Pearl City Medical Associates, Inc.

98-1079 Moanalua Road / Suite 555 / Aiea, Hawaii 96701-4794

Welcome to Pearl City Medical Associates, Inc.
Please fill out this form to the best of your knowledge. Thank you.

Patient Name:	Today's Date:
Mother's Name:	Father's Name:

BIRTH HISTORY

Birth Date:	Gender:	Birth Weight: _________ lbs. _________ oz.
Was child born within 3 weeks of expected due date?	☐ Yes	☐ No
Any complications during birth?	☐ Yes	☐ No
If yes, please describe complications:		

MEDICAL HISTORY

ILLNESSES					
Conditions			Date of onset	Conditions	Date of onset
Asthma	☐ Yes	☐ No		Other:	
Eczema	☐ Yes	☐ No		Other:	
Diabetes	☐ Yes	☐ No		Other:	
Seizures	☐ Yes	☐ No		Other:	
ADHD	☐ Yes	☐ No		Other:	
Developmental Delay	☐ Yes	☐ No		Other:	

HOSPITALIZATIONS / OPERATIONS			
Reason for hospitalization	Date	Type of operation / surgeon	Date
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	

Patient Name: ______________________________ Today's Date: ______________

ALLERGY LIST	
Allergies	Type of reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

MEDICATION LIST			
Prescription medications, dose, frequency, and route	Date started	Herbals, supplements, and over-the-counter drugs	Date Started
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	
7.		7.	
8.		8.	
9.		9.	
10.		10.	

FAMILY HISTORY Use a check mark (✓) to indicate positive history									
	Father	Mother	Sisters	Brothers	Daughters	Sons	Maternal grand-parents	Paternal grand-parents	Other
Deceased									
Hypertension									
Heart disease									
High Cholesterol									
Stroke									
Diabetes									
Obesity									
Genetic disorder									
Asthma									
Depression									
Cancer									
Other:									
Other:									
Other:									

Patient Name: ______________________________ Today's Date: ______________

SOCIAL HISTORY

Location of home/address:			Who lives at home?
Pet(s)?	☐ Yes	☐ No	If yes, please list type of pet(s):
Attends daycare/school?	☐ Yes	☐ No	If yes, name of daycare/school:
Smokers in the household?	☐ Yes	☐ No	If yes, whom (ex. mom, dad, etc.):
Mother's occupation:			Name of employer:
Father's occupation:			Name of employer:

NUTRITION / DIET

Describe:

____

____

____

____

PHYSICAL ACTIVITIES / INTERESTS

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

OTHER TREATING PHYSICIANS AND PROVIDER OF CARE

(Please include eye doctors and dentists)

Name	Specialty / type of care	Date discontinued
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Patient Name: ______________________________ Today's Date: ______________

Are there any concerns or questions you have regarding your child?	☐ **Yes**	☐ **No**
If yes, please explain:		

______________________________ ______________________________
PRINTED NAME OF PERSON FILLING OUT FORM RELATIONSHIP TO PATIENT

____
SIGNATURE OF PERSON FILLING OUT FORM

Thank you for joining Pearl City Medical Associates, Inc. We looking forward to serving you with the highest quality of compassionate care!