HUI NO KE OLA PONO

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Maui's Native Hawaiian Health Care System
KEIKI CLINICAL INTAKE FORM

Date: _____

PATIENT INFORMATION
Name: _____ **Date of Birth:**_____

CURRENT MEDICAL CARE:

1. Who is your child's Primary Care Provider (PCP)? _____
2. When was the last time your child visited their PCP? ☐ Within the year ☐ More than one year ago ☐ Don't know
3. List any hospitalizations or surgeries your child has had:

   _____

   _____

4. List your child's current medications/supplements/traditional remedies/. (Include dosage and frequency)

   _____

   _____

   _____

   _____

_____ _____

Parent/Guardian Signature *Date*

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