MEDICAL CLINIC, INC.

Philip H.K. Kuo, M.D. *Sylvia Wang, M.D.* *Myrna Kuo, M.D.* *Philip I.L. Kuo, M.D., Ph.D.*

Queen's Physician's Office Building II
1329 Lusitana Street, Suite 202
Honolulu, HI 96813
P(808) 523-1600 F(808) 526-0221

414 Uluniu Street
Kailua, Hawaii 96734
P(808) 261-8345
F(808) 262-5239

Patient Name:	**Date of Birth:**	**SSN:**	**Sex:** M / F
Home address:	**City:**	**State:**	**Zip Code:**
Billing address (If different than above):	**City:**	**State:**	**Zip Code:**
Telephone: Home:	Work:	Mobile:	
If patient is a child, parent(s) or guardian's name:			
Name of patient's employer:	Occupation/Title:		
Business phone:	Business Address:		
Person responsible for payment:	Address:		
PRIMARY INSURANCE INFORMATION			
Subscriber Name:	**Date of Birth:**	Subscriber SSN:	
Insurance Company Name:			
Member ID:	Effective Date:	Relationship to Insured:	
SECONDARY INSURANCE INFORMATION			
Subscriber Name:	**Date of Birth:**	Subscriber SSN:	
Insurance Company Name:			
Member ID:	Effective Date:	Relationship to Insured:	

Race (Choose ONE; most dominant)				**Ethnicity (Choose ONE):**	
☐	American Indian or Alaska Native	☐	Asian	☐	Hispanic or Latin
☐	Black/African American	☐	Native Hawaii/Other Pacific Islander	☐	Not Hispanic or Latin
☐	White/Caucasian	☐	Other (Please describe):	☐	REFUSED TO REPORT
☐	Hispanic	☐	UNREPORTED/REFUSED TO REPORT		
Language (Primary Language; most frequently used):				Translator Needed? ☐ Yes ☐ No	
Preferred Pharmacy (Please specify):					
May we take your picture for your electronic medical records? ☐ Yes ☐ No					

Emergency contact not residing with you:	**Relationship:**	**Phone:**
If patient is a child, who may authorize treatment for the child:	Relationship:	Phone:
Primary Care Physician:	Phone:	Fax:
Referring Physician:	Phone:	Fax:

*I have read the "**Notice of the Uses and Disclosures of Protected Health Information**" that was presented in your office. I was informed that I may also obtain a printed copy of the "**Notice**" from your receptionist. I hearby acknowledge that I received from Medical Clinic Inc. a copy of the "**Notice**".

Patient, Parent, or Guardian Signature: _____ **Date:** _____

Philip H.K. Kuo, M.D. ● *Sylvia Wang, M.D.* ● *Philip I.L. Kuo, M.D., Ph.D.* ● *Myrna Kuo, M.D.*
MEDICAL CLINIC, INC

QUEEN'S PHYSICIAN'S OFFICE BUILDING II
1329 LUSITANA STREET, SUITE 202
HONOLULU, HAWAII 96813
PHONE (808) 523-1600

414 ULUNIU STREET
KAILUA, HAWAII 96734
PHONE (808) 261-8345

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____

Pursuant to Chapter 323-C, Hawaii Revised Statutes, I hereby authorize Drs. Kuo/Wang to disclose my health information, including copies of medical records to: (a) any health insurance plan or company that provides insurance for me or the named patient, for the purposes of payment of charges; (b) any insurance company that provides liability insurance to Drs. Kuo/Wang, to evaluate clinical performance; (c) any worker's compensation, no-fault or administrative proceeding for the purpose of evaluating my medical condition. (d) Schools or places of work for the purpose of school or employment physical examination. (e) Any consulting physicians for the evaluation of my medical condition.

- This authorization shall cover the period of time from my first visit to my last visit.
- I understand that I can revoke this authorization at any time.
- This authorization shall end two years after the date of my last visit.

Name and relationship of person signing, if not the patient:

_____

Signed: _____ Date: _____
(Name of patient or parent or legal guardian of a minor)

MEDICAL CLINIC, INC.

Philip H. Kuo, M.D., F.A.A.A
Philip I.L. Kuo, MD – PhD
Allergy and Immunology
Internal Medicine, Board Certified

Queen's Physicians Office Building II
1329 Lusitana Street, Suite 202
Aiea, HI 96701
(808) 523-1600

414 Uluniu Street
Kailua, HI 96734
(808) 261-8345

NAME _____ AGE_____ SEX _____ DATE_____

Chief complaints:

Present Illness:

Physical examination:
HEIGHT_____ WEIGHT_____ B/P _____ PULSE _____ TEMP._____

General Appearance:
SKIN:
EARS: lobes canal eardrums
NOSE: crease mucosa pale pink polyp edema septal deviation
EYES: lids shiners conjuctival Fundi
THROAT: oral mucosa injection post pharyngeal hypertrophy exudates
NECK: L-N thyroid
CHEST: rhonchi wheezing-insp. exp. rales coarse sound diminished sound
CARDIAL: rhythm murmur PMI
ABDOMEN: wall tenderness liver spleen bowel sound abnormal mass
EXTREMITIES: pitting edema
NEUROLOGICAL FINDINGS:

Diagnosis:

PAST MEDICAL HISTORY:

Past Illnesses: 1)_____ 2)_____ 3)_____

Drug Reactions (i.e. Aspirin, Penicillin, Sulfa, etc.) _____

Previous Allergy Immunotherapy from _____ to _____ Response_____

What medicines are you taking now?

Name	No. of Medicine/Day	Response	Side Effects
1.			
2.			
3.			

Family History: Include any heart attack, cancer, or stroke and at what age.

Father	
Paternal Grandfather	
Paternal Grandmother	
Mother	
Maternal Grandfather	
Maternal Grandmother	
Siblings/Children	

Social History

Marital Status_____ Occupation_____

Do you drink alcoholic beverages? yes no If yes, how much? _____

Smoke? yes no If yes, how long and how much a day?_____

PLEASE CIRCLE THE POSITIVE SYMPTOMS:

HEADACHE: where_____ how often_____ dull or sharp_____

SINUSES: fatigue poor concentration headache itchy sensation

EARS: earache plugged sensation hearing loss congestion

EYES: itching tearing discharge (color)____ swelling redness rubbing

NASAL: stuffy nose sneezing nose bleeding itchy nose frequent colds
mouth breathing running nose (color or discharge)_____

THROAT: sore throat throat clearing palate itching tonsillitis coughing
Tonsillectomy & Adenoidectomy post nasal drip

CHEST: day cough night cough sputum (mucus) describe_____ pain
wheezing shortness of breath tightness smoking how long?_____
how many packs per day?_____

G.I: poor appetite nauseation vomiting diarrhea constipation gas
Belching abdominal pain fatty and foul smelling stools ulcer history

SKIN: Eczema hives Impetigo contact dermatitis
Other skin rashes (describe)_____

G.U.: burning polyuria (frequently) Hematuria (bloody urine) Dysuria (pain)
Enuresis

CARDIOVASCULAR: Hypertension arrhythmia (irregular beat) chest pain
Shortness of breath after exertion

ENDOCRINE: Diabetes Thyroidothers

FOOD INTOLERANCE:

SYMPTOMS AFFECTED BY:

Please answer the following questions by entering I (improved) W (worse) or N (not affected)

Weather change_____ Infection _____ Morning or Evening _____

Mowed Lawn _____ Change residence _____ Animals: type _____

Trips (out of state) _____ Foods _____ Air condition _____

Cold Beverages _____ Dusting _____ Drugs (Aspirin, beta bl.) _____

Exercise _____ Dampness & Smog _____ Aerosol Sprays _____

Rain _____ Perfumes _____ Tobacco Smoke_____

Wind _____ Odors or flowers _____ Alcoholic Beverages _____

Excitement _____ Frustration _____ Laughter _____

Are your symptoms all year round? yes no Which months are worse? _____

ENVIROMENT: (Please circle the appropriate response)

Do you live in an: Apartment Condominium House

Do you have air conditioning? yes no Humidifier? yes no

Does anyone at home smoke? yes no

BEDROOM:

Floor: Carpet Area Rugs Wall-to-Wall Tile Wood Vinyl

Windows: Drapes Curtains Shades Blinds Shutters

Bedding: Mattress Box Springs Covered with dust proof cover Wool Blankets

Quilt Bedspread (dry clean or washable)

Pillows: Foam Rubber Feather Kapok Polyester

Other: Bookcase Stuffed Toys Wall Hangings/Oriental Rugs

Stuffed Furniture Plants Cleaning Frequency _____

Animals: Dog Cat Bird Rabbit Horse Other_____

How long have animals been present_____

Are you affected by the animal(s)? yes no

Where does the animal(s) sleep or stay? Outside Inside Both