**WEST HAWAII MEDICAL GROUP**
77-311 Sunset Drive, Kailua-Kona, HI 96740, 808-329-6355/808-327-4357, Receptionist@whmgmail.com

# Patient Follow-up Visit Form

Name: _____ DOB: _____ DATE _____

***Please fill out the sections below as completely as possible. You may use the back for more space.**

| | |
|---|---|
| What is the main reason for today's visit? | |
| When did it start? | Where is it located? |

Has anything changed or happened with your health since your last visit?
*(New, changed or discontinued medications; new allergies; change in social history; recent surgery, treatments, or therapies; pregnancy or plans to become pregnant and other changes in health or skin condition).*

Yes ☐ No ☐

If Yes, please describe below.

**Please update if there are any changes below:**

**Name Change:** _____

**Address Change:** _____

**Phone Number Change:** _____ **Health Insurance Change:** _____

*****If change of Health Insurance please give card to the Receptionist.*****

**MEDICATION LIST … IS REQUIRED… FOR YOUR SAFETY…**
**Please print meds below or provide a list of it, which may be given to the Receptionist…**

I understand the information above is an important part of my medical care and I have answered all of the above questions truthfully and to the best of my abilities.

**Patient/Guardian signature:** _____ **Date:** _____

Print name of guardian, if applicable: _____

I have been given the opportunity to review West Hawaii Medical Group/Urgent Care of Kona's Notice of privacy practices.

_____

**Signature of patient or legal guardian**

YOU WILL RECEIVE A SEPARATE BILL FOR ALL SERVICES REFERRED TO AN OUTSIDE SOURCE INCLUDING BUT NOT LIMITED TO PATHOLOGY AND LABORATORIES.

_____

**Signature**