



Maui's Native Hawaiian Health Care System
CLINICAL INTAKE FORM

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:	