NEW PATIENT REGISTRATION FORMS

GROWING WELLNESS IN OUR COMMUNITIES.

Our clinics offer primary care services to the entire family—from Pediatric, OB-Gyn through Geriatrics.

- We treat colds and fevers, provide complete disease management of diabetes, high blood pressure and other chronic issues, annual physicals, pregnancy and women's health services
- We offer prescription medicines at a reduced cost
- We can arrange your specialist referrals and hospital admission
- We provide you with the time you need to visit with our medical team who will answer your questions about your healthcare needs
- Referrals to mental health and oral healthcare for adolescents and adults are also available

OUR LOCATIONS:

DELAND MEDICAL CLINIC
844 W. PLYMOUTH AVE, DELAND
(386) 738-2422

DELTONA MEDICAL CLINIC
2160 HOWLAND BLVD, DELTONA
(386) 532-0515

PIERSON MEDICAL CLINIC
216 N. FREDERICK ST, PIERSON
(386) 749-9449

DELAND PEDIATRIC CLINIC
1015 N. STONE ST, DELAND
(386) 736-7933

DELAND DENTAL CLINIC
1015 N. STONE ST, DELAND
(386) 736-7931

OUR MISSION:

"Provide quality primary health care services, accessible to all persons in our community."

Florida Federally Qualified Community Health Center
Northeast Florida Health Services, Inc.

Family Health Source Medical Centers

Name ____ Date of Birth: ________

YOUR PATIENT RIGHT

- Be treated with courtesy, respect and dignity and have privacy concerning your care.
- Have impartial access to medical treatment regardless of race, religion, source of payment, national origin, disability or sexual orientation.
- Be told clearly about your diagnosis, planned course of treatment, alternative treatment, risks and prognosis. Your physician should give you this information.
- Receive prompt and reasonable replies to your questions and requests.
- Know the names of the physicians responsible for your care and of any other health care team members responsible for procedures and treatment.
- Know if your medical treatment is for experimental research purposes.
- Accept medical care or refuse treatment as allowed by law.
- See your medical records in accordance with Florida law.
- Receive written information about Advance Directives and healthcare decision making options.
- Take part in considering ethical issues related to your care.
- Be treated for any emergency conditions that will worsen if treatment is delayed.
- Be given, on request, full information and counseling on financial resources available for your care.
- Receive a reasonable estimate of the charges for your medical care before your treatment, if requested. The actual cost may be higher based on changes in your condition or treatment needs.
- Receive a copy of an itemized bill that you can understand. You may, on request, have your charges explained.
- Express grievances about any violation of your rights.

Name ______________________________ Date of Birth: ________

PATIENT REGISTRATION FORM

-All information is required and confidential-

Account Number: ____________________ **Date:** ____________________

ALLERGIES: ____

MAILING ADDRESS: ____________________ City:__________ State: _______ Zip: ________
PHYSICAL ADDRESS: ____________________ City:__________ State: _______ Zip: ________
GENDER: ❑Male ❑Female **MARITAL STATUS**: ❑Single ❑Married ❑Divorced ❑Widowed ❑Other
HOME PHONE: (_____) ____________________ WORK PHONE: (_____) ____________________
CELL PHONE: (_____) ____________________ EMAIL: ____________________
DATE OF BIRTH: _____/_____/__________ SOCIAL SECURITY #: ________-______-________
EMPLOYED: ❑ Yes ❑No **EMPLOYER/SCHOOL**: ____________________

PERSON TO NOTIFY IN AN EMERGENCY: ____________________ **RELATIONSHIP**: __________ **PHONE#**: __________

RACE: ❑Black/African American ❑White/Caucasian ❑American Indian ❑Asian
❑Native Hawaiian ❑Hispanic/Latino ❑Pacific Islander ❑Unreported/Refused

*****Below is strictly confidential information and is used for Rural Healthcare benefits***** Please check one:

❑Migrant Worker ❑Seasonal Worker ❑N/A | Homeless ❑Yes ❑No | Veteran ❑Yes ❑No

IF PATIENT IS A CHILD: LIST PARENT/GUARDIAN INFORMATION HERE:
LAST NAME: ____________________ FIRST NAME: ____________________ SS#: ____________
MAILING ADDRESS: ____
DOB: ____________ RELATIONSHIP TO THE CHILD: ____________________
HOME/CELL PHONE: (_____) ____________________ WORK PHONE: (_____) ____________________

CONSENT FOR TREATMENT: I authorize the staff of Family Health Source Medical Centers of Northeast Florida Health Services, Inc. (NEFHS) to provide medical and/or dental treatment, including any necessary procedures required in the course of diagnosis and treatment, and of such treatment if necessary.

Signature: ____________________ **Date:** ____________________

INSURANCE ASSIGNMENT: I hereby assign to NEFHS my right to the insurance benefits that may be payable for services provided, arising from any insurance policy, in my name or in my behalf. I authorize payment of benefits directly to NEFHS. I understand that this assignment of benefits does not relive me from responsibility for the balance on my account for services which may not be covered by insurance, Medicare or Medicaid.

Signature: ____________________ **Date:** ____________________

Name ____ Date of Birth: ________

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check all that apply)

HOME PHONE	WORK PHONE	WRITTEN CORRESPONDENCE
❑OK to leave detailed message	❑OK to leave detailed message	❑OK to mail to home address
❑Leave message with call back number only	❑Leave message with call back number only	❑Mail to this address instead: ________________________________

COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR CARE:
Please list any family members or others who may be involved in coordinating your care. Also, please indicate what kind of information may be shared with each individual.

NOTE: This designation will be active from one year of signature.

		Type of Information			
Name	**Relationship to Patient**	**All**	**Appointment**	**Medical**	**Billing/Payment**

I understand that I may cancel this designation at any time by signing the revocation section below. I understand that any cancellation can only apply to future disclosures and cannot cancel actions taken or disclosures made while the designation was in effect.

Patient's Signature:_________________________________ **Date:**_________________________________

REVOCATION SECTION:

I hereby cancel this authorization for designated individuals to have access to my protected health information.

Patient's Signature:_________________________________ **Date:**_________________________________

Place Patient ID label here

Name ____ Date of Birth: ________

INCOME CERTIFICATION FORM

Northeast Florida Health Services, Inc. is a non-profit organization that receives a defined amount of Federal funding to supplement the cost of providing medical care to patients who are eligible to participate in the sliding fee scale program. Eligible patients will also qualify for reduced cost prescriptions. To determine your eligibility for this federally funded program, verification of your income is required within 10 days of your visit. *You must update this information at least annually to continue your participation in the program.*

DISCLOSURE OF INCOME IS OPTIONAL

You do not have to disclose income or provide income verification if you choose not to participate in the sliding fee scale program. Please indicate with your initials below if you wish to participate in the sliding fee scale program.

______ **Yes** I want to participate in the sliding fee scale program. I will complete the income verification portion of this form and provide verification of my income. If I qualify for the program, I agree to pay the portion of the charges after the sliding fee scale discount is applied.
***If yes, you need Sliding Fee Scale Information & Verification of Support Forms**

______ **No** I do not want to participate in the sliding fee scale program at this time. I agree to pay NEFHS's usual and customary fee for services rendered.

Number of family members in the household: __________

Source of Income	Amount Received

I understand that misrepresentation of income in order to participate in the sliding fee scale program is Federal Fraud. I also understand and agree that I am responsible for payment of my portion of the charges after the sliding fee scale is applied. I understand that it is my obligation to inform NEFHS when my financial situation changes.

Signature:___________________________________ **Date:**__________________________

Place Patient ID label here

Name ____ Date of Birth: ________

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT OR HELATHCARE OPERATIONS

I understand that as part of my health care, Northeast Florida Health Services, Inc. originates and maintains paper and/or electronic medical records describing my health history, symptoms, examinations and test results; diagnosis, treatment, any plans for my future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnostic information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided a copy of NEFHS's NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to have my health information copied at fees that NEFHS has set
- The right to amend your health information if you feel we have incomplete or incorrect information
- The right to an accounting of disclosure of your health information
- The right to request restrictions regarding your health information
- The right to request confidential communications regarding your health information

I understand that Northeast Florida Health Services, Inc. is not required to agree to the restrictions requested if it is not possible for us to ensure our compliance or believe it will negatively impact the care we may provide you.

I understand and accept the terms of this consent.

Signature:_________________________________ **Date:**______________________________

Name ____ Date of Birth: ________

AUTHORIZATION FOR RELEASE OF INFORMATION

SOCIAL SECURITY #: _________ - __________ - _____________ MEDICAL RECORD#: _______________________

ADDRESS: ____________________________________ CITY: ____________________ STATE: ______ ZIP: _________

DAY PHONE#: ____EVENING PHONE#: ______________________________

I hereby authorize _____________________________________ (Print name of doctor) to release information from my medical record as indicated below to:

NAME: ____

ADDRESS: ____ CITY: ____________________ STATE: _ ZIP: _________

DAY PHONE#: ____FAX #: ______________________________________

INFORMATION TO BE RELEASED:

	Dates:
❑ History and physical exams	____________
❑ Progress notes	____________
❑ Lab reports	____________
❑ X-Ray reports	____________
❑ Other: ____________________	____________

I specifically authorize the release of information relating to:

❑ Substance abuse (including alcohol/drug abuse)

❑ Mental health (including psychotherapy notes)

❑ HIV related information (AIDS related testing)

X________________________________ ____________

Signature of Patient or Legal Guardian **Date**

PURPOSE OF DISCLOSURE:

❑Changing doctors ❑Consultation/second opinion ❑Continuing care ❑Legal ❑School

❑Insurance ❑Workers Compensation ❑Other (please specify:___________________________)

1. I understand that this authorization will expire on __________ (print the date this form expires) days after I have signed the form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by _______________________ (Print name of doctor) for the purpose of: ____

a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.

b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.

c. I have been informed that ______________________(Print name of doctor) ❑will ❑will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

5. I understand that in compliance with _____________ (print State whose laws govern the doctor) statute, I will pay a fee of $_________ (print the fee charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

______________________________ ____________ OR ______________________________________ ____________

SIGNATURE OF PATIENT **DATE** **PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON** **DATE**

______________________________ ____________ ______________________________________

RECORDS RECEIVED BY **DATE** **RELATIONSHIP TO PATIENT**

FOR OFFICE USE ONLY

DATE REQUESTED: _____________ BY: ______________________________ID PRESENTED: _________ FEE COLLECTED $_______

Family Health Source
Medical Centers

Name ____ Date of Birth: ________

Adult Initial Health History

Today's Date__________________________________

Address____

Telephone Number (home) (____________) ______________________________

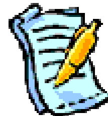
(cell) (____________) ______________________________

(work) (____________) ______________________________

Filling out this form

- Answering these questions will help your doctor understand your health and how best to treat you.
- If you need help filling out this form:
    - Call one of our clinics before your appointment and someone can help you over the phone or you can come meet with our patient care coordinator.

Bring to your appointment:



1. This **Initial Health History Form** and any other important

   medical records

2. Your **insurance information**

3. All **your medicines** (prescription bottles, herbal, over-the-counter pills and creams)

We look forward to working with you, to meet your medical needs!

Family Health Source Medical Centers

Name ____ Date of Birth: _______

GENERAL HEALTH

1. **Why did you make this appointment**? (Check all that apply.)

☐ regular checkup

☐ first appointment to start care with a new doctor

☐ switching doctors (from whom: ____)

☐ have a specific health problem (if so, explain ______________________________)

2. In general, what do you consider to be your **main health problem**(s)? (Check all that apply.)

☐ heart problems ☐ diabetes

☐ stomach problems ☐ depression/emotional problems

☐ ear, nose, or throat problems ☐ joint problems

☐ high blood pressure

☐ Other(s) – please explain____

____

3. How would you **describe your health**?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. Are you taking any **prescription medicines**?

☐ Yes. Please list your medicines below OR ☐ I brought my pill bottles or a list.

☐ No, I do not take any prescription medicines. (If no, go to question #5.)

Name of medicine	**Amount / size of pill**	**How many pills or doses do you take at**
Example: Furosemide	20 mg	_2_morning _2_noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed
		___morning ___noon ___dinner ___bed

Family Health Source Medical Centers

Name ____ Date of Birth: ________

		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed
		___morning ____noon ___dinner ___bed

(Please use the back of this form if you have more prescription medicines.)

5. What **over-the-counter medicines**, do you take regularly?

☐ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)

☐ Vitamins

☐ Antacid (for example: Tums, Prilosec)

☐ Herbal medicine (please list) ____

☐ Other (please list) ____

☐ None - I do not take any over-the-counter medicines regularly.

6. Have you ever had any **allergic reaction (bad effects) to a medicine** or a shot?

☐ Yes. (Please write the name of the medicine and the effect you had.)

☐ No, I am not allergic to any medicines.

Medicine I am allergic to	**What happens when I take that medicine**
Example: Atenolol	I get a rash

7. Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)

☐ latex (rubber gloves)

☐ grass or pollen

☐ eggs

Family Health Source Medical Centers

Name ____ Date of Birth: ________

☐ shellfish

☐ Other (please describe) ____

☐ No - I have no allergies that I know of.

8. Have you ever been a **patient in a hospital** overnight?

☐ Yes. (If yes, explain EACH reason and when.)

☐ No, I have never been a patient in a hospital. (If no, go to question #9)

I was in the hospital because:	**When**
Example: Heart Attack	6 years ago

9. Have you ever had a **colonoscopy** (a test to look at your insides by sending a camera through your bottom)?.. ☐ Yes ☐ No

When _______________

10. Have you ever received a **blood transfusion** (when you are given extra

blood)? .... ☐ Yes ☐ No

When_______________

FOR WOMEN ONLY

11. Have you ever been **pregnant**? .... ☐ Yes ☐ No

How many times?___________________

How many children have you given birth to?_________________

12. Have you had a **PAP smear**? .... ☐ Yes ☐ No

Date of last one ____________________

13. Have you ever had a **PAP smear that was not normal**? .... ☐ Yes ☐ No

14. Have you had a **mammogram** (breast x-ray)?................................. ☐ Yes ☐ No Date of last one_______________

Family Health Source Medical Centers

Name ____ Date of Birth: ________

SHOTS

15. When was your last **Tetanus shot**?.............Year_____ ☐ never ☐ don't know

16. When was your last **Pneumonia shot**?........ Year_____ ☐ never ☐ don't know

17. When was your last **Flu shot**?.................... Year_____ ☐ never ☐ don't know

SOCIAL HISTORY

18. Circle the **highest grade** you finished in school?

1 2 3 4 5 6 7 8	9 10 11 12 GED	1 2 3	1 2 3 4+
Grade School	High School	Vocational School	College

19. What **language** do you prefer to speak? ☐ English ☐ Spanish ☐ Other ___________

20. How well can you **read**?

☐ Very well ☐ Well ☐ Not well ☐ I can not read

21. **What do you do during the day**?

☐ Work full-time

☐ Work part-time

☐ Attend school

☐ Take care of children at home

☐ Go out most days (shop, visit, appointments)

☐ Stay home most days

☐ Other____

22. Have you **ever smoked cigarettes, cigars, used snuff, or chewed tobacco**?

☐ No (if no, go to question #23.) ☐ Yes

a. When did you start?____

b. How much per week? ____

c. Have you quit?............................ ☐ No ☐ Yes, when____________________

d. Do you want to quit?.................... ☐ No ☐ Yes ☐ Already Quit

Family Health Source Medical Centers

Name ____ Date of Birth: ________

23. Do you drink **alcohol**?

☐ No (if no, go to question #24.)

☐ Yes

a. Have you ever felt you ought to cut down on your drinking?... ☐ Yes ☐ No

b. Have people ever annoyed you by criticizing your drinking?.... ☐ Yes ☐ No

c. Have you ever felt bad or guilty about your drinking? .... ☐ Yes ☐ No

d. Have you ever had a drink first thing in the morning? .... ☐ Yes ☐ No

24. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed?

25. Who lives in your house?____

____

26. Do you have **sex** with ☐ men ☐ women ☐ both ☐ neither

27. Do you have any **beliefs or practices from your religion, culture, or otherwise** that your doctor should know? For example:

☐ I am a **Jehovah's Witness** and do not accept blood/blood products.

☐ I **do not use birth control** because of personal or religious beliefs.

☐ I **fast** (go without food) for periods of time for personal or religious reasons.

☐ I am a **vegetarian** (do not eat meat.)

☐ I am a **vegan** (do not eat anything that comes from an animal.)

☐ Other special diets or eating habits. (Please describe.) __________________________

☐ I use traditional medicines or treatments, such as acupuncture or herbs.

☐ Other beliefs____

☐ **No**, I have no beliefs or practices that need to be included in my care.

28. Check any of the following things you use to **help you walk**.

☐ Cane ☐ Walker ☐ Wheelchair

☐ Other _________________________

☐ I do not need any help walking

Name ____ Date of Birth: ________

29. Check any of the following types of **help at home** you receive (paid help or family and friends).

☐ Help with cleaning/laundry.

☐ Help with shopping.

☐ Help with personal care (bathing, dressing).

☐ Help with taking my medications.

☐ I do not use any help at home.

30. In the past year, have you been **emotionally or physically abused** by your partner or someone important to you?.. ☐ Yes ☐ No

31. In the past year have you been **hit, pushed, shoved, kicked or threatened** by a partner or someone important to you?.. ☐ Yes ☐ No

32. **EXERCISE**

Describe what kind of exercise you do. (Check all that apply.)	**How many days per week do you exercise?**	**For how long do you exercise each day?**
☐ walking	☐ once per week	☐ less than 15 minutes
☐ biking	☐ twice per week	☐ 15-30 minutes
☐ swimming	☐ 3 times a week	☐ 30 – 45 minutes
☐ weight training	☐ 4 times a week	☐ 45 minutes – 1 hour
☐ yoga	☐ 5 times a week	☐ over 1 hour
☐ other	☐ 6 times a week	
☐ I do not exercise	☐ 7 times a week or more	
Comments:		

Family Health Source
Medical Centers

Name ____ Date of Birth: ________

FAMILY HISTORY

What medical problems do people in your family have?

Family Member	Medical Problems
Mother:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: ________________________
Father:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: ________________________
Sisters:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: ________________________
Brothers:	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ other: ________________________

HISTORY OF MEDICAL CONDITIONS

Have you **ever** had any of the following conditions? (Check all that apply)

☐ Anemia (low iron blood) ☐ Asthma (wheezing) ☐ Diabetes (sugar)

☐ Heart Trouble ☐ Hemorrhoids (piles) ☐ Cancer

☐ Hepatitis (yellow jaundice) ☐ Tuberculosis (TB) ☐ Liver Trouble

☐ Pneumonia ☐ Rheumatic fever ☐ Ulcers

☐ Stroke ☐ High Blood Pressure

☐ Skin problems ☐ Depression (feeling down or blue)

☐ Epilepsy (fits, seizures) ☐ Anxiety (nerves, panic attacks)

☐ VD, STD (syphilis, gonorrhea, chlamydia, HIV)

☐ Other____

Family Health Source Medical Centers

Name ____ Date of Birth: ________

REVIEW OF SYMPTOMS

Sleeping	Do you **feel tired** a lot?	☐ yes	☐ no
	Do you have **trouble falling or staying asleep**?	☐ yes	☐ no
	Do you have **other problems with sleep**?	☐ yes	☐ no
Eating	Have you **lost your appetite** recently?	☐ yes	☐ no
	Have you **lost weight** in the last year without trying?	☐ yes	☐ no
	Do you **eat too much** or **have you gained weight** recently?	☐ yes	☐ no
	Do you have **other problems with eating**?	☐ yes	☐ no
Throat	Do you have **sore throats** a lot?	☐ yes	☐ no
	Do you have **other problems with your throat**?	☐ yes	☐ no
Ears	Do you have **trouble hearing**?	☐ yes	☐ no
	Do you wear a **hearing aid**?	☐ yes	☐ no
	Do you have constant **ringing or noises** in your ears?	☐ yes	☐ no
	Do you have **other problems with your ears?**	☐ yes	☐ no

Family Health Source Medical Centers

Name ____ Date of Birth: _______

Back	Do you have **back pain**?	☐ yes	☐ no
	Do you have any **other problems with your back**?	☐ yes	☐ no
Eyes	Do you have **trouble with your vision** or seeing?	☐ yes	☐ no
	Do you wear **glasses or contacts**?	☐ yes	☐ no
	Do you have **other problems with your eyes**?	☐ yes	☐ no
Nose and Sinuses	Do you have a **runny or stopped up nose** a lot?	☐ yes	☐ no
	Do you have **other problems with your nose or sinuses?**	☐ yes	☐ no
Teeth and Mouth	Do you have **sore or bleeding gums**?	☐ yes	☐ no
	Do you wear **plates or false teeth**?	☐ yes	☐ no
	Do you have **other problems with your teeth and mouth?**	☐ yes	☐ no
Heart or Breathing	Do you ever have **pain/tightness in your chest** when working or exercising?	☐ yes	☐ no
	Do you **wake up at night with trouble breathing**?	☐ yes	☐ no
	Do you have a **racing or skipping heartbeat** at times?		

Family Health Source Medical Centers

Name ______________________________________ Date of Birth: _________

	Do you have **other heart or breathing problems**?	☐ yes ☐ yes	☐ no ☐ no
Bowel movements	Do you have **bowel movements (poop) that are black, like tar, or bloody?**	☐ yes	☐ no
	Do you have **any other problems with your bowel movements (poop)?**	☐ yes	☐ no
Peeing and Kidney Stones	Do you have **trouble passing your urine (peeing)?**	☐ yes	☐ no
	Does it **burn when you pass urine (pee)?**	☐ yes	☐ no
	Do you have to **pee more than 2 times a night**?	☐ yes	☐ no
	Do you **leak urine (pee)?**	☐ yes	☐ no
	Have you ever passed **kidney stones**?	☐ yes	☐ no
	Do you have any **other problems with your peeing**?	☐ yes	☐ no
Joints	Do you have **swollen or painful joints**?	☐ yes	☐ no
	Do you have any **other problems with your joints**?	☐ yes	☐ no
Head, Balance, Fever and	Do you have **frequent or severe headaches**?	☐ yes	☐ no

Family Health Source Medical Centers

Name ____ Date of Birth: ________

Weakness	Have you ever **fainted (passed out)**?	☐ yes	☐ no
	Have you **lost your balance and fallen** recently?	☐ yes	☐ no
	Do you have **weakness** in any part of your body?	☐ yes	☐ no
	Have you had a **fever** within the past month?	☐ yes	☐ no
	Do you have any **other problems with your head or balance?**	☐ yes	☐ no
Emotional Health	Do you get **upset easily**?	☐ yes	☐ no
	Do **frightening thoughts** keep coming into your mind?	☐ yes	☐ no
	Have you ever been **hospitalized for nerves, thoughts or moods**?	☐ yes	☐ no
	During the past 2 weeks, have you often been bothered by having **little interest or pleasure in doing things**?	☐ yes	☐ no
	During the past 2 weeks, have you often been bothered by feeling **down, depressed, or hopeless**?	☐ yes	☐ no

Family Health Source Medical Centers

Name ____ Date of Birth: ________

	Do you have any **other problems with your emotional health?**	☐ yes	☐ no
Men Only	Have you ever had **prostate trouble**?	☐ yes	☐ no
	Do you have any **other male problems**?	☐ yes	☐ no
Women Only	Do you have **pain or lumps in your breast**?	☐ yes	☐ no
	Do you have unusual **vaginal discharge or itching**?	☐ yes	☐ no
	Do you or have you taken **hormones (such as birth control pills)**?	☐ yes	☐ no
	Do you have any **other female problems**?	☐ yes	☐ no

Nurse/MA Review Signature: ___________________ **Date:** _________ **Physician Signature:** ___________________**Date:** __________

Family Health Source Medical Centers

NAME: ____ **DATE OF BIRTH:** _______________

A GUIDE TO ADVANCE DIRECTIVE

Florida law gives every adult the right to make certain decisions about his or her treatment. You have the right, under certain conditions, to decide whether to accept or reject medical treatment and other procedures that would prolong your life artificially. The law also makes certain your rights and personal wishes are respected even if you are too sick to make your own decisions.

The decisions, known as Advance Directives can authorize the physician to provide, withhold or withdraw life prolonging procedures. They can also designate another individual to make medical decisions if necessary.

Some people make Advance Directives when they are diagnosed with a life threatening illness. Others do it while they are in good health. Advance Directives are not just for the elderly, but for anyone over the age of 18. A serious accident or sudden onset of a disease could trigger the need for these instructions.

In Florida there are three kinds of Advance Directives documents:

- **Living Will**
- **Designated Health Care Surrogate**
- **An Anatomical Donation (organ donor)**

This document provides information to help you decide what best fits your needs.

Types of Advance Directives:

Living Will: A living will is a statement about the patient's desire regarding medical treatment that directs physicians when the patient is no longer able to communicate their wishes. This statement specifies the type of care the patient wants or does not want if unable to make decisions, for example, if the patient does not want to receive feeding through tubes or other artificial means of providing food and water, receive CPR, or be kept on a respirator (a machine that breathes for you), this should be stated in the Living Will. The Living Will requires 2 witnesses, one of whom is not a spouse or blood relative.

Designated Health Care Surrogate: A Designated Health Care Surrogate allows you to appoint another adult person to make health care decisions on your behalf when you are unable to do so. It is recommended that you appoint an adult who knows your wishes and will carry them out. It is suggested that you choose a person who has shown special care and concern for you and has maintained regular contact and is familiar with your personal, religious, moral and cultural beliefs. Your Health Care Surrogate will have the authority to make all medical decisions on your behalf according to your wishes including but not limited to the withholding/withdrawal of life prolonging procedures.

Anatomical Donation (Organ donor): An anatomical donation indicates your wish to donate, at the time of your death, all or part of your body, organ and tissue donations can go to persons in need, or the body can be donated for the training of healthcare workers. You can indicate your choices to be an organ donor by designating it on your driver's license or signing a uniform donor form, or expressing your wishes in a Living Will.

Make Your Wishes Known

If you have an Advance Directive, tell your family and make sure they know where it is located. Also, tell your doctor and make sure that the Advance Directive is part of your medical records. If you have a Designation of Health Care Surrogate, give a copy to the person you have chosen to act on your behalf.

I would like to fill out a:

ADVANCE DIRECTIVE/LIVING WILL	❑Yes	❑No
HEALTH CARE SURROGATE FORM	❑Yes	❑No
I ALREADY HAVE AN ADVANCE DIRECTIVE	❑Yes	❑No

*If patients checks off **YES**, please provide documents being requested.

SIGNATURE: ____________________________________ DATE: ______________________________