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

Patient Visit Form/Medical History

Name: _____ DOB: _____ DATE _____

Primary Physician _____ Preferred Pharmacy _____

***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?

What other signs and symptoms are you experiencing? (itching , burning/stinging, pain/ tenderness, drainage)

Severity/ How bad is it? Please check one. Mild ☐ Moderate ☐ Severe ☐

How often does it occur? Rarely ☐ Intermittently ☐ Constantly ☐

Have you had a similar problem in the past? If yes, when?

What have you used to make it better/ what makes it worse? (medicines, over the counter products, treatments, etc)

Females: Are you pregnant? Yes ☐ No ☐ If yes, Due date? _____

Are you trying to become pregnant? Yes ☐ No ☐ Are you breast-feeding? Yes ☐ No ☐

Medications: Please list all prescription/ non-prescription medications (include topical, supplements, vitamins, etc) None ☐

Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____
Medication: _____ Dose: _____ Frequency: _____

Allergies: Please list the allergy and the reaction you experienced None ☐

Name: _____ Name: _____ Name: _____
Reaction: _____ Reaction: _____ Reaction: _____

Do you have an allergy or sensitivity to: Lidocaine ☐ Epinephrine ☐ Latex ☐ Rubbing Alcohol ☐ Polysprin ☐ Iodine ☐ Adhesives ☐

Family History: Check the box if your blood-relative family member has had the following: None ☐

Skin Cancer (other than Melanoma) ☐ Melanoma ☐ Eczema ☐ Psoriasis ☐ Lupus/Rheumatoid Arthritis ☐

Diabetes ☐ Thyroid Problems ☐ Bleeding Disorders ☐ Other ☐ _____

Social History:

Have you had blistering/peeling sunburns? Yes ☐ No ☐
Do you use sunscreen regularly? Yes ☐ No ☐ If yes, SPF? _____
Tobacco use? Yes ☐ No ☐ Years _____ Alcohol Use Yes ☐ No ☐ Amount _____
Recent travel out of the country? Yes ☐ No ☐ If yes, where? _____
Recent exposure to chemicals, radiation or toxins? Yes ☐ No ☐ If yes, what _____

Hospital/Surgical History: List previous surgeries and dates of surgery **FOR THE PAST 10 YEARS** None ☐

Surgery: _____ Date: _____ Surgery: _____ Date: _____
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PLEASE SEE THE REVERSE

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Name:_____**DOB:** _____

Review of Systems/Past Medical History

Do you have any of the following?	**Have you had any of the following?**
Specific skin condition? ☐ Yes ☐ No If yes, please describe:	Recent fever, fatigue, or weight loss, night sweats? ☐Yes ☐No
Skin Cancer? ☐ Yes ☐ No If yes, what type?	Heart condition / Heart Attack? ☐Yes ☐No
Skin Rashes or Skin Allergies? ☐ Yes ☐ No	Slow or Rapid Heart Rate? ☐Yes ☐No
Drying, peeling, itching, flaking or burning of skin? ☐ Yes ☐ No	Stroke, Seizures? ☐Yes ☐No
New changing, bleeding, itching or abnormal moles? ☐ Yes ☐ No	HIV / AIDS? ☐Yes ☐No
Nail Problems? ☐ Yes ☐ No	Liver disease, Hepatitis? ☐Yes ☐No
Difficulty with healing of wounds? ☐ Yes ☐ No	Difficulty breathing, wheezing or shortness of breath? ☐Yes ☐No
Thickened skin or scarring from surgery / injury? ☐ Yes ☐ No	Asthma and / or Allergies? ☐Yes ☐No
Darkening / lightening skin after injury, treatments or surgery? ☐ Yes ☐ No	Rheumatologic disease, Arthritis, Lupus? ☐Yes ☐No
Bleeding Problems / Bleed easily? ☐ Yes ☐ No	Autoimmune Disease? ☐Yes ☐No If yes, what type?
Varicose Veins or Swollen Legs or Ankles? ☐ Yes ☐ No	Muscle or Joint Pain? ☐Yes ☐No
Accutane use in the last 6 Months? ☐ Yes ☐ No	Diabetes, Thyroid or other Hormone Disease? ☐Yes ☐No
Fainting Spells? ☐ Yes ☐ No	Frequent infections, Immunocompromised? ☐ Yes ☐ No
Are you under the care of another Dermatologist? ☐ Yes ☐ No If yes, who?	Cancer? ☐ Yes ☐ No If yes, what type?
Other current signs or symptoms?	Other illnesses, health problems or medical conditions?

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