Dr. Harry Pepe & Assoc., Inc.

PREVENTIVE COUNSELING

To Our Valued Patients:

The promotion of healthy lifestyles and early identification of potential health risks will benefit you and are important to us. With this mind, the following guidelines have been developed. Please discuss any concerns that you may have with your doctor during your visit.

Lifestyle Changes

Diet

Choose a balanced diet low in saturated fat, cholesterol, sugar and salt. Eat plenty of vegetables, fruits and grains, which provide vitamins, minerals and fiber, and lean meats and pastas. Excessive weight is detrimental to your well being and can predispose you to diabetes. This office has low calorie diets available to you and can help instruct you on programs involving diet and exercise. Beware of fad diets and talk to your doctor before starting any weight loss program.

Exercise

Twenty minutes of exercise, three times a week (i.e. walking swimming, etc.) will keep your and bones healthy.

Abusive Habits

Smoking has been shown to cause heart disease, cancer, strokes, and other illnesses. Your doctor can help find a program that can help you quit smoking.
Excessive alcohol intake (more than 2oz. liquor or one beer daily) is associated with many illnesses such as cancer and liver disease.
Illicit drug use has many health risks, such as AIDS, hepatitis, heart problems, mental and social disorders.
Sexually promiscuity and certain sexual practice can expose you to potentially fatal diseases such as AIDS, and numerous other sexually transmitted diseased (STD's).
Sun exposure that is excessive can cause skin cancer. Always use sunscreen when exposed to sun.

Injury Prevention

Safety products help to prevent serious injuries. They include seat belts, bicycle helmets, and smoke detectors. Try to develop a safety awareness in all you do including safe work habits(lifting, bending, etc.), firearm safety, water safety practices, CPR training, poison prevention, and good driving habits. Courses are available within the community. Try to prevent falls by keeping hallways well lit; and be careful when using walkers and canes.

Domestic Violence

Domestic violence and abuse can be helped. If you are in immediate danger, please call 911. The domestic abuse hotline is (800)799-7233.

Dental Health

Brush two times per day and floss every day. See your dentist for routine visits every six months.

The above counseling has been reviewed with _____
Patient Name

By _____ Date _____
Health Care Professional

Dr. Harry Pepe & Assoc., Inc.

CONSENT FOR TREATMENT PAYMENT and HEALTHCARE OPERATION

I consent to the use or disclosure of any protected health information by Dr. Harry Pepe & Assoc., Inc., for the purpose of diagnosing or providing treatment, obtaining payment for health care services or in the performance of health care operations for me by Dr. Harry Pepe & Assoc., Inc., its physicians or staff, may be conditioned upon my consent as evidenced by my signature on the document.

My "protected health information" means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. The protected health information reasonably indentifies me and related to my past, present, or future physical or mental health condition.

I understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations to the practice. Dr. Harry Pepe & Assoc., Inc., its physicians and staff are not required to agree to the restrictions that I may request. However, if Dr. Harry Pepe & Assoc., Inc., its physician and staff members agree to a restriction and that I request, the restriction is binding on Dr. Harry Pepe & Assoc., Inc., its physicians and staff.

I have the right to revoke this consent, in writing, at any time, except to the extent that Dr. Harry Pepe & Assoc., Inc., its physicians and staff have taken action in reliance on this consent. I understand that I have the right to review Dr. Harry Pepe & Assoc.,Inc. Notice of Privacy Practices, which has been provided prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Dr. Harry Pepe & Assoc., Inc.

This notice of Privacy Practices also describes my rights and the duties of the physician and staff of Dr. Harry Pepe & Assoc., Inc., with respect to my protected health information. Dr Harry Pepe reserves the right to change the privacy practices that are describe in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

_____ _____

Signature of Patient/Personal Representative Date

_____ _____

PRINTED name of Patient of Personal Rep Relationship to Patient

CONSENT FORM
DR. HARRY PEPE & ASSOCIATES, INC.

Dear Patient,

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

_____ _____

Patient Signature Date

_____ _____

Witness Date

PATIENT DISCLOSURE CONSENT
DR. HARRY PEPE & ASSOCIATES, INC,

The Health Insurance Portability and Accountability Act (HIPPA) privacy rules gives patients the right to request a restriction on uses and disclosures of a patients Protected Health Information (PHI). The Individual is also provided the right to request confidential communications or that a Communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

(check all that apply)

Home Telephone (___)_____

____It's OK to leave messages with detailed information.
____Leave message with call back number only.
____Speak to ME only. DO NOT leave message.
____OK to speak to the following person (write number):

_____

_____

_____

Work Telephone (____)_____

____It's OK to leave messages with detailed information.
____Leave message with call back number only.
____Speak to ME only. DO NOT leave message.

Cellular Telephone (____)_____

____It's OK to leave messages with detailed information.
____Leave message with call back number only.
____Speak to ME only. DO NOT leave a message.

Written Communication

____It's OK to mail to my home address.
____It's OK to fax to this number. (____)_____
____It' OK to email to this address _____

_____ _____

Signature of Patient/Legal Guardian Date

_____

Print Patient's Name

Living Will

Declaration made this _____ day of _____, 2____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____(initial) I have a terminal condition,
or _____(initial) I have an end-stage condition,
or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ___, I do not ___ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____
Street Address _____
City _____ State _____ Phone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): _____
_____
_____
_____
_____

(Signed) _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

Witness _____
Street Address _____
City _____ State _____
Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____
Street Address _____
City _____ State _____ Phone _____
Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____
Street Address _____
City _____ State _____ Phone _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.
Additional instructions (optional):

_____
_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____
Name _____

Signed _____

Date _____

Witnesses 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

FLORIDA DEPARTMENT OF HEALTH

State of Florida
DO NOT RESUSCITATE ORDER

(please use ink)

Patient's Full Legal Name: _____ Date: _____
(Print or Type Name)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

- ☐ Surrogate
- ☐ Court appointed guardian
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2002

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896,Revised December 2002

HEALTH **State of Florida**
DO NOT RESUSCITATE ORDER

_____
Patient's Full Legal Name (Print or Type) (Date)

PATIENT'S STATEMENT
Based upon informed consent, I, the undersigned,hereby direct that CPR be withheld or withdrawn. **(If not signed by patient, check applicable box):**

- ☐ Surrogate
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ Court appointed guardian
- ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

DR. HARRY PEPE & ASSOCIATES, INC.

Harry N. Pepe, D.O., Retired
Michael I. Margolis, D.O.
Adan Hernandez, M.D.
Eddy L. Perez-Stable, M.D.
Marilee Meeler, PA-C

William F. Pepe
Administrator

Hollywood Office
4510 Sheridan Street
Hollywood, Florida 33021
Tel: (954) 893-8900
Fax: (954) 893-8992

Dear Valued Patient,

Your health is very important to us. Medical care must be a cooperative effort between medical personnel and the patient. Therefore, both parties must do their part so that the goal of optimum health can be achieved. It is very important for you to keep your scheduled appointments.

In the future you must cancel any appointment you cannot keep at least 24 hours in advance. **Your failure to comply with this policy will result in a charge on your account of $25.00.** This fee is not covered by your insurance. A pattern of missed appointments may also result in your discharge from our practice.

We value the trust you have placed in us to provide for your primary care medical needs. We will make every effort possible to provide you with an appointment time that is convenient for you. Thank you for your cooperation.

Patient Name _____

Patient Signature_____

Date _____

Sincerely,

William Pepe

William F. Pepe
Administrator
Dr. Harry Pepe & Assoc., Inc.

Wp
cc: File

DR. HARRY PEPE & ASSOC INC

4510 Sheridan Street
Hollywood, Fl 33021
Tax ID: 59-2466190

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

YOU MUST COMPLETE EVERY SECTION BELOW OR THIS FORM MAY BE RETURNED TO YOU FOR COMPLETION

1. Identity: Patient Name: _____ Social Security Number: _____

Address: _____ Date of Birth: _____

_____ Phone number: _____

2. Sender and Receiver:

I authorize disclosure of medical information (as indicated):

From:
(Facility to Disclose Records) _____

_____

_____

Disclose To: _____

☐ By Mail: _____

_____

_____

☐ I would like to pick up my records. Please call: _____

3. What to disclose: Please check the records you would like disclosed:

HOSPITAL

☐ Records related to (specify): _____
☐ Discharge summary
☐ X-Ray Report(s)
☐ X-Ray Film(s)
☐ ER Notes
☐ Other: (specify) _____
☐ Operative Report(s)
☐ Pathology Report(s)
☐ Laboratory Report(s)
☐ Photo/Video/Other

OUTPATIENT FACILITY/LOCATION
(Indicate from choices on back): _____

☐ Records related to (specify): _____
☐ Out patient notes
☐ Laboratory Report(s)
☐ OB/GYN Notes/Reports
☐ TB screening
☐ X-Ray Report(s)
☐ X-Ray Film(s)
☐ Psychological test report
☐ Other: (specify) _____
☐ Pathology Report(s)
☐ Immunization Record
☐ Photo/Video/Other

4. Timeframe: I would like records from the following dates: _____ through _____.

5. Disclosure of special protected records: I authorize the disclosure of information pertaining to:

a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) ☐ YES ☐ NO/NA
b. The diagnosis or treatment of drug and/or alcohol abuse ☐ YES ☐ NO/NA
c. Treatment and/or consultation for mental health or psychiatric disorders ☐ YES ☐ NO/NA

6. Purpose of Use/Disclosure: Please indicate/describe each authorized purpose of the use or disclosure:

☐ Request of individual ☐ Other (specify) _____.

7. Expiration date: This authorization will expire in 90 days or _____, which ever occurs last.

- I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- I further understand that treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

_____
Date

_____
Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
☐ Minor ☐ Incompetent ☐ Deceased
Proof of designation must be filed in the chart or sent with this request.

_____
Signature of Legal Representative and Relationship to Patient

_____
Signature of Witness for Psychiatric Records

PATIENT'S PERSONAL HISTORY & HEALTH ASSESSMENT

Date _____

PATIENT'S NAME: _____ SOC. SEC. #: _____ D.O.B.: _____ SEX: _____

PATIENT'S STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PHONE: (_____) _____

EMPLOYER: _____ EMPLOYER PHONE: (_____) _____

NEAREST RELATIVE/KIN: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ PHONE: (_____) _____ WORK: (_____) _____

DATE OF LAST PHYSICAL EXAM: _____ PHYSICIAN: _____

MEDICAL EQUIPMENT:

Do you use a Cane_____ Oxygen_____ Catheter_____ Walker _____ Wheelchair_____ Nebulizer_____

Do you own or rent this equipment?_____

Do you use Glasses _____ Hearing Aid _____

SOCIAL HISTORY:

Alcohol_____ Smoking_____ Drugs_____ Other_____

RELIGION: _____

MARITAL STATUS:

Married _____ Widowed_____ Single _____ Divorced_____ Separated_____ Live Alone_____

IMMUNIZATIONS:

Pneumococcal_____ Rubella_____ Tetanus_____ Influenza_____ Diptheria _____ Other_____

FAMILY HISTORY:

	Alive	Dead	Age	Cause of Death
Mother				
Father				
Brother				
Sister				

Check if you have/had any of the following illnesses. If unsure, leave blank:

	Self	No	Relative		Self	No	Relative		Self	No	Relative
Alcohol Overuse	☐	☐	☐	Frequent Kidney/Bladder Infections	☐	☐	☐	Mumps	☐	☐	☐
Allergies (other than medications)	☐	☐	☐	Frequent Lung Infections	☐	☐	☐	Nervous Breakdown	☐	☐	☐
Anemia	☐	☐	☐	Gallbladder Disease	☐	☐	☐	Radiation Treatments	☐	☐	☐
Arthritis	☐	☐	☐	Goiter	☐	☐	☐	Rheumatic Fever	☐	☐	☐
Asthma	☐	☐	☐	Gout	☐	☐	☐	Sexually Transmitted Diseases	☐	☐	☐
Bleeding Tendency	☐	☐	☐	Hay Fever	☐	☐	☐	Sickle Cell Anemia	☐	☐	☐
Cancer	☐	☐	☐	Heart Attack	☐	☐	☐	Stomach Ulcers	☐	☐	☐
Chicken Pox	☐	☐	☐	Hepatitis	☐	☐	☐	Stroke	☐	☐	☐
Colitis	☐	☐	☐	High Blood Pressure	☐	☐	☐	Suicide Attempt	☐	☐	☐
Congenital Heart Disease	☐	☐	☐	Intestinal Polyps	☐	☐	☐	Thyroid	☐	☐	☐
Depression	☐	☐	☐	Jaundice	☐	☐	☐	Tuberculosis	☐	☐	☐
Diabetes	☐	☐	☐	Leukemia	☐	☐	☐	Whooping Cough	☐	☐	☐
Dialysis	☐	☐	☐	Measles	☐	☐	☐	Other	☐	☐	☐
Emphysema	☐	☐	☐	Migraine	☐	☐	☐				
Epilepsy	☐	☐	☐								

OPERATIONS: List and indicate approximate year.

SERIOUS INJURIES: (Other than the above)
List injuries and give approximate dates.

HOSPITALIZATIONS: (Other than operations, **especially in the last year)**

MEDICATIONS:

Do you take any of the following:

- ☐ Asthma wheezing medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol or similar products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough medicine
- ☐ Digitalis or heart medicine
- ☐ Hormones
- ☐ Insulin or diabetic pills
- ☐ Anemia medicine
- ☐ Laxatives
- ☐ Motrin, Advil
- ☐ Sleeping Pills/Tranquilizers
- ☐ Thyroid medicine
- ☐ Stomach/digestive medicine
- ☐ Weight-reducing pills
- ☐ Blood thinners or Coumadin
- ☐ Dilantin
- ☐ Water pills, diuretics
- ☐ Antibiotics
- ☐ Phenobarbital/barbituates
- ☐ Vitamins
- ☐ Other prescription or over the counter drugs

List each drug, its amount, and how often you take it.

Are you allergic to any medications? Yes ☐ No ☐
If yes, please list medications and the reaction you had with them:

PLEASE BRING ALL MEDICINES YOU ARE TAKING TO EVERY VISIT!

PATIENT NAME_____ DATE_____

Do you have any health complaints that are especially important to you today?

*Please check **YES** to the following question **ONLY** if the problem is of significant concern in the recent past (1 month) or unless the question specifically states "**EVER**".*

REVIEW OF SYSTEMS:

	Yes	No
1. GENERAL:		
Do you usually feel persistently tired or worn out?	☐	☐
Have you recently been drinking more waters or fluids?	☐	☐
Has there been any unusual weight gain or loss recently?	☐	☐
2. CARDIOVASCULAR:		
Do you have pain, tightness or pressure in the front or back of your chest?	☐	☐
Have you been told your electrocardiogram was abnormal?	☐	☐
Do you have any swelling of your feet or ankles?	☐	☐
Does your heart ever beat fast or irregularly?	☐	☐
Do you have cramps in the calf muscles when you walk?	☐	☐
Do your fingers or toes ever get cold, become numb, or get very white or bluish?	☐	☐
3. CENTRAL NERVOUS SYSTEM:		
Do you have frequent or severe headaches?	☐	☐
Do you often have spells of dizziness, faintness or lightheadedness?	☐	☐
Do you sometimes lose the ability to speak?	☐	☐
Have you recently fainted, blacked out, lost consciousness?	☐	☐
Do you have trouble remembering recent events?	☐	☐
Do you ever have convulsions or fits?	☐	☐
Have you ever wanted to commit suicide?	☐	☐
Do you ever hear voices or see people when no one is around?	☐	☐
4. EYES:		
Have you had:		
any pain in your eyes?	☐	☐
glaucoma?	☐	☐
blurry vision?	☐	☐
halo around lights?	☐	☐
change in vision?	☐	☐
cataracts or implants?	☐	☐
Do you wear glasses?	☐	☐
When did you last see an eye doctor?	_____	
5. ENT:		
Do you have:		
any trouble hearing?	☐	☐
ringing or buzzing in your ears?	☐	☐
earaches or discharge from your ears?	☐	☐
drainage down the back of your throat?	☐	☐
frequent or severe nosebleeds?	☐	☐
persistent hoarseness?	☐	☐
bleeding gums?	☐	☐
Do you use a hearing aid?	☐	☐

	Yes	No
6. GASTROINTESTINAL:		
Have you recently had any change in your eating habits?	☐	☐
Have you recently noted any trouble in swallowing?	☐	☐
Do you have a lot of indigestion or heartburn?	☐	☐
Have you ever vomited blood?	☐	☐
Are you bothered with constipation?	☐	☐
Do you have frequent loose stools or diarrhea?	☐	☐
7. SKIN:		
Do you have:		
any change in the color of your skin?	☐	☐
any rashes or itching?	☐	☐
any growths or lumps on your skin?	☐	☐
any sores or wounds that do not heal?	☐	☐
any change in the color or size of warts or moles?	☐	☐
8. GENITOURINARY:		
Do you have:		
burning or pain when you urinate?	☐	☐
to pass water frequently?	☐	☐
to get up at night?	☐	☐
trouble with losing urine when you cough or sneeze?	☐	☐
a problem when dribbling urine?	☐	☐
Have you ever passed blood in your urine?	☐	☐
Have you ever had an operation to prevent pregnancy?	☐	☐
(Vasectomy or sterilization, such as tubal ligation)	☐	☐
MEN: Do you have prostate gland trouble?	☐	☐
Have you had herpes?	☐	☐
9. MUSCULOSKELETAL:		
Do you ever have a problem with back pain?	☐	☐
Does back pain interfere with your work or activities?	☐	☐
Do you have joint pain or stiffness(arthritis)?	☐	☐
Do you have trouble walking or using your hip, knee joints?	☐	☐
10. RESPIRATORY:		
Do you have:		
frequent chest colds or pneumonia?	☐	☐
a constant or bothersome cough?	☐	☐
coughing or blood?	☐	☐
difficulty breathing?	☐	☐
wheezing or whistling in your chest?	☐	☐

11. WOMEN ONLY:

	Yes	No
Did you have any pregnancies?	☐	☐
How many?	_____	
Have you had any lumps in your breast?	☐	☐
Have you had any abnormal bleeding from the vagina in the past year?	☐	☐
Have you passed the menopause or change?	☐	☐
Do you have any prolapse ("falling out") of the vagina or uterus?	☐	☐
Have you had a hysterectomy?	☐	☐
Do you have any vaginal drainage?	☐	☐
Have you had herpes?	☐	☐

LIVING ARRANGEMENTS:

Do you own your home?	☐	☐
Do you rent your home?	☐	☐
Do you live alone?	☐	☐
Do you have a Will?	☐	☐
Do you have a Living Will?	☐	☐
Do you need other legal assistance?	☐	☐

PERSONAL HABITS:

Have you ever smoked tobacco?	☐	☐
Are you a regular smoker now?	☐	☐

Number of cigarettes per day_____ Cigars ☐ Pipe ☐

How long have you been smoking? _____ Years

Check if you regularly drink.

Hard liquor	1-3 oz. per day ☐	Over 3 oz. per day ☐	
Beer	1 bottle per day ☐	2 bottles ☐	3 or more ☐
Wine	1 glass per day ☐	2 glasses ☐	3 or more ☐

Do you drink coffee? ☐ Yes ☐ No 3 or more cups ☐

Do you exercise?
Regulary ☐ Occasionally ☐ Rarely ☐

Have you used any of the following:
Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐
Speed ☐ Other similar substances ☐

LIFESTYLES: (OPTIONAL)

	Yes	No
Are you sexually active?	☐	☐
If yes, please answer the following questions:		
Sexual preference-		
Partner same sex	☐	☐
Partner opposite sex	☐	☐
Partners of both sexes	☐	☐
Do you consistently use contraceptives?	☐	☐

ACTIVITIES OF DAILY LIVING:

Do you use: a cane?	☐	☐
a walker?	☐	☐
a wheelchair?	☐	☐
a hearing aid?	☐	☐
a catheter for urine?	☐	☐
Are these aids in good order?	☐	☐
Do you have a problem using the toilet? (for urination and bowel movement)	☐	☐
Do you drive?	☐	☐
If not, are you dependent on:		
A relative and/or friend?	☐	☐
Public transportation?	☐	☐

OCCUPATIONAL:

Are you presently employed?	☐	☐
Does or did your work involve unusual work, exposure to dust, noise, radioactivity, etc.?	☐	☐
Are you limited at work because of disability?	☐	☐
Are you retired?	☐	☐

Types of work you have done:

_____

_____

SOCIAL HISTORY:

Have you recently lived or traveled outside the U.S.?	☐	☐
Do you eat less than three meals a day?	☐	☐
Do you have special food customs or restrictions?	☐	☐
Do you use any community services now? (VNA, Meals on Wheels, Sr. Citizens Ctrs., Transportation)	☐	☐