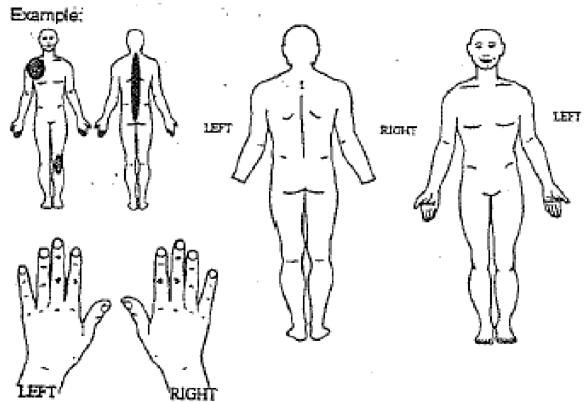
Deryll U. Ambrocio, MD
500 Ala Moana Boulevard, Tower 5, Suite 300
Honolulu, HI 96813
808-531-7111

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 Work phone________________Other___________________
☐Separated ☐ Widowed 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:_______________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
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) |
|---|---|---|---|---|---|
| | Arthritis (unknown type) | | | Lupus or "SLE" | |
| | Osteoarthritis | | | Rheumatoid Arthritis | |
| | Gout | | | Ankylosing Spondylitis | |
| | Childhood arthritis | | | 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")
☐ Cancer ☐ Heart Problems ☐ Asthma
☐ Goiter ☐ Leukemia ☐ Stroke
☐ Cataracts ☐ Diabetes ☐ Epilepsy
☐ Nervous breakdown ☐ Stomach Ulcers ☐ Anemia
☐ Rheumatic Fever ☐ Bad Headaches ☐ Colitis
☐ High blood pressure ☐ Kidney disease ☐ Psoriasis
☐ Tuberculosis ☐ Emphysema ☐ HIV/AIDS
☐ Jaundice ☐ Pneumonia ☐ Glaucoma
☐ 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):

☐ Cancer_________________ ☐ Heart Disease______________ ☐ Rheumatic fever______________ ☐Goiter_____________

☐ Tuberculosis____________ ☐ Leukemia_________________ ☐ High blood pressure___________ ☐ Stroke____________

☐ Alcoholism_____________ ☐ Epilepsy__________________ ☐ Bleeding tendency____________ ☐ Colitis____________

☐ Psoriasis________________ ☐ 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/Strength (mg, mcg, mL, Units) | Directions (How much daily, weekly, or monthly) | How many years have you been on the medication? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

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 practice of Deryll U. Ambrocio, M.D. does 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 $20.00 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____________________