Aloha Nui DPC, LLC
69 Lanihuli Street, Hilo, Hawaii 96720
808.961.1400 / 808.961.1300 (fax)
AlohanuiDPC@gmail.com
www.AlohanuiDPC.com

How were you referred to us?

- ○ family
- ○ friend
- ○ medical professional
- ○ medical organization
- ○ medical insurance
- ○ coworker
- ○ print ad
- ○ internet
- ○ radio
- ○ social media

Client Demographics:

Last Name: _____ First Name: _____ MI: _____

Nickname or name you prefer: _____

DOB: _____/_____/_____ Gender: ○ M ○ F ○ TG Sexuality: ○ HET ○ LBGT ○ Single ○ Married ○ Partner ○ Divorced ○ Widow

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Contact phone: _____ (mobile) _____ (Home)

Email: _____ ***will never be used for solicitation**

Emergency contact: _____ Relationship: _____ Phone #: _____

Medical Records:

Who may access your medical records? *remains in effect until changed by client

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Medical History (Check all that apply)

Allergies: Penicillin Sulfa drugs Bee stings Other: _____

Chronic Medical Conditions:

Hypertension Obesity Hyperlipidemia Diabetes Anxiety Kidney disease Hepatitis / Liver Disease

HIV / AIDS Anemia Thyroid disease Birth Defects Irritable Bowel Asthma COPD

Depression Suicidal Bipolar disorder Arthritis Stroke / Aneurysm Emphysema

Cancer: Breast Colon Skin Prostate Lung Other: _____

Alcohol use:

How often: ○ Never ○ Socially ○ Daily Is alcohol use an addiction: ○ Yes ○ No

Tobacco use:

How many packs per day: ○ 1 ○ 2 ○ 3+ Have you ever tried to quit: ○ Yes ○ No What age did you start? _____

Drug use:

Cannabis Cocaine Methamphetamine Opioids Ecstacy Others: _____

Aloha Nui DPC, LLC.
The Dan Harmeling Medical & Wellness Center
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PREVENTATIVE SCREENING HISTORY

- ☐ Bone Density (DEXA) Date:_____
- ☐ Pap Smear Date:_____
- ☐ Mammogram Date:_____
- ☐ Colonoscopy Date:_____

SURGICAL HISTORY

- ☐ Appendectomy Date:_____
- ☐ Breast Biopsy Date:_____
- ☐ Carpal Tunnel Date:_____
- ☐ C-Section Date:_____
- ☐ Gall Bladder Date:_____
- ☐ EGD Date:_____
- ☐ Heart Cath Date:_____
- ☐ Heart Stent Date:_____
- ☐ Hernia Repair Date:_____
- ☐ Hysterectomy Date:_____
- ☐ Mastectomy Date:_____
- ☐ Ear Tubes Date:_____
- ☐ Prostate Date:_____
- ☐ Spine Date:_____
- ☐ Tonsils Date:_____
- ☐ Knee Date:_____
- ☐ Hip Date:_____
- ☐ Shoulder Date:_____
- ☐ Other:_____ Date:_____

OB HISTORY	GYN HISTORY
Total: ____	LMP: _____
Full Term:____	Age of Menopause: _____
Premature: ____	Sexually Active?: _____
Abortions: _____	Irregular Menses? _____
Miscarriage: ____	
Multiple Births: ____	
Living Children: ____	