NEW PATIENT REGISTRATION FORM

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____

Maiden Name: _____

Date of Birth: _____/_____/_____ Gender: ☐ F ☐ M Age: _____

Address: _____ Apt/Unit #: _____

City: _____ State: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (___) _____ Cell Phone: (___) _____

Social Security: _____ Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other _____

Race: (Optional) ☐ Black ☐ White ☐ Asian ☐ Hispanic ☐ Other _____

Employer: _____ Occupation: _____

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (__) _____ Work Phone: (__) _____ Cell Phone: (__) _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Phone #: (__) _____

Insured Name (if other than self): _____ Relationship: _____

Social Security #_____ Date of Birth: _____/_____/_____

Policy/Member #: _____ Group #: _____

Secondary Insurance: _____ Phone # (___) _____

Insured Name (if other than self): _____ Relationship: _____

Social Security #: _____ Date of Birth: _____/_____/_____

Pharmacy Information

1ry Pharmacy Name: _____ Address: _____

Phone #: _____

2ry Pharmacy Name: _____ Address: _____

Phone #: _____

Assignment & Release:

I, the undersigned, have coverage with _____and assign directly to Optimum Point of Care. All medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. I authorize the use to this signature on all insurance submissions.

Patient/Guardian Signature:_____

I understand and agree that I am personally responsible for all charges incurred regard less of my insurance coverage .In the event that my account is referred to an attorney for collection, I agree that in addition to the balance owed, I will be responsible for collection and attorney fees in addition to the balance owed, Payment for the services rendered or to be rendered in the future, is irrevocably and unconditionally guaranteed by Guarantor whose signature appears below, together with interest thereon and all late charges, attorney's fees cost and expenses of collection incurred in enforcing any of such liabilities.

I agree that all above information is correct to the best of my knowledge.

Patient / Responsible Party Signature_____ Date:_____

Optimum Point of Care Physicians Group

Lloyd Leiva, MD
Nilsa Leiva, MD

Board Certified in Internal Medicine *Board Certified in Geriatric Medicine*

Medication Refill Policy

Prescription refills require close monitoring by our providers to ensure its safety and effectiveness.

1. Our practice requires that you keep your scheduled appointment to ensure that you receive timely refills of your medication. Medications are prescribed at your visit and you will be prescribed enough refills until your next scheduled appointment.

2. Bring a list of current medications to every appointment. Please include any medication that has been prescribed, discontinued, or dosage changed by another physician.

3. If you still need a prescription after the appointment, follow the instructions below.
   a. Call pharmacy first to initiate refill. If you have any trouble with the refill, contact the office and speak with a nursing staff.
   b. Please allow 24 – 48 hours for medication refill.
   c. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

4. Controlled Substance Medication:
   a. Must keep scheduled appointment. Controlled medication cannot be refilled without an appointment.
   b. Must sign and abide by the Controlled Substance Agreement.

5. Patients requesting new prescriptions or antibiotics must be seen for an appointment. They are not prescribed over the phone it requires an office visit.

Signature: _____ Date: _____

3904 Cortez Road West
Bradenton, FL 34210
Tel: (941) 345-1943 Fax: (941) 345-1944
Email: optimumoffice@optimumpoc.com
Website: optimumbradentondoctors.com

Optimum Point of Care Physicians Group

Credit and Payment Policy

It is our goal to provide you the best Medical Care we possibly can. Part of your care includes the billing of your insurance provided we've received the correct and complete information from you. **If complete information is not provided at the time of your visit, you will be billed. Please read the following information as it will answer many of your questions regarding our billing policies.**

All Patients: Are expected to have their current insurance card, valid picture ID, Co-pay, co-insurance, and any balance that is due at the time of service.

Co-pays: Primary and secondary insurances co-pays **must be paid** at time of check in.

Collections: Patients that have an unresolved balance will be sent to Collections; patients will then accrue an additional collections fee of 35%. Patients are expected to resolve all balances and/ or Collection issues before setting up their next appointment; **Optimum point of care** does not permit patients to carry balances. If patient balances are not addressed patients are running the risk of being discharged from **Optimum Point of Care Physicians Group, LLC.**

No Shows: Failure to cancel an appointment within **24 hours prior** to your appointment will resulting a **$25.00 no show fee**. Any diagnostic study (Echo, Abdominal Ultrasound, ABIs, or General ultrasound) not canceled within 48 hours prior your appointment will be resulting a **$50.00 no show fee**.

Please remember a confirmation call is a courtesy done by this office and not an obligation, therefore will not be a reason to waive a no-show fee.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I understand that it is my responsibility to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf.

Patient Signature: _____ Date: _____

****

Office use only

Account Number: _____

Date: _____

Patient General Consent to Treatment

I, _____, hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medication
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after the specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize Optimum Point of Care to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services at Optimum Point of Care.

I acknowledge that I have been notified of Optimum Point of Care Privacy Practices and understand that if I have a question or complain that I should contact the Privacy Official.

I, the undersigned, authorize to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____ Date: _____

Legal Guardian/POA: _____ Relationship: _____

Optimum Point of Care Physicians Group

Lloyd LeivaMD & Nilsa Leiva
Board Certified Internal medicine & Geriatric Medicine
3904 Cortez rd. W. Bradenton FL 34210
Phone # 941-345-1943 Fax # 941-345-1944

Authorization to Release Healthcare Information

Patient Name: _____ Birth Date: _____
Previous Name: _____ Social Security: _____
(Last 4 digits)

I request and authorize _____ to release healthcare
(Name of Doctor or Facility we are requesting from)
Information of the patient named above to:

Optimum Point of Care Physicians Group, LLC
Dr. Nilsa Leiva Dr. Lloyd Leiva
3904 Cortez Road West, Bradenton, FL 34210
Phone: (941) 345-1943 Fax: (941) 345-1944

- Healthcare information relating to the following treatment, condition or dates:
  _____
- All Healthcare information:
- Other: _____

Definition: *Sexually Transmitted Disease (STD) as defined by law, RCW70.24 et seq., include herpes, herpes simples, human papilloma virus, war, genital wart, canlyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, AIDS (Acquired Immunodeficiency Syndrome) and Gonorrhea.*

( ) Yes ( ) No **I authorize of my STD results, HIV/AILDS testing, whether negative or positive, to person (s) listed above, I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.**

( ) Yes ( ) No **I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.**

Patient Signature: _____ Date: _____

Optimum Point of Care Physicians Group

Lloyd Leiva, MD
Nilsa Leiva, MD

Board Certified in Internal Medicine *Board Certified in Geriatric Medicine*

Disclosures to Friends and/or Family Members
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below.

Name 1: _____ _____ _____
Authorized Person *Relationship to patient* *Phone Number*

Name 2: _____ _____ _____
Authorized Person *Relationship to patient* *Phone Number*

Providers (other doctors):

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Consent to Receive Messages or Emails about Appointment Reminders:
Patients in our practice may be contacted via email, phone, to remind you of an appointment.

___ I consent to receive messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive messages or email will apply to all future appointment reminders unless I request a change in writing.

The cell phone number that I authorize to receive messages for appointment reminders is _____.
The email that I authorize to receive messages for appointment reminders is _____.

Send appointment information to your home?	( ) Yes	( ) No
Send test results to your home?	( ) Yes	( ) No
Leave information on answering machine/voicemail?	( ) Yes	( ) No
Appointment information?	( ) Yes	( ) No
Billing Information?	( ) Yes	( ) No
Medical Information?	( ) Yes	( ) No

Please complete below if you want any of the above Revoked.
I hereby revote my request for future communications via email and/or text.
__ I hereby revoke my request to receive any future appointment reminders via text messages.
__ I hereby revoke my request to receive any future appointment reminders via email.
NOTE: This revocation only applies to communications from this practice.

Patient Name: _____ **Date:** _____

3904 Cortez Road West
Bradenton, FL 34210
Tel: (941) 345-1943 Fax: (941) 345-1944
Email: optimumoffice@optimumpoc.com
Website: optimumbradentondoctors.com

A. Notifier: Optimum Point of Care Physicians Group

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
In office visits, treatment, diagnostic testing, ancillary, and all in-office services		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Optimum Point of Care Physicians Group

Notice of Privacy Practices

THIS NOTICE DESCRIBE SHOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GETACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describe show we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations(TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information "is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/ hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories ,worker comp adjusters and nurse case managers, etc. to ensure that the health care provider has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that you're relevant protected health information be disclosed to your health plan to obtain approval for the procedure.

Health care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, and training of medical students, licensing, fund raising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fund raising activities, (Continued on back page...)

We will provide you the choice to opt out of those activities. You may also choose to opt back in. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes.

We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health

information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply)–Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information–This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request confidential communications–You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, up on request, even if you have agreed to accept this notice alternatively i. e. electronically. (Continued on back page...)

You have the right to request an amendment to your protected health information– If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare are butt alto your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures–You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach–We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complaint o us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

HIPAA COMPLIANCE OFFICER: Maritza Rodriguez, Office Manager.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions about this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main

Optimum
Point of Care
Physicians Group

Notice and Acknowledgement

I acknowledge I have been informed that the Notice of Privacy Practices from Optimum Point of Care is available to me to review on the company website www.Optimumbradentondoctors.com, or in the patient waiting room. Additionally, a copy is Available to me up on request in the office.

_____ _____

Patient or personal representative Date

If Personal Representative's signature appears above, please describe Personal Representative's Relationship to patient.

Optimum Point of Care Physicians Group

Lloyd Leiva, MD
Nilsa Leiva, MD
Board Certified in Internal Medicine *Board Certified in Geriatric Medicine*

Patient Name: _____ DOB: _____
Appointment Date: _____

New Patient Health History Questionaire

Reason for todays visit: ○ Establish Medical Care ○ Other Concerns: _____

_____

Please use a check mark ✓ to indicate what applies to you.

Patient History

Which medical conditions do you have now or have you had in the past?

Heart
- ○ Heart Attack, year: _____
- ○ Heart Failure
- ○ High blood pressure
- ○ Heart Valve problem
- ○ Angina
- ○ High cholesterol
- ○ Atrial fibrillation
- ○ Irregular heartbeats (arrhythmias)
- ○ Other (specify): _____

Gastrointestinal Tract
- ○ Heartburn/refux/GERD
- ○ Ulcers
- ○ Irritable bowel
- ○ Liver disease/cirrhosis
- ○ Hepatitis
- ○ Gallbladder disease
- ○ Colon polyps
- ○ Diverticulosis
- ○ Bleeding problems
- ○ Hemorrhoids
- ○ Other (specify): _____

Lungs
- ○ Asthma
- ○ COPD/emphysema
- ○ Bronchitis / Pneumonia
- ○ Other: (Specify): _____

Kidney & Urinary Tract
- ○ Chronic Kidney disease
- ○ Kidney stones
- ○ Urinary incontinence
- ○ Enlarged prostate
- ○ Other (specify): _____

Bones
- ○ Gout
- ○ Lower back pain
- ○ Osteoarthitis degenetarive
- ○ Rheumatoid arthritis
- ○ Other (specify): _____

Eyes & Ears
- ○ Macular degeneration
- ○ Cataracts
- ○ Glaucoma
- ○ Hearing loss/hearing aid
- ○ Other: (specify) _____

Glands

Thyroid: ◯ Underactive/Low ◯ Overactive/High

Diabetes: ◯ Type II (adult) ◯ Type I (child onset)
◯ Requiring insulin

Diabetes complications: ◯ Eyes ◯ Neuropathy ◯ Kidney
◯ Other complications: _____

◯ Other (specify) _____

Nervous System

◯ Dementia or Alzheimer's disease ◯ Parkinson's disease ◯ Stroke
◯ Epilepsy or seizures ◯ Neuropathy/nerve damage
◯ Depression ◯ Anxiety
◯ Other (specify): _____

Other Health Problems

◯ Thrombosis/blood clots: ◯ In the leg ◯ In the lung ◯ Other: _____
◯ Syncope (loss of consciousness) ◯ Hernia ◯ Anemia ◯ Fibromyalgia
◯ Sexual function problems (specify): _____
◯ Other: (Specify) _____

Cancer

◯ Breast: Date: _____ Surgery: _____ Other tx: _____
◯ Prostate Date: _____ Surgery: _____ Other tx: _____
◯ Colon/Rectum Date: _____ Surgery: _____ Other tx: _____
◯ Lung Date: _____ Surgery: _____ Other tx: _____
◯ Skin Date: _____ Surgery: _____ Other tx: _____
◯ Lymphatic Date: _____ Surgery: _____ Other tx: _____
◯ Other cancer (specify): _____

Surgical History (Operations or Procedures)

◯ Heart Stent Date: _____
◯ Heart vale replacement: ( ) Aortic ( ) Mitral ( ) other: Date: _____
◯ Defibrillator/ICD placement Date: _____
◯ Tonsils removed Date: _____
◯ Appendix removed Date: _____
◯ Gallbladder removed Date: _____
◯ Hysterectomy Date: _____
◯ Hip repair due to hip fracture Date: _____
◯ Cataract Date: _____
◯ Cosmetic / Plastic Surgery Date: _____
◯ Other Surgeries
◯ _____ Date: _____

Preventive Health Measures

	Date		Date
Annual Wellness Exam	_____	Eye Exam	_____
Mammogram	_____	Fecal Occult Blood	_____
Pap Smear	_____	Prostate Test (PSA)	_____
Bone Density	_____	Any other that may apply:	_____
Colonoscopy	_____	Name of Gastroentorologist:	_____

◯ I do not agree with this specific measure. _____ ◯ I do not agree with any measures

Vaccine History

Dates of your **last** vaccinations:

Influenza	Year: _____		Pneumonia	Year: _____
Tetanus booster	Year: _____		Hepatitis B	Year: _____
Shingrix / Shingles vaccine (2 Doses):	Year: _____			

Covid: ◯ Moderna ◯ Pfyzer ◯ Johnson & Johnson

1st Dose: _____ 2nd Dose: _____ 3rd Dose: _____

◯ Mark here if you do not agree with immunizations / vaccines.

Hospitalizations

Reason for Hospitalization	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History

Mother:	◯ Alive	◯ Deceased	Age (Currently or at death): _____				
Father	◯ Alive	◯ Deceased	Age (Currently or at death): _____				
Mother:	◯ High Blood Pressure		◯ Diabetes	◯ Cancer	◯ Heart	◯ Unknown	
Father:	◯ High Blood Pressure		◯ Diabetes	◯ Cancer	◯ Heart	◯ Unknown	
Sister: (s)	◯ High Blood Pressure		◯ Diabetes	◯ Cancer	◯ Heart	◯ Unknown	
Brother (s)	◯ High Blood Pressure		◯ Diabetes	◯ Cancer	◯ Heart	◯ Unknown	

◯ Other disease that run in your family. (Specify) _____

Medical Forms

Please check any of the following forms you have completed: Bring a copy to our office of these forms to keep in your records:

◯ Advance Directive for Health Care (ADHC)

◯ Durable Power of Attorney (DPA) for healthcare decisions

◯ Living Will

Allergies

Do you have any drug allergies? ◯ Yes ◯ No

If yes, please list the name of the medication and specify the reaction:

Name of Medication	Rash	Shortnes of breath	Naussea	Other (specify)

Medication List

List all medicines that you use. (Include all Prescription, Non-Prescription, and natural products(s):

Current Medication	**What strength?**	**How do you use it, (How many? How many times a day?)**
Example: *Tylenol*	*500 mg*	*1 pill 3 X a day*

Social History

Relationship Status
- ◯ Single
- ◯ Domestic Partership
- ◯ Married
- ◯ Separated
- ◯ Divorced
- ◯ Widowed

Religion (Optional) _____

Employment Status
- ◯ Currently on disability
- ◯ Unemployed
- ◯ Part time
- ◯ Full time
- ◯ Retired
- ◯ Volunteer work

Tabacco Use

◯ Never ◯ Current Former, Quit:_____

How Much? _____packs/day Started: _____

Use other tabacco products?

◯ Yes, Type: _____ ◯ No

◯ E-Cigarette

Recreational Drug Use:

◯ Never ◯ Current

◯ Former, Quit: _____

Type: _____

Occupation (Current/previous) _____

Highest Education / Degree _____

Exercise
- ◯ Exersises regularly
- ◯ Exercising occasionally
- ◯ Not exercising

Alcohol:

◯ Yes, _____ drinks per day No

Do you feel you should cut back your drinking?	◯ Yes	◯ No
Do people annoy you or criticize your drinking?	◯ Yes	◯ No
Do you ever feel guilty about drinking?	◯ Yes	◯ No
Do you use alcohol to get going in the morning?	◯ Yes	◯ No

Review of Systems

General:
- ◯ Weight Change
- ◯ Chills
- ◯ Fever/Night Sweats
- ◯ Fatigue

Eyes/Ears/Nose/Throat
- ◯ Headache
- ◯ Facial Pain
- ◯ Eye or Vision Problems
- ◯ Ear Pain
- ◯ Hearing Loss
- ◯ Nosebleeds (Epistaxis)
- ◯ Neck Problems

Neurological
- ◯ Dizziness
- ◯ Fainting
- ◯ Motor Disturbance
- ◯ Sleep Disturbance
- ◯ Other symptom (s): _____

Cardiovascular
- ◯ Chest Pain or Discomfort
- ◯ Palpitations

Respiratory
- ◯ Shortness of Breath
- ◯ Cough
- ◯ Wheezing

Gastrointestinal
- ◯ Loss of Appetite
- ◯ Heartburn
- ◯ Nausea or Vomiting
- ◯ Abdominal Pain
- ◯ Dark or Bloody Stool

Gynecological
- ◯ Breast Pain/Discharge
- ◯ Menstrual Problems
- ◯ Last Period: _____

Musculoskeletal
- ◯ Joint Pain/Stiffness
- ◯ Muscle Aches

Urinary
- ◯ Difficulty Urinating
- ◯ Blood in Urine

Dermatology
- ◯ Rash
- ◯ Skin Lesion

Endocrine
- ◯ Excessive Thirst
- ◯ Blood Sugar Problems

Other
- ◯ Anxiety
- ◯ Depression
- ◯ Bleeding Problems
- ◯ Other: _____

Please answer the following Questions

Over the last 2 weeks, how ofthen have you been bothered by any of the following problems:

	No at all (0)	Several Days (1)	More than Half The Days (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor Appetite or overeating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, like reading the newspaper or watching TV				
8. Moving or speaking so slowly that other people have noticed or being so fidgety or restless that you have been moving a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself				

If you chedked off any problems above, how difficult have theese problems made it for you to work, take care of things at home, or get along with others?

◯ Somewhat Difficult ◯ Very Difficult ◯ Extremely Difficult

For adults age 65 and over, please answer the following questions

Activities of Daily Living/Function

Do you need assistance with dressing, bathing or feeding yourself? ◯ Yes ◯ No

Do you need help with shopping, preparing food, housekeeping, or transportation ◯ Yes ◯ No

Do you need assistance handling your own money or finances? ◯ Yes ◯ No

Do you need assitance managing your medications? ◯ Yes ◯ No

Do you have difficulty with mobility? ◯ Yes ◯ No

◯ Yes ◯ No

Balance

Do you feel dizzy or lightheaded when standing up? ◯ Yes No

Have you fallen 2 or more times in the past year? ◯ Yes ◯ No

◯ Yes ◯ No

Hearing

◯ Yes ◯ No

Do you have difficulty understanding speech or conversations?

Do you have to listen to the television or radio at a high volume to hear? ◯ Yes ◯ No

◯ Yes ◯ No

Cognitive

Do you have difficulty remembering recent events? ◯ Yes ◯ No

Do you have diffuiculty finding the right words or using the wrong words often? ◯ Yes ◯ No

Patient Signature: _____ Date: _____