
# Intake Form – Health Care Services

Welcome to the Waianae Coast Comprehensive Health Center. Please take a moment to fill out the following intake form to help us better serve you.

| BASIC INFORMATION | | | |
|---|---|---|---|
| Legal Last Name | Legal First Name | | M.I. |
| Preferred Name | | | |
| Legal Sex<br>□ Male □ Female | Date of Birth | | |
| Home Address | City | State | Zip Code |
| Contact Method<br>□ Home Phone ( ) - | □ Cell Phone ( ) - | □ Day Phone ( ) - | □ Email Address |

| HISTORY OF HEALTH CARE SERVICES | |
|---|---|
| Did you previously have a Primary Care Provider (PCP)?<br>□ Yes □ No | Name(s) of PCP |
| Have you ever seen a Specialist?<br>□ Yes □ No | Name(s) of Specialist |
| Where have you previously received health care?<br>□ Hawaii Pacific Health □ Queen's Medical Center □ Kaiser □ VA/Tripler □ Urgent Care<br>□ Private Practice Office (please list):<br>□ Other (please list): | |

| MEDICATION & ALLERGIES | |
|---|---|
| Do you have any allergies? □ Yes □ No | |
| *If YES, please provide more information below.* | |
| Name | Reaction |
| Name | Reaction |
| Name | Reaction |
| What Pharmacy do you prefer? | |

| Do you take medications on a regular basis?<br>□ Yes □ No | Do you take any supplements?<br>□ Yes □ No |
|---|---|
| *If YES, please list medications and/or supplements below. If you have trouble remembering, please look at your medication or supplement bottle.* | |
| | |

## HABITS

| Do you use Tobacco (Chew / Smoke/ E-cigs)?<br>□ Yes □ No | □ Chew □ Smoke □ E-cigs<br># per day: |
|---|---|
| Do you drink Alcohol (Beer/Wine/Hard/Liquor)?<br>□ Yes □ No | □ Beer □ Wine □ Hard □ Liquor<br># per day: |
| Do you use Street Drug (Marijuana/Ice/Cocaine)?<br>□ Yes □ No | □ Marijuana □ Ice □ Cocaine<br># per day: |

## MEDICAL HISTORY

| Have you ever been hospitalized overnight?<br>□ Yes □ No | Have you ever had surgery?<br>□ Yes □ No |
|---|---|
| *If YES, please list reason for hospitalization and the date when you were hospitalized.* | |
| Reason: | Date (MM/YY): |
| Reason: | Date (MM/YY): |
| Reason: | Date (MM/YY): |
| Reason: | Date (MM/YY): |

Have you ever been treated for the following medical conditions?
□ Diabetes □ High Blood Pressure □ High Cholesterol □ Heart Problems □ Lung Problems
□ Cancer □ Depression/Anxiety □ Thyroid Problems

## PRIMARY HEALTH CONCERN

What is your biggest health concern that you would like us to address at your first visit?