Maui's Native Hawaiian Health Care System
CLINICAL INTAKE FORM

To use the submit feature, you must first download the form, complete, then submit

Date: ___________________________

PATIENT INFORMATION

Name: ___________________________ **Date of Birth:** ___________________________

MEDICAL HISTORY

Have you ever been told you have any of the following medical conditions?

- ☐ Heart Disease/Heart Attack
- ☐ Stroke/TIA
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Cancer - Specify: ______________________
- ☐ Other – Specify: ______________________

CURRENT MEDICAL CARE:

1. Who is your Primary Care Provider (PCP)? ___________________________
2. When was the last time you visited your PCP? ☐ Within the year ☐ More than one year ago ☐ Don't know
3. *FEMALES*: Are you currently pregnant? ☐ YES ☐ NO
   a. If YES, in what month of your pregnancy did you first receive care?
      ☐ 1st Trimester ☐ 2nd Trimester ☐ 3rd Trimester ☐ Have not started care
4. List any hospitalizations or surgeries you had:

   ____

   ____

5. List your current medications/supplements/traditional remedies/. (Include dosage and frequency)

   ____

   ____

   ____

   ____

(If additional space is needed, please use the back of the paper)

Signature: ___________________________ **Date:** ___________________________

Client Signature *Date*

For Office Use Only:						
Height:	**Weight:**	**BMI:**	**BP:**	**P:**	**O_2:**	**Temp:**

TC:	**HDL:**	**R:**	**RBS:**