

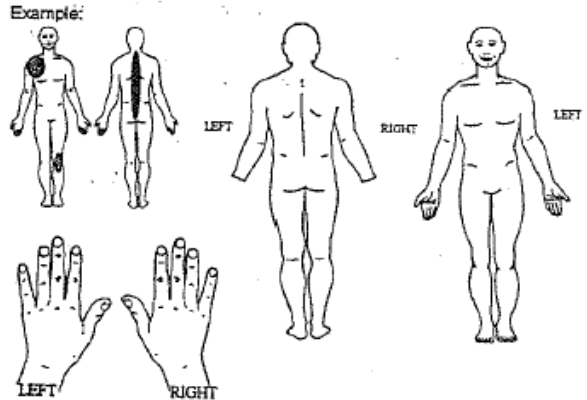
David John, MD
 Deryll U. Ambrocio, MD
 1329 Lusitana St. Suite 804
 Honolulu, HI 96813
 Physicians' Office Building II
 808-531-7111
 808-528-5507 (fax)

Birthplace _____

Name _____ Birthdate ____/____/____
 Last First MI Maiden Month Day Year
 Address _____ Age _____ Sex: F M SSN: _____
 Home phone _____ Cell phone _____
 Marital Status: Never Married Married Divorced Separated Widowed
 Work phone _____ Other _____
 Spouse/Significant Other: Alive/Age _____ Deceased/Age _____
 Education: Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School _____
 Occupation _____ Number of hours worked/ average per week _____

Name of person making referral: _____
 Name of Primary Care Physician: _____
 Do you have an orthopedic surgeon? Yes No If yes, Name: _____
 Describe your present symptoms briefly: _____

Please shade all the locations of your pain over the past week on the body figures and hands.



Date symptoms began (approximate): _____
 Diagnosis: _____
 Previous treatment for this problem (include physical therapy, surgery and injections, medications.): _____

Rheumatologic (arthritis) History

At any time have you or a blood relative had any of the following? (check if "yes")

Self	Relative (Relationship)	Self	Relative (Relationship)
<input type="checkbox"/>	Arthritis (unknown type)	<input type="checkbox"/>	Lupus or "SLE"
<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	Gout	<input type="checkbox"/>	Ankylosing Spondylitis
<input type="checkbox"/>	Childhood arthritis	<input type="checkbox"/>	Osteoporosis

Other arthritis conditions: _____

Social History

Do you drink caffeinated beverages? Yes No
 Cups/ glasses per day? _____
 Do you smoke? Yes No Past—How long ago? _____
 Do you drink alcohol? Yes No Number per week? _____
 Has anyone ever told you to cut down on your drinking?
 Yes No
 Do you use drugs for reasons that are not Medical? Yes No
 If yes, please list _____

 Do you exercise regularly? Yes No

Type _____
 Amount per week? _____
 How many hours of sleep do you get per night? _____
 Do you get enough sleep at night? Yes No
 Do you wake up feeling rested? Yes No

Past Medical History

Do you now or have ever had: (check if "yes")

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Anemia
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Bad Headaches	<input type="checkbox"/> Colitis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> High cholesterol		

Other significant illness (please list) _____

Natural or Alternative Therapies (chiropractic, magnets, massage, over-the-counter preparations, etc.)

Previous Operations

Type	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Any previous fractures? Yes No Describe: _____
 Any other serious injuries? Yes No Describe: _____

Family History

	If Living		If Deceased	
	Age	Health	Age of Death	Cause
Father				
Mother				

Number of siblings _____ Number living _____ Number deceased _____
 Number of children _____ Number living _____ Number deceased _____ List age of each _____
 Health of children _____

Do you know of any blood relatives who has or had (check and give relationship):

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Goiter _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Leukemia _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Colitis _____ |
| <input type="checkbox"/> Psoriasis _____ | <input type="checkbox"/> Asthma _____ | | |

Medications

Drug allergies: No Yes To what? _____

Type of Reaction: _____

Present medications (List any medications you are taking, including all over-the-counter medications also.)

Name of Drug	Dose (Include strength & pills taken per day)	How long has medication been taken?	Please check: Helped?		
			A lot	Some	Not at All
1.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Name _____ Date _____ Physician Initials _____

Employer Information

Employer Name _____

Address _____

Insurance Information

* Primary Insurance _____ Subscriber Name _____

Member Number _____ Subscriber Date of Birth _____

Subscriber SSN _____ Relationship _____

*Secondary Insurance _____ Subscriber Name _____

Member Number _____ Subscriber Date of Birth _____

Subscriber SSN _____ Relationship _____

Emergency Contacts

Name _____ Phone Number _____

Address _____

Relationship _____

Name _____ Phone Number _____

Address _____

Relationship _____

The following information is presented for informational purposes and as formal notification:

1. The practices of David John, M.D. and Deryll U. Ambrocio, M.D. do not participate with Workmen’s Compensation or No-Fault and that you attest that the issues at hand are not related to such events.
2. That, by tradition, a copy of medical records will be forwarded at no charge to a requesting doctor’s office. All other records requested are subject to copying charges.
3. As of January 1, 2010, charge will occur for certain forms and for preparation of letters to outside entities. The volume of such requests has dramatically increased. Examples are jury duty letters, travel-related letters, FMLA forms and insurance company appeal letters. The charge will be \$10.00 unless otherwise stated in advance.
4. Finally, we reserve the right to impose a \$25.00 fee for “no-show” or late cancellation of appointments. Please call to cancel/reschedule at least 24 hours prior to your scheduled appointment.

Patient’s Signature _____ Date _____