Phone () () () <input type="checkbox"/> Email Address				
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		Do You Need an Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary or Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other:
Employer/School Name: <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Casual <input type="checkbox"/> Unemployed				
Occupation:	Family Size: (includes self, spouse, & children under 18):	Family Income: \$	<input type="checkbox"/> Monthly <input type="checkbox"/> Annual	

Patient Registration: MINOR

Patient Name: _____
 Parent/Guardian Name: _____

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:	Relationship:	
Home Phone:	Work Phone:	Cell Phone:
Emergency Contact Name:	Relationship:	
Home Phone:	Work Phone:	Cell Phone

_____ Initial
 I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize KHC to release information to my insurance carrier or organization in order to process claims on my behalf. I authorize payment of medical benefits to KHC for services rendered.

_____ Initial
 I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initial
 I consent and authorize Ko'olauloa Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

_____ Initial
 I received the Notice of Privacy Practices.

Signature of Parent/Legal Guardian Date Signed Signature of Responsible Party Date Signed

FOR OFFICE USE ONLY		
MEDICAL SERVICES – Record #		
Pt Status Type: <input type="checkbox"/> Scheduled <input type="checkbox"/> Inactive <input type="checkbox"/> Active <input type="checkbox"/> Dental Patient Only	Valid ID: <input type="checkbox"/> Scan ID <input type="checkbox"/> Update Pt Picture	Insurance: <input type="checkbox"/> Scan card <input type="checkbox"/> Update info
Collected By: _____ Date: _____	Entered By: _____ Date: _____	
DENTAL SERVICES – Record #		
Pt Status Type: <input type="checkbox"/> Scheduled <input type="checkbox"/> Inactive <input type="checkbox"/> Active <input type="checkbox"/> Dental Patient Only	Valid ID: <input type="checkbox"/> Scan ID <input type="checkbox"/> Update Pt Picture	Insurance: <input type="checkbox"/> Scan card <input type="checkbox"/> Update info
Collected By: _____ Date: _____	Entered By: _____ Date: _____	

Patient Name: _____

PRIMARY MEDICAL INSURANCE INFORMATION						
Patient's Relationship to the Insured (check one) <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____						
Policy Holder Name				Date of Birth		
Plan Name	Policy#/Subscriber#		Group#	Effective Date	Expiration Date	
Home Address			City	State	Zip Code	
Home Phone		Cell Phone		Work Phone		
SECONDARY MEDICAL INSURANCE INFORMATION						
Patient's Relationship to the Insured (check one) <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____						
Policy Holder Name				Date of Birth		
Plan Name	Policy #/Subscriber#		Group#	Effective Date	Expiration Date	
Home Address			City	State	Zip Code	
Home Phone		Cell Phone		Work Phone		
PRIMARY DENTAL INSURANCE INFORMATION						
Patient's Relationship to the Insured (check one) <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____						
Policy Holder Name				Date of Birth		
Plan Name	Policy #/Subscriber#	Group#		Effective Date	Expiration Date	
Home Address			City	State	Zip Code	
Home Phone		Cell Phone		Work Phone		
SECONDARY DENTAL INSURANCE INFORMATION						
Patient's Relationship to the Insured (Check one) <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Child <input type="checkbox"/> Other: _____						
Policy Holder Name				Date of Birth		
Plan Name	Policy#/Subscriber#	Group#		Effective Date	Expiration Date	
Home Address			City	State	Zip Code	
Home Phone		Cell Phone		Work Phone		

I, _____, the _____
 Parent or Legal Guardian Relationship

of _____ and
 Minor's Full Legal Name Date of Birth

of _____ and
 Minor's Full Legal Name Date of Birth

of _____ and
 Minor's Full Legal Name Date of Birth

of _____ and
 Minor's Full Legal Name Date of Birth

Authorize and consent to any examinations, x-rays, anesthetic, medical diagnosis, immunization, or treatment rendered by Ko'olauloa Health Center in the event that my child(ren) are brought to the Center by the following persons:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Signature of Parent or Legal Guardian	Date

Telephone number where Parents/Legal Guardians can be reached:

_____	_____	_____
Father's Name	Business Phone	Cell Phone
_____	_____	_____
Mother's Name	Business Phone	Cell Phone
_____	_____	_____
Legal Guardian's Name	Business Phone	Cell Phone

I, _____ the undersigned, hereby give Ko'olauloa Health Center permission to examine my (son/daughter/ward):

_____ Child's Name	_____ Date of Birth

To make such tests as are necessary for his/her diagnosis and care, and to give such treatment as the Ko'olauloa Health Center providers deem necessary. This includes diagnosis and care at the Center's clinic, at laboratories, X-ray facilities, clinics, emergency rooms and offices of specialists, and psychological tests.

I understand that for major surgery or other major procedures, special explanations will be made to me and special permission will be requested of me, unless the emergency is too great to wait to contact me.

This consent which I am signing is for the ongoing health care of my (son/daughter/ward) until I withdraw him/her from the Center. I understand that it includes consent for general tests, tuberculin tests, applications to skin or mucous membranes, examination of mouth, genitals, rectum and ears, repair of small cuts, and all other ordinary medical office procedures.

I am not hereby consenting to any experimental procedures, not to tests for research or scientific study.

My photograph and that of my child may be used for medical records and for publicizing Ko'olauloa Health Center.

I certify that I have read (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

Parent/Legal Guardian Signature

Date

Printed Name

As a Ko 'olauloa Health Center Patient, you have the right to:

- ❖ Be treated with courtesy, dignity and respect regardless of race, color, sex, age, national origin, or beliefs.
- ❖ Be seen in a safe, secure environment and in a timely manner.
- ❖ Know the name of your health provider and the names and positions of staff you encounter.
- ❖ Be informed of your condition and understand the treatments.
- ❖ Refuse treatment at any time and to be informed of the risks of the refusal of treatment.
- ❖ Be informed of the reasons for tests and treatments and to receive the results in a timely manner.
- ❖ Refuse to sign consent forms until you understand what you are signing.
- ❖ Refuse to participate in educational or experimental activities by choice.
- ❖ Participate in all decisions regarding your care as stated within the law.
- ❖ Identify a person whom you would like to make decisions for you when you are unable to do so, using the Advanced Care Directives.
- ❖ Be referred for emergency or specialized services not provided by KHC.
- ❖ Have your health information protected and held in confidentiality.
- ❖ Obtain explanations of monies that you owe to the health center on your bill.
- ❖ Request and receive copies of your medical records at a small fee.

As a Ko 'olauloa Health Center Patient, your responsibilities are to:

- ❖ Treat all persons in the health center with courtesy, dignity, and respect at all times.
- ❖ Provide accurate information for registration, billing, payment, informed consents, and changes that occur, including any changes in your address, phone number, insurance, and or any other contact information.
- ❖ Provide information regarding your concerns to a patient service representative or may request to speak with the Chief Clinical Officer, Chief Medical Officer, Chief Operations Officer or Chief Executive Officer.
- ❖ Be on time for scheduled appointments and to cancel appointments before the scheduled appointment, according to Ko'olauloa Health Center policies. This includes any specialty or referral appointments made for you.
- ❖ Provide requested information for your medical history accurately including past illnesses, medications, allergies, hospitalizations, family and social histories,
- ❖ Ask questions if you are unclear about papers and information that you and your provider have agreed upon
- ❖ Keep your personal belongings in a safe place. Lost and/or stolen personal items are not the responsibility of Ko'olauloa Health Center.

Ko'olauloa Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you need language assistance, services free of charge, are available to you. Call (808) 293-9231.

WE WISH TO OFFER YOU THE BEST HEALTH CARE POSSIBLE AND APPRECIATE YOUR INPUT AS A HIGHLY VALUED TEAM PLAYER.

I have reviewed and received a copy of the above Patient Rights and Responsibilities. I understand that if I or any of my family members do not follow the rules, I may not be able to receive care at this health center.

Signature of Patient/Legal Guardian

Date

Printed Name

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION

Ko'olauloa Health Center uses your health information for:

- Planning your care and treatment;
- Documenting the care you receive;
- Communicating with other health professionals involved in your care;
- Assessing and continually working to improve the care we provide;
- Obtaining payment for services rendered; and
- Verifying that the services billed to your health insurer or other third-party payers were provided.

Your health information may include data regarding your family, social, educational, and other information provided by you and is maintained in your health record.

Your record may also contain your screening and test results, immunization record, diagnoses, treatment, and a plan for your ongoing care. Medical and hospital reports, and other information obtained with written permission may be part of your record.

YOUR HEALTH INFORMATION AND PRIVACY RIGHTS

The records of your examination and treatment at Ko'olauloa Health Center are the physical property of the Center, and the information contained in those records belongs to you. You have the right to:

- Receive confidential communications related to your health information;
- Ask that certain health information not to be shared with particular people or entities. We will consider your request but may not be able to comply with your requested restriction if it is against the law or disclosure is necessary to obtain payment for services rendered by Ko'olauloa Health Center;
- Ask to add or correct information contained in Ko'olauloa Health Center records;
- Obtain a written report on when and why your health information was shared and for what purposes the information was shared; and
- Obtain a paper copy of this Notice of Privacy Practices upon request, even if you had previously agreed to receive the Notice electronically.

RESPONSIBILITIES OF KO'OLAULOA HEALTH CENTER

Ko'olauloa Health Center is required by law to:

- Maintain the privacy of your protected health information within the law, rules and regulations governing the privacy and disclosure of such information;
- Inform you of how your information may be used and disclosed;
- Inform you of your rights with respect to the use and disclosure of your information;
- Inform you that you may exercise your rights including how to make a complaint;
- Provide you with this Notice which describes our legal duties and privacy practices regarding information we collect and maintain about you; and
- Notify you if a breach of your health information occurred.

We shall abide by the terms of the Notice of Privacy Practices currently in effect. However, should our privacy practices change, we reserve the right to make the new provisions effective for all health information we

Notice of Privacy Practices

maintain. Any significant change will be reflected in a revised Notice of Privacy Practices which will be made available on our after the effective date of the change on our website.

How to Get More Information, File a Complaint or Report a Problem

If you have any objections, questions, or complaints, please contact the Ko'olauloa Health Center Privacy Officer, Dr. Lum at (808) 293-9231 ext. 2015 or Security Officer, Terrence Aratani at (808) 293-9231 ext. 1007. If you feel that your privacy rights have been violated, you also have the right to complain to the U.S. Department of Health and Human Services, Office for Civil Rights at the following address:

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
50 United Nations Plaza-Room 332
San Francisco, CA 94102
Phone: (415) 437-8310
Fax: (415) 437-8329
TDD: (415) 437-8311

The complaint must describe the violation of your privacy right and the date on which you believe the violation to have occurred.

Individuals may file a complaint without fear or retaliation or decrease in the quality of services received from the Ko'olauloa Health Center.

By signing below, I acknowledge that I have received and have reviewed and understand the foregoing Notice of Privacy Practices.

Signature of Patient/Legal Guardian

Date

Printed Name

Patient Representative (in cases where the patient lacks capacity to sign)

I have agreed to participate in telemedicine with Ko 'olauloa Health Center, which means that 1) I will be able to attend consultations with my health care proviers at Ko'olauloa Health Center through the use of simultaneous video communication systems; 2) my health care providers will not be in the same room as me during the telemedicine consultation.

The benefits of telemedicine include saving time and money by not having to travel away form home as well as reduced exposure to accident of the risk of catching an infectious disease by allowing me to stay home.

I understand there are also potential risks to this technology, including interruptions due to technical difficulties and the limitations posed by not mbeing in the same room as my health care provider. Either my health care provider or I may choose to discontinue a telemedicine consultation if either of us believe that telemedicine is not adequate to address my concerns and an in person consultation is necessary.

I understand that Ko'olauloa Health Center will at its sole discretion choose the videoconferencing systems, which will be used in telemedicine consultations and will ensure the privacy and security of my consultation.

Ko'olauloa Health Ceter has explained to me how to use the technology that will be used to participate in telemedicine.

I am aware that my healthcare information may be shared with other individuals for telemedicine scheduling and related business purposes such as billing and coordinating my healthcare with business associates but only consistent with the practices set forth in Ko'olauloa Health Center's Notice of Privacy Practices.

In the case of an emergency, I understand that telemedicine is not a substitute for a 911 emergency call or a visit to the emergency room. I understand that if I need to speak with my healthcare provider, I should call them directly at their office using the telephone.

In the course of telemedicine conferences, I agree to: 1) answer questions fully about my condition, my treatment and medicines; 2) Follow the guidelines and instructions given to me regarding the safe use of the telemedicine technoloyg; and 3) If Ko'olauloa Health Center lends telemedicine devices or equipment to me for use at my house, be careful with it, and return it in the same condition as which it was given to me. Furthermore, I agree to pay for any damages, repairs, or replacement of any telemedicine devices or equipment which I fail to return in the same condition as when it was given to me.

Questions that I may have regarding the telemedicine technology or use of the devices and equipment fo rmy healthcar have been answered to my satisfaction.

I have read this consent carefully and understand all the contents of this consent, and hereby consent to participate in Ko'olauloa Health Center's telemedicine program under the terms described herein.

Signature

Date

Printed Name

Patient Representative (in cases where patient lacks capacity to sign)

Updates to this policy: This policy may be updated from time-to-time and it is your responsibility to check our website for updates to this policy.

I have agreed to receive personal health information from Ko'olauloa Health Center electronically, and understand that Ko'olauloa Health Center is required by law to give me certain information in writing and on paper unless I choose the option to receive such information by electronic means. Ko'olauloa Health Center has offered to me the option to receive communications regarding my health care appointments and treatment by email or text message. By signing this form, I have read and agree to this Consent to Electronic Communications and specifically agree to receive communications from Ko 'olauloa Health Center electronically at the email address or phone number designated on this form.

I understand that standard unencrypted email tools such as Gmail and text messaging services pose the risk that such communications may be intercepted by unauthorized persons or inadvertently disclosed after receipt. Ko'olauloa Health Center will take steps to ensure that such communications are secure before it is sent, but it is my obligation to ensure that such communications are secured from disclosure by choosing the appropriate email address or mobile phone number, protecting access to my devices through the use of passwords, and maintaining control of my mobile devices to avoid inadvertent disclosure. I also understand that options such as secure messaging apps and similar measures are also available to prevent inadvertent disclosure.

Method of Electronic Communication

I request that all communications covered by this Consent be sent to the following email address or mobile phone number:

Email Address: _____ ; or

Mobile Phone Number: _____

I understand that I may revoke my consent to communicate electronically at any time by notifying Ko 'olauloa Health Center in writing, but if I do, the revocation will not have any effect on actions my healthcare provider has already taken in reliance upon my prior consent.

I agree to release my provider and the practice from any and all liability that may occur due to electronic communication over a non-secure network, and hereby consent to electronic communication via non-secure e-mail services.

Signature

Date

Printed Name

Patient Representative (in cases where patient lacks capacity to sign)

Updates to this policy: This policy may be updated from time-to-time and it is your responsibility to check our website for updates to this policy.



Name	Date of Birth
Physician	Today's Date

PATIENT'S PAST MEDICAL HISTORY:				
Check any condition that the patient now or have had in the past as well as any family members who may have or have had				
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Uncle <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Asthma / Frequent, Persistent Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Abdomen / Bowel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Severe Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Skin / Hair /Nails	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Prolonged Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Stomach / Digestive Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Bones / Joints / Muscles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Birth Defect(s) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin
Depression / Mental Health Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Mother <input type="checkbox"/> Aunty	<input type="checkbox"/> Father <input type="checkbox"/> Uncle <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Grandparents <input type="checkbox"/> Cousin



Depression Screening: Over the last 2 weeks , how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day	
• Have a little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
• Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

History of Domestic Violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date _____ / _____ / _____
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Allergies: Please List _____ Reactions _____	_____ Reactions _____
Penicillin <input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No
Tylenol <input type="checkbox"/> Yes <input type="checkbox"/> No	Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No
Latex <input type="checkbox"/> Yes <input type="checkbox"/> No	

Use of Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarettes per day _____	Would you like help on quitting? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Use of Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No	Average use _____ per <input type="checkbox"/> DAY <input type="checkbox"/> Week <input type="checkbox"/> Month
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Use of Recreational Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No	What Type?	Dose (How Much) _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month
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HIV or AIDS <input type="checkbox"/> Positive <input type="checkbox"/> Negative	Last Tetanus Shot _____ / _____ / _____
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Current Medication	Dose (How Much)	Frequency (How Often)

Hospitalizations / Surgeries		
Condition / Surgery	Year	Hospital