

1100 S 56 AVE
HOLLYWOOD, FL 33023

Date:

222 S. Flamingo Rd.
Pembroke Pines, FL 33027

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

First Name	Middle Name / MI	Last Name
_____	_____	_____
Gender:	DOB:	Marital Status:
_____	_____	_____
Previous or referring doctor:	Date of last physical exam:	
_____	_____	

PERSONAL HEALTH HISTORY

Child Illness (check all that apply):

- Measles
- Mumps
- Rubella
- Chickenpox
- Rheumatic Fever
- Polio

Please list Dates for Immunizations you have received.

Tetanus:	Hepatitis:	Influenza:
_____	_____	_____
Pneumonia:	Chickenpox:	MMR (Measles, Mumps, Rbuella)
_____	_____	_____

List any medical problems that other doctors have diagnosed.

Surgeries

Year:	Reason:	Hospital:
_____	_____	_____
Year:	Reason:	Hospital:
_____	_____	_____
Year:	Reason:	Hospital:
_____	_____	_____
Year:	Reason:	Hospital:
_____	_____	_____
Year:	Reason:	Hospital:
_____	_____	_____

Other hospitalizations

Year:	Reason:	Hospital:
_____	_____	_____
Year:	Reason:	Hospital:
_____	_____	_____
Year:	Reason:	Hospital:
_____	_____	_____

Year: _____ Reason: _____ Hospital: _____

Year: _____ Reason: _____ Hospital: _____

Have you ever had a blood transfusion?

Yes No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name of Drug: _____ Strength: _____ Frequency Taken: _____

Name of Drug: _____ Strength: _____ Frequency Taken: _____

Name of Drug: _____ Strength: _____ Frequency Taken: _____

Name of Drug: _____ Strength: _____ Frequency Taken: _____

Name of Drug: _____ Strength: _____ Frequency Taken: _____

Allergies to medications

Name the Drug: _____ Reaction you had: _____ Name the Drug: _____ Reaction you had: _____

Name the Drug: _____ Reaction you had: _____

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise

Frequency:

- Sedentary (No exercise)
- Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
- Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
- Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet

Are you dieting?

- Yes
- No

If yes, are you on a physician prescribed medical diet?

- Yes
- No

of meals you eat in an average day?

Rank salt intake:

- High
- Medium
- Low

Rate fat intake:

- High
- Medium
- Low

Caffeine:

- None
- Coffee
- Tea
- Cola

Number of Cups per day:

Alcohol

Do you drink alcohol?

- Yes
- No

If Yes, what kind?

How many drinks per week?

Are you concerned about the amount you drink?

- Yes
- No

Have you considered stopping?

- Yes
- No

Have you ever experienced blackouts?

- Yes
- No

Are you prone to "binge" drinking?

- Yes
- No

Do you drive after drinking?

- Yes
- No

Tobacco

Patient Smoking Status

Type:

- Cigarettes
- Chew
- Pipe
- Cigar

Patient Smoking Frequency

Number of years or Year quit:

Drugs

Do you currently use recreational or street drugs?

- Yes
- No

Have you ever given yourself street drugs with a needle?

- Yes
- No

Sex

Are you sexually active?

- Yes
- No

If yes, are you trying for a pregnancy?

- Yes
- No

If not trying for a pregnancy list contraceptive or barrier method used:

Any discomfort with intercourse?

- Yes
- No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?

- Yes
- No

Personal Safety

Do you live alone?

- Yes
- No

Do you have frequent falls?

- Yes
- No

Do you have vision or hearing loss?

- Yes
- No

Do you have an Advance Directive and/or Living Will?

- Yes
- No

Would you like information on the preparation of these/

- Yes
- No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?

- Yes
- No

FAMILY HEALTH HISTORY

Father:

Mother:

Brother(s):

Sister(s):

Children - Boys:

Children - Girls:

Grandmother (Maternal):

Grandfather (Maternal):

Grandmother (Paternal):

Grandfather (Paternal):

MENTAL HEALTH

Is stress a major problem for you?

Yes No

Do you have problems with eating or your appetite?

Yes No

Have you ever seriously thought about hurting yourself?

Yes No

Do you feel depressed?

Yes No

Do you cry frequently?

Yes No

Do you have trouble sleeping?

Yes No

Do you panic when stressed?

Yes No

Have you ever attempted suicide?

Yes No

Have you ever been to a counselor?

Yes No

WOMEN ONLY

Age at onset of menstruation:

Date of last menstruation:

of days between periods (average):

Heavy periods, irregularity, spotting, pain, or discharge?

Yes No

Number of pregnancies:

Number of live births:

Are you pregnant or breast feeding?

Yes No

Have you had a D&C, hysterectomy, or Cesarean?

Yes No

Any urinary tract, bladder, or kidney infections within the last year?

Yes No

Any blood in your urine?

Yes No

Any problems with control of urination?

Yes No

Any hot flashes or sweating at Night?

Yes No

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?

Yes No

Experienced any recent breast tenderness, lumps, or nipple discharge?

Yes No

Date of last pap and rectal exam?

MEN ONLY

Do you usually get up to urinate during the night?

Yes No

If yes, # of times:

Do you feel pain or burning with urination?

Yes No

Is there blood in your urine?

Yes No

Do you feel burning discharge from penis?

Yes No

Has the force of your urination decreased?

Yes No

Have you had any kidney, bladder, or prostate infections within the last 12 months?

Yes No

Do you have any problems emptying your bladder completely?

Yes No

Any difficulty with erection or ejaculation?

Yes No

Any testicle pain or swelling?

Yes No

Date of last prostate and rectal exam?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

- Skin
- Chest/Heart
- Head/Neck
- Back
- Ears
- Intestinal
- Nose
- bladder
- Throat
- Bowel
- Lungs
- Circulation

Recent changes in:

- Weight
- Energy level
- Ability to sleep

Other pain/discomfort:

FLORIDA Advance Directive Planning for Important Health Care Decisions

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
 - o Instructions for preparing your advance directive, please read all the instructions.
 - o Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
3. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

Introduction to Your Florida Advance Directive

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete Part One, Part Two, or both, depending on your advance planning needs. You must complete Part Three.

Part One. The **Florida Designation of Health Care Surrogate** lets you name a competent adult to make decisions about your medical care, including decisions about life-prolonging procedures, if you can no longer speak for yourself. The designation of health care surrogate is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your health care surrogate's powers go into effect when your doctor determines that you are physically or mentally unable to communicate a willful and knowing health care decision.

Part Two. The **Florida Living Will** lets you state your wishes about health care in the event that you are in a persistent vegetative state, have an end-stage condition or develop a terminal condition. Your living will goes into effect when your physician determines that you have one of these conditions and can no longer make your own health care decisions.

Your living will also allows you to express your organ donation wishes.

Part Three contains the signature and witness provisions so that your document will be effective.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs. However, unless your Designation of Health Care Surrogate expressly states otherwise, your health care surrogate presumptively may make health care decisions regarding mental health treatment.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Completing Your Florida Advance Directive

Whom should I appoint as my surrogate?

Your surrogate is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your surrogate may be a family member or a close friend whom you trust to make serious decisions. The person you name as your surrogate should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate surrogate. The alternate will step in if the first person you name as a surrogate is unable, unwilling, or unavailable to act for you.

How do I make my Florida Advance Directive legal?

The law requires that you sign your Advance Directive in the presence of two adult witnesses, who must also sign the document. If you are physically unable to sign, you may have someone sign for you in your presence and at your direction and in the presence of your two witnesses.

Your surrogate and alternate surrogate cannot act as witnesses to this document. At least one of your witnesses must not be your spouse or a blood relative.

Note: You do not need to notarize your Florida Advance Directive.

Should I add personal instructions to my Florida Advance Directive?

One of the strongest reasons for naming a surrogate is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your surrogate carry out your wishes, but be careful that you do not unintentionally restrict your surrogate's power to act in your best interest. In any event, be sure to talk with your surrogate about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You can always revoke your Florida Advance Directive. State law permits you to revoke your document in the following ways:

1. through a signed and dated writing showing your intent to revoke;
2. by physically destroying the original, or having someone destroy it for you in your presence at your direction;
3. by orally expressing your intent to revoke; or
4. by executing a new Advance Directive that supersedes the older document.

You should notify your health care provider and surrogate(s) to ensure that your revocation is effective.

If you name your spouse as your surrogate and you are divorced or your marriage is subsequently annulled, your spouse's powers as surrogate will be automatically revoked. If you would like your spouse's powers to continue in the event of a divorce or annulment, you can state this in the "Additional Instructions" section on page 2 of the form by adding an instruction such as, "The authority of my surrogate shall not be revoked by divorce or annulment of our marriage."

What other facts should I know?

If you would like to give your surrogate the authority to refuse life-prolonging treatment for you in the event that you become terminally ill and incompetent while you are pregnant, you must add an instruction such as, "My surrogate has the authority to order the withholding or withdrawal of life-prolonging treatment, even if I am pregnant," under the "Additional Instructions" section on page 2 of the form.

Also, unless you expressly state otherwise under the "Additional Instructions" section, your health care surrogate, if you appoint one, does not have authority to authorize abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments, or voluntary admission to a mental health facility.

Part One. Designation of Health Care Surrogate

First Name _____ **Middle Name / MI** _____ **Last 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 of Surrogate _____ **Phone Number** _____

Address of Surrogate _____ **City/State/Zip** _____

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

Name of Alternate Surrogate	Phone Number
_____	_____
Address of Alternate Surrogate	City/State/Zip
_____	_____

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; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

Additional instructions (optional)

Part Two. Declaration

Today's Date

I, the patient, 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 incapacitated and

Select any that apply

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

Initial

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.

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.

My failure to designate a health care surrogate in Part One shall not invalidate this declaration.

ORGAN DONATION (OPTIONAL)

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (select one choice below):

- any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;
- only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education (listed below)
- my body for anatomical study if needed. Limitations or special wishes, if any listed below
- I have already arranged to donate

I give only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education

Limitations or special wishes I put on my body for anatomical study if needed

Initials

If I have already arranged to donate selected

- I donate any needed organs, tissues, or eyes,
- I donate the following specified organs, tissues, or eyes

Specified organs, tissues, or eyes

Name of Donee	Phone Number
_____	_____

Donee Address _____

City/State/Zip _____

Part Three. Execution

I, the patient, understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Dated _____

Signed

Witness 1:
Signed

Address of Witness 1 _____ City/State/Zip _____

Witness 2:
Signed

Address of Witness 2 _____ City/State/Zip _____

(Optional) 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	Address	City/State/Zip
_____	_____	_____
_____	_____	_____

You Have Filled Out Your Health Care Directive, Now What?

1. Your Florida Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your surrogate and alternate surrogate, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your surrogate(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Florida document.
7. Be aware that your Florida document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Patient Stress Questionnaire*

Date

First Name

Middle Name / MI

Last Name

Date of Birth

Over the last two weeks, how often have you been bothered by any of the following problems?

(Please select your answer & check the boxes that apply to you)

1. Little interest or pleasure in doing things

- 0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

2. Feeling down, depressed, or hopeless

- 0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

3.

—

- Trouble falling or staying asleep, or
 Sleeping to much

- 0 - Not at all 1 - Several days
 2 - More than half the days
 3 - Nearly Every day

4. Feeling tired or having little energy

- 0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

5.

—

- Poor appetite or
 overeating

- 0 - Not at all 1 - Several days
 2 - More than half the days
 3 - Nearly Every day

- 0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

- 0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

8.

—

- Moving or speaking so slowly that other
people could have noticed, or
 the opposite - being so fidgety or restless
that you've been moving around a lot
more than usual

- 0 - Not at all 1 - Several days
 2 - More than half the days
 3 - Nearly Every day

9.

—

- Thoughts that you would be better off
dead, or
 hurting yourself in some way

- 0 - Not at all 1 - Several days
 2 - More than half the days
 3 - Nearly Every day

Total Score

1. Feeling nervous, anxious or on edge

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

2. Not being able to stop or control worrying

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

3. Worrying too much about different things

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

4. Trouble relaxing

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

5. Being so restless that it is hard to sit still

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

6. Becoming easily annoyed or irritable

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

7. Feeling afraid as if something awful might happen

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

Total Score

Are you currently in any physical pain?

No Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. have had nightmares about it or thought about it when you did not want to?

No Yes

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

No Yes

3. Were constantly on guard, watchful, or easily startled?

No Yes

4. Felt numb or detached from others, activities, or your surroundings?

No Yes

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

These questions are about your drinking habits. We've listed the serving size of one drink below.

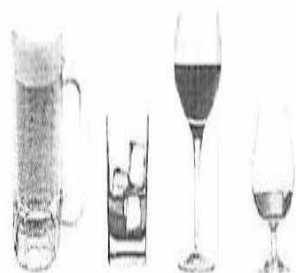
Standard serving of one drink:

12 ounces of beer or wine cooler

1.5 ounces of 80 proof liquor

5 ounces of wine

4 ounces of brandy, liqueur or aperitif



How often do you have one drink containing alcohol?

0 - Never 1 - Monthly or less 2 - 2-4 times a month 3 - 2-3 times a week 4 - 4+ times per week

How many drinks containing alcohol do you have on a typical day when you are drinking?

- 0 - 1 or 2 1 - 3 or 4 2 - 5 or 6 3 - 7 to 9 4 - 10 or more

How often do you have four or more drinks on one occasion?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

How often during the **last year** have you...

... found that you were not able to stop drinking once you had started?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... failed to do what was normally expected from you because of drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... needed a first drink in the morning to get yourself going after heavy drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... had a feeling of guilt or remorse after drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... been unable to remember what happened the night before because you had been drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

Have you or someone else been injured as a result of your drinking?

- 0 - No 1 - Yes, but not in the last year 3 - Yes, during the last year

Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- 0 - No 1 - Yes, but not in the last year 3 - Yes, during the last year

FINANCIAL AGREEMENT

CLEOPATRA GORDON-PUSEY, MD

Life is Beautiful

1100 S 56 Ave, Hollywood, FL 33023

222 S. Flamingo Rd. Pembroke Pines, FL 33027

Telephone: (954) 392-9026, (954) 392 9025

Fax: (954) 357-2353

lifeisbeautifulmd@gmail.com

First Name

Middle Name / MI

Last Name

I, the above named person, acknowledge that payment is due at time of treatment, unless other arrangements are made. I agree that parents, guardians or person representatives are responsible for all fees and services rendered for treatment of minor/child. I accept full financial responsibility for all charges for services or items provided to me, to minor/child, or to the patient for whom, I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

Signature of Patient, Guardian or Personal Representative:

Date:

**Name of Patient, Guardian or
Personal Representative:**

Date:

1100 S 56 AVE
HOLLYWOOD, FL 33023

222 S. Flamingo Rd.
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Health Care Advance Directives

The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A- 4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

Questions About Health Care Advance Directives

What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Which is best?

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

What is an anatomical donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

Where can I find advance directive forms?

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

More Information On Health Care Advance Directives

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.

When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or www.med.ufl.edu/anatbd.

- If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your health care provider.

- Various organizations also make advance directive forms available. One such document is "Five Wishes" that includes a living will and a health care surrogate designation. "Five Wishes" gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity

www.AgingWithDignity.org

(888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)

www.aarp.org (Type "advance directives" in the website's search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues

www.FloridaHealthFinder.gov

(888) 419-3456

ATTENTION!

TO OUR PATIENTS:

PLEASE NOTE THAT CO-PAYMENTS
AND PLAN DEDUCTIBLES
ARE DUE AT THE TIME SERVICES ARE RENDERED.

THANK YOU.

Note: \$25.00 missed appt fee

DATE

SIGNATURE

--

CLEOPATRA GORDON-PUSEY, M.D.

1100 S 56 AVE
HOLLYWOOD, FL 33023
Phone: (954)-392-9026 Fax: (954)-357-2353
E-mail: lifeisbeautifulmd@gmail.com

Medication Form

First Name	Middle Name / MI	Last Name	
_____	_____	_____	
Date of Birth	Diagnosis:	Allergy:	
_____	_____	_____	
MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES
_____	_____	_____	_____
MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES
_____	_____	_____	_____
MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES
_____	_____	_____	_____
MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES
_____	_____	_____	_____
MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES
_____	_____	_____	_____
MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES
_____	_____	_____	_____
MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES
_____	_____	_____	_____

Date

Dr. Cleopatra Gordon-Pusey
700 North Hiatus Rd Suite # 213
Pembroke Pines, FL 33026

(954) 392 9026

1100 S 56 AVE
HOLLYWOOD, FL 33023
222 S. Flamingo Rd.
Pembroke Pines, FL 33027

New Patient Annual Physical Exam

General Information

Date

First Name

Middle Name / MI

Last Name

Date of Birth

Age

Sex

Allergies:

Medications:

Chief Complaint:

HPI:

Past Medical/Surgical History:

Family History:

Social History:

Marital Status

Patient Smoking Status

Alcohol:

Drugs:

Religion:

Review of Systems

General

Appetite

- Abnormal
 Normal

Weakness

- Abnormal
 Normal

Fever

- Abnormal
 Normal

Malaise

- Abnormal
 Normal

Chills

- Abnormal
 Normal

Wt loss

- Abnormal
 Normal

Wt gain

- Abnormal
 Normal

Fatigue

- Abnormal
 Normal

ENT

Ear pain R

- Abnormal
 Normal

Ear pain L

- Abnormal
 Normal

Hearing

- Abnormal
 Normal

Tinnitus

- Abnormal
 Normal

Epistaxis

- Abnormal
- Normal

Eyes

Redness

- Abnormal
- Normal

Cardio

Chest pain

- Abnormal
- Normal

Pulm

SOB

- Abnormal
- Normal

Hemoptysis

- Abnormal
- Normal

GI

Abd. Pain

- Abnormal
- Normal

Melena

- Abnormal
- Normal

GU

Hematuria

- Abnormal
- Normal

GYN

G

- Abnormal
- Normal

Musculo

Back pain

- Abnormal
- Normal

Sore throat

- Abnormal
- Normal

Discharge

- Abnormal
- Normal

Palpitations

- Abnormal
- Normal

Non-prod cough

- Abnormal
- Normal

N/V

- Abnormal
- Normal

Hematochezia

- Abnormal
- Normal

Dysuria

- Abnormal
- Normal

P

- Abnormal
- Normal

Neck pain

- Abnormal
- Normal

Pain

- Abnormal
- Normal

PND

- Abnormal
- Normal

prod Cough

- Abnormal
- Normal

Constipation

- Abnormal
- Normal

Freq

- Abnormal
- Normal

LMP

- Abnormal
- Normal

Calf pain

- Abnormal
- Normal

Blurry Vision

- Abnormal
- Normal

Diaphoresis

- Abnormal
- Normal

Wheezing

- Abnormal
- Normal

Diarrhea

- Abnormal
- Normal

Vag Disch/bleed

- Abnormal
- Normal

Arthralgia

- Abnormal
- Normal

Myalgia

- Abnormal
- Normal

Skin

Immune Dz

- Abnormal
- Normal

Swelling

- Abnormal
- Normal

Neuro

LOC

- Abnormal
- Normal

Paresis

- Abnormal
- Normal

Psych

Suicidal

- Abnormal
- Normal

Endo

Weight gain

- Abnormal
- Normal

Heme

Bruising

- Abnormal
- Normal

Swelling

- Abnormal
- Normal

Itching

- Abnormal
- Normal

Confusion

- Abnormal
- Normal

Homicidal

- Abnormal
- Normal

Weight loss

- Abnormal
- Normal

Anemia

- Abnormal
- Normal

Rash

- Abnormal
- Normal

Headache

- Abnormal
- Normal

Change in mental status

- Abnormal
- Normal

Cold intolerance

- Abnormal
- Normal

Bleeding disorder

- Abnormal
- Normal

Dryness

- Abnormal
- Normal

Dizziness

- Abnormal
- Normal

Prior Psych Hx

- Abnormal
- Normal

Heat intolerance

- Abnormal
- Normal

Patient Demographics

Date:

_____	_____	_____	_____
Last Name	First Name	Middle Name / MI	Name Suffix
_____	_____	_____	_____
Date of Birth	Social Security Number	Professional Title	
_____	_____	_____	
Allergies:			

Home Phone	Cell Phone	Work Phone	
_____	_____	_____	
Patient Fax	Email		
_____	_____		
Patient Address Line 1	Patient Address Line 2		
_____	_____		
City	State	Zip	
_____	_____	_____	
Referred by:	Race	Ethnicity	Religion:
_____	_____	_____	_____
Marital Status	Education:	Language	
_____	_____	_____	

EMERGENCY CONTACT/NEXT OF KIN:

_____	_____	_____
Emergency Contact Name	Emergency Contact Address Line 1	Emergency Contact Address Line 2
_____	_____	_____
Emergency Contact City	Emergency Contact State	Emergency Contact Zip
_____	_____	_____
Emergency Contact Home Phone	Emergency Contact Cell Phone	
_____	_____	

Patient Health Questionnaire (PHQ-9)

Important Notice: The information gathered on this questionnaire will remain confidential.

First Name

Last Name

Date of Birth

Visit Date

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

1. Little interest or pleasure in doing things

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

2. Feeling down, depressed, or hopeless

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

3. Trouble falling or staying asleep, or sleeping too much

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

4. Feeling tired or having little energy

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

5. Poor appetite or overeating

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way

- 0 - Not at all
- 1 - Several days
- 2 - More than half the days
- 3 - Nearly every day

For Office Coding:

Total Score of 1's

+ Total Score of 2's

+ Total Score of 3's

= Total Overall Score

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

Patient Stress Questionnaire*

Date

First Name

Middle Name / MI

Last Name

Date of Birth

Over the last two weeks, how often have you been bothered by any of the following problems?

(Please select your answer & check the boxes that apply to you)

1. Little interest or pleasure in doing things

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

2. Feeling down, depressed, or hopeless

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

3.

—

Trouble falling or staying asleep, or

0 - Not at all 1 - Several days

Sleeping to much

2 - More than half the days

3 - Nearly Every day

4. Feeling tired or having little energy

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

5.

—

Poor appetite or

0 - Not at all 1 - Several days

overeating

2 - More than half the days

3 - Nearly Every day

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

8.

—

Moving or speaking so slowly that other people could have noticed, or

0 - Not at all 1 - Several days

the opposite - being so fidgety or restless that you've been moving around a lot more than usual

2 - More than half the days

3 - Nearly Every day

9.

—

Thoughts that you would be better off dead, or

0 - Not at all 1 - Several days

hurting yourself in some way

2 - More than half the days

3 - Nearly Every day

Total Score

1. Feeling nervous, anxious or on edge

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

2. Not being able to stop or control worrying

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

3. Worrying too much about different things

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

4. Trouble relaxing

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

5. Being so restless that it is hard to sit still

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

6. Becoming easily annoyed or irritable

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

7. Feeling afraid as if something awful might happen

0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly Every day

Total Score

Are you currently in any physical pain?

No Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. have had nightmares about it or thought about it when you did not want to?

No Yes

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

No Yes

3. Were constantly on guard, watchful, or easily startled?

No Yes

4. Felt numb or detached from others, activities, or your surroundings?

No Yes

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking.

These questions are about your drinking habits. We've listed the serving size of one drink below.

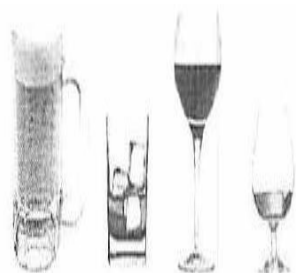
Standard serving of one drink:

12 ounces of beer or wine cooler

1.5 ounces of 80 proof liquor

5 ounces of wine

4 ounces of brandy, liqueur or aperitif



How often do you have one drink containing alcohol?

0 - Never 1 - Monthly or less 2 - 2-4 times a month 3 - 2-3 times a week 4 - 4+ times per week

How many drinks containing alcohol do you have on a typical day when you are drinking?

- 0 - 1 or 2 1 - 3 or 4 2 - 5 or 6 3 - 7 to 9 4 - 10 or more

How often do you have four or more drinks on one occasion?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

How often during the **last year** have you...

... found that you were not able to stop drinking once you had started?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... failed to do what was normally expected from you because of drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... needed a first drink in the morning to get yourself going after heavy drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... had a feeling of guilt or remorse after drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

... been unable to remember what happened the night before because you had been drinking?

- 0 - Never 1 - Less than monthly 2 - Monthly 3 - Weekly 4 - Daily or almost daily

Have you or someone else been injured as a result of your drinking?

- 0 - No 1 - Yes, but not in the last year 3 - Yes, during the last year

Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- 0 - No 1 - Yes, but not in the last year 3 - Yes, during the last year

Quality of Life Questionnaire

First Name	Middle Name / MI	Last Name	Date of Birth
_____	_____	_____	_____

1. Have you ever been diagnosed with Allergies?

- Yes No

2. Are you currently taking or have taken within the last year any over-the-counter medication or have prescribed prescription strength medications for allergies, hay fever, or nasal congestions?

- Yes No

If yes, please list all that apply

3. Have you ever been diagnosed with asthma?

- Yes No

4. Is your doctor currently treating your asthma with medications?

- Yes No

If yes, please list all that apply

5. Please check any/all of the following symptoms that you experience more than three times in a month or for more than three consecutive months. Please note that in the case of seasonal allergies, you may not be experiencing these now, but may experience them regularly during a different season of the year. Please select all that apply:

- Stuffy Nose
- Runny Nose
- Nasal Congestion
- Itchy Eyes
- Watery Eyes
- Itchy Throat
- Sore Throat
- Cough
- Post Nasal Drip
- Headaches
- Trouble Sleeping
- Fatigue

1100 S 56 AVE
HOLLYWOOD, FL 33023

222 S. Flamingo Rd.
Pembroke Pines, FL 33027

Cleopatra Gordon-Pusey, M.D., P.A.

REGISTRATION FORM

Today's Date:

PCP:

Patient Information

Last Name	First Name	Middle Name / MI	Name Suffix
_____	_____	_____	_____
Marital Status	Is this your legal name?	If not, what is your legal name?	(Former Name)
_____	<input type="radio"/> Yes <input type="radio"/> No	_____	_____
Date of Birth	Age:	Sex	
_____	_____	_____	
Patient Address Line 1	Patient Address Line 2		
_____	_____		
City	State	Zip	
_____	_____	_____	
P.O. Box:	City	State	Zip
_____	_____	_____	_____
Social Security Number	Home Phone		
_____	_____		
Professional Title	Employer Name	Employer Phone	
_____	_____	_____	

Chose clinic because/referred to clinic by (Please check one box):
 Dr. Insurance Plan Hospital Family Friend Close to Home/Work Yellow Pages Other

Other: _____
Other family members seen here: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth Date:	Home Phone:	Is this person a patient here?
_____	_____	_____	<input type="radio"/> Yes <input type="radio"/> No
Address (If different):	Address (If different) Cont.		
_____	_____		
Occupation:	Employer:	Employer Address:	Employer Phone:
_____	_____	_____	_____
Is this patient covered by insurance?	Primary Insurance Name	Subscriber Name:	Subscribers SSN#:
<input type="radio"/> Yes <input type="radio"/> No	_____	_____	_____
Birth Date:	Primary Group No.	Primary Subscriber ID	Co-Pay:
_____	_____	_____	_____
Primary Relationship to Insured			

IN CASE OF EMERGENCY

Emergency Contact Name	Emergency Contact Relationship to Patient	Emergency Contact Home Phone	Emergency Contact Work Phone
_____	_____	_____	_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this practice or insurance company to release any information required to process my claims.

Signature:

Date:
