NEW PATIENT *Forms*

The Villages Health

www.TheVillagesHealth.com

Please do not complete these forms before scheduling an appointment.
If you would like to schedule an appointment, please call ***352-205-4032****.*

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The Villages Health

NOTICE OF PRIVACY PRACTICES

At The Villages Health, we are committed to handle and use your protected health information with care. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected personal health information (PHI). This Notice is effective August 2018, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

A record of your visit is made each time you visit The Villages Health. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A tool we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others. You have a right to receive notification of breaches of unsecured protected health information.

Your Health Information Rights

Although your health record is the physical property of The Villages Health, the information belongs to you.

You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction of PHI regarding care and services you pay for out-of-pocket (in writing)
- Request a copy of your health record in an electronic format if applicable
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken

Our Responsibilities

The Villages Health System is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you following a breach of unsecured PHI
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Required Authorization

A written authorization is required from you for:

- Disclosure of psychotherapy notes
- Use of PHI in marketing
- Sales of PHI

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Practice's Privacy Officer at (352) 674-8905.

If you believe your privacy rights have been violated, you can file a complaint with the Practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201.

Examples of Disclosures for Treatment, Payment and Health Operations (TPO)

We will use your health information for treatment.

KEEP THIS PAGE

For example, information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment.
For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example, members of the medical staff, the risk or quality improvement manager or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates
There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification
We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication from Offices
We may call your home or other designated location and leave a message on voice mail or in person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to your clinical care. We may mail to your home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked Personal and Confidential. We may e-mail to your home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

Communication with Family
Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Open Treatment Areas
Sometimes patient care is provided in an open treatment area. While special care is taken to maintain patient privacy, some patient information may be overheard by others while receiving treatment. Should you be uncomfortable with this, please bring this to the attention of our privacy officer.

Research
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors
We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ Procurement Organizations
Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Marketing
We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA)
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.

Workers' Compensation

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

KEEP THIS PAGE

Patient Financial Responsibility
I understand that in consideration of the services provided, I am directly and primarily responsible to pay for services and procedures rendered at **The Villages Health** and I am responsible for any applicable deductible or co-payments.

The Villages Health will file a claim for payment with my insurance company (if applicable) as required by contractual agreement. If the insurance company fails to pay for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to **The Villages Health**.

Responsibility to Provide Proof of Insurance
I understand that it is my responsibility to provide **The Villages Health** with a copy of my current insurance card. I will notify **The Villages Health** immediately upon any change in my insurance.

Insurance Waiver and Non-Covered Services Waiver
There may be a service I desire, suggested or provided that is not covered under my insurance plan ("Non-Covered Services"). I understand I must pay for "Non-Covered" services. If feasible, a waiver will be completed for each "Non-Covered Service."

Additional Information
The Villages Health accepts payments in: Cash, Check and Credit Cards. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to **The Villages Health**, and send to **The Villages Health**.

Previous Medical Records
Your completion of the new patient form is the most efficient and accurate way of obtaining the medical information your new physician needs in order to provide you with the best care possible.

Please do not forward outside medical records in advance of your first appointment.

After meeting with you and reviewing the information you provide in this new patient form, your physician will help determine if more detailed information is needed from outside medical records.

Health Information Exchange
The Villages Health may participate in a Health Information Exchange (HIE) to facilitate access to and retrieval of clinical data between medical organizations within the community and the hospital system. The goal of the HIE is to provide safer and more timely, efficient, effective and equitable patient-centered care. If you **do not** wish to have your information included in the HIE, you must opt out by completing the Restriction to Release of PHI (Protected Health Information) form available at your Care Center.

KEEP THIS PAGE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND COMPLIANCE WITH HIPAA STANDARDS

Notice to Patient

We are required to provide you with a copy of our Notice of Privacy Practices (pages 2 and 3), which states how we may use and/or disclose your health information. Your signature on this form is to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I authorize The Villages Health to leave medical information pertaining to my care by the following methods:

Home Telephone	☐ Yes	☐ No	☐ OK to leave voice mail?	**SMS/Text**	☐ Yes	☐ No
Work Telephone	☐ Yes	☐ No	☐ OK to leave voice mail?	**E-mail**	☐ Yes	☐ No
Cell Phone	☐ Yes	☐ No	☐ OK to leave voice mail?			

I authorize The Villages Health, and hospitals where I may be a patient, to leave medical information pertaining to my care with the following people:

Spouse ☐ Yes ☐ No _____ ( ) _____
PRINT SPOUSE'S NAME — SPOUSE'S PHONE NUMBER

Other _____ _____ ( ) _____
PRINT NAME — RELATIONSHIP TO PATIENT — PHONE NUMBER

Other _____ _____ ( ) _____
PRINT NAME — RELATIONSHIP TO PATIENT — PHONE NUMBER

Other _____ _____ ( ) _____
PRINT NAME — RELATIONSHIP TO PATIENT — PHONE NUMBER

I acknowledge that I have been offered and/or received a copy of this office's Notice of Privacy Practices. I understand that at the discretion of The Villages Health I may be asked to update this information periodically.

SIGN HERE **Patient's Signature** _____ _____
PRINT NAME

SIGN HERE **Guardian/Power of Attorney Signature** _____

Date ____/____/____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this Patient. It could not be obtained because:

☐ The Patient refused to sign. ☐ Due to an emergency situation it was not possible. ☐ We could not communicate with the Patient.

☐ Other. Explain _____

_____ _____ _____
EMPLOYEE'S PRINTED NAME — EMPLOYEE SIGNATURE — DATE

INSURANCE ASSIGNMENT AUTHORIZATION TO RELEASE INFORMATION

Release of Information

I, the below named patient, do hereby authorize any physician examining and/or treating me to release to any third party payer (such as UnitedHealthcare or Blue Cross) any medical and psychiatric information and records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment. I specifically consent to the release of any material in your possession, including, if any exists, results of HIV (AIDS) tests, and any that might address chemical dependence, depression or other psycho-emotional issues.

Physician Insurance Assignment

I, the below named subscriber, hereby authorize payment directly to any physician examining or treating me of any group and/or individual surgical and/or medical benefits herein specified and otherwise payable to me for their services as described, but not to exceed the reasonable and customary charge for these services.

Medicare — Patient's Certification/Authorization to Release Information and Payment Request

I certify that the information given by me in applying for payment under title XVII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to Social Security Administration Division of Family Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I hereby certify all insurance pertaining to the treatment shall be assigned to the physician treating me.

I permit a copy of these authorizations and assignments to be used in place of the original, which is on file at The Villages Health Care Center's office.

I understand and agree with the financial responsibilities and health information exchange outlined on page 4.

By signing, I acknowledge understanding the above patient information.

Patient's Name

FIRST NAME _____ MI _____ LAST NAME _____

PATIENT'S DATE OF BIRTH _____ – _____ – _____
MONTH DAY YEAR

SIGN HERE **Patient's Signature** _____ **Date** _____

SIGN HERE **Guardian/Power of Attorney Signature** _____

Person responsible for payment if different than above

Please sign as self if you are the responsible party. If not, please have responsible party sign, such as parent, guardian, etc.

FIRST NAME _____ MI _____ LAST NAME _____

PATIENT'S DATE OF BIRTH _____ – _____ – _____ DRIVER'S LICENSE# _____
MONTH DAY YEAR

RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGN HERE **Responsible Party's Signature** _____

PATIENT DEMOGRAPHIC INFORMATION

FIRST NAME _____ MI _____ LAST NAME _____

PATIENT'S DATE OF BIRTH _____ – _____ – _____ SOCIAL SECURITY NUMBER _____ – _____ – _____
MONTH DAY YEAR

SEX ☐ FEMALE ☐ MALE MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ SEPARATED

PERMANENT/MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHAT VILLAGE DO YOU LIVE IN? _____ VILLAGE ID# _____

HOME PHONE ( ) _____ CELL PHONE ( ) _____

E-MAIL _____

SEASONAL ADDRESS _____ CITY, STATE _____ ZIP _____ HOW MANY MONTHS? _____ WHEN? _____

WORK STATUS ☐ STILL WORKING CURRENT OCCUPATION _____

☐ RETIRED ☐ DISABLED FORMER OCCUPATION _____

RACE ☐ WHITE ☐ BLACK/AFRICAN AMERICAN ☐ HISPANIC ☐ OTHER _____ ☐ DECLINE TO ANSWER

ETHNICITY ☐ HISPANIC/LATIN ☐ NOT HISPANIC/LATIN ☐ DECLINE TO ANSWER PREFERRED LANGUAGE _____

EMERGENCY CONTACT _____ TELEPHONE ( ) _____

RELATIONSHIP TO PATIENT _____ CELL PHONE? ☐ YES ☐ NO TEXT ENABLED? ☐ YES ☐ NO

INSURANCE INFORMATION

Primary Insurance

REQUIRED INFORMATION: PLEASE NOTE: Insurance is considered a method of reimbursing the member for fees paid by you to the doctor and is not a substitute for payment - unless our office is a provider for your insurance company.

POLICY HOLDER'S FIRST NAME _____ MI _____

POLICY HOLDER'S LAST NAME _____

PATIENT'S DATE OF BIRTH _____ – _____ – _____ INSURANCE COMPANY _____
MONTH DAY YEAR

POLICY/ID # _____ GROUP NAME _____

Prescription Drug Coverage? ☐ YES ☐ NO If Yes, Plan Name _____

Do you have Medicare Part D? ☐ YES ☐ NO If Yes, Plan Name _____

Secondary Insurance

POLICY HOLDER'S FIRST NAME _____ MI _____

POLICY HOLDER'S LAST NAME _____

INSURANCE CO. _____ POLICY/ID # _____ GROUP NAME _____

All co-pays, coinsurance, and deductibles are expected to be paid in full at the time of your visit. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and/or cost of collection. If this account is assigned to a collection agency, an administrative fee will be applied. I understand that an 18% interest rate will be applied to any and all accounts that are 30 days or more past due.

SIGN HERE **Patient's Signature** _____ **Date** _____

SIGN HERE **Guardian/Power of Attorney Signature** _____

CONSENT TO OBTAIN PRESCRIPTION HISTORY

I authorize The Villages Health and its affiliated providers to view my external prescription history via the RX History service. I understand that my history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff of TVH, and it may include prescriptions back in time for several years. My signature certifies that I have read and understand the scope of my consent and I authorize access.

SIGN HERE **Patient's Signature** _____ **Date** _____

Pharmacy Information/Local Pharmacy
Please, **PRINT** all information requested below.

Name _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ or Fax Number _____

Is this the primary pharmacy you want our office to use? ☐ Yes ☐ No

Mail Order Pharmacy

Name _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ or Fax Number _____

Is this the primary pharmacy you want our office to use? ☐ Yes ☐ No

MEDICATION INFORMATION

Note: Please bring **ALL** medications you are currently using (in their original containers) to your **FIRST** appointment.

Current Prescription Medications
This may include ointments, creams, inhalers or any items for which you would need a prescription. This may include items that are used only rarely.

Name	Strength [Formulation]	Frequency	Refill required in the next 90 days?		
				Supply	**Supply**
Example: Lisinopril	*10 mg [tablets]*	*Once daily*	☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day
			☐ No	☐ 90 day	☐ 30 day

Current Non-Prescription Medications

Name	Strength [Formulation]	Frequency	Purpose
Example: Advil	*200 mg [capsules]*	*1 capsule every 6 hours*	*Headaches*

Current Supplements

Name	Strength [Formulation]	Frequency	Purpose
Example: Fish Oil	*500 mg [tablets]*	*1 tablet twice daily*	*Heart Health*

Discontinued Medications

It would be helpful for us to know of any medication you have previously used that has been stopped for any reason, besides those you have listed under the "allergies/intolerances" section above, such as those that may have been ineffective, or simply no longer needed.

Name	Reason Discontinued
Example: Lisinopril	*My ankles became swollen*

Medical Supplies I Use

These are items for which you may need a prescription, such as diabetic shoes, oxygen, prosthetics, etc.

Name	Purpose
Example: Insulin Syringes	*To take insulin for diabetes*

Allergies/Intolerances

Type of Medication	Type of Reaction
Example: Penicillin	*Rash*

PAST MEDICAL HISTORY

Please complete the following in as much detail as possible. If you cannot recall certain information, that is okay.

DIAGNOSES/CONDITIONS *Please check all that apply.*

Cardiovascular

☐ Heart Disease ☐ Heart Attack ☐ Cardiac Catheterization
☐ Heart Valve Disorder ☐ Atrial Fibrillation ☐ Stent Placement/Angioplasty
☐ Pacemaker ☐ Implantable Defibrillator ☐ High Blood Pressure
☐ Elevated Cholesterol ☐ Vascular Disease ☐ Peripheral Arterial Disease
☐ Palpitations ☐ Blood Clotting Disorder ☐ Deep Venous Thrombosis
☐ Abdominal Aortic Aneurysm Screening [AAA Ultrasound] (DATE OF LAST EXAM) _____
☐ Other _____

Endocrine

☐ Diabetes (Type 2) ☐ Diabetes (Type 1) ☐ Osteoporosis (weak bones)
☐ Overactive Thyroid ☐ Underactive Thyroid
☐ Fractures (please specify date and type of fracture) _____
☐ Other _____

Gastrointestinal

☐ Heartburn/Reflux ☐ Ulcer ☐ Cirrhosis
☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ Diverticulosis ☐ Colon Polyps ☐ Inflammatory Bowel Disease
☐ Irritable Bowel ☐ Constipation
☐ Other _____

	NORMAL	ABNORMAL	UNKNOWN
Last Colonoscopy (DATE OF LAST EXAM) _____	☐	☐	☐

Hepatitis C Screening in the past? ☐ Yes ☐ No

Genitourinary

☐ Overactive Bladder/Incontinence ☐ Urinary Tract Infections
☐ Kidney Stones ☐ Chronic Kidney Disease
☐ Kidney Cysts ☐ Enlarged Prostate
☐ Erectile Dysfunction ☐ PSA Screen (DATE OF LAST EXAM)_____
Are you sexually active? ☐ Yes ☐ No
☐ Sexually Transmitted Diseases (Chlamydia, Gonorrhea, Genital Herpes)

Gynecological

	NORMAL	ABNORMAL	UNKNOWN
Cervical Cancer Screening (Pap) (DATE OF LAST EXAM) _____	☐	☐	☐
Dexa (DATE OF LAST EXAM) _____	☐	☐	☐
Mammogram (DATE OF LAST EXAM) _____	☐	☐	☐

Menstrual Period (DATE OF LAST) _____
Number of Pregnancies _____ Number of Deliveries _____

Neurologic/ Psychiatric

☐ Dementia ☐ Parkinson's Disease ☐ Anxiety
☐ Post-Traumatic Stress Disorder ☐ Stroke ☐ Neuropathy
☐ Transient Ischemic Attacks (TIA) ☐ Depression
☐ Other _____

Oncologic (Cancer) and Hematologic (Blood Disorders) *Please provide year of diagnosis and check if disease is in remission or active.*

	YEAR OF SURGERY	REMISSION	ACTIVE		YEAR OF SURGERY	REMISSION	ACTIVE
Lung Cancer		☐	☐	Colon/Rectal Cancer		☐	☐
Breast Cancer		☐	☐	Prostate Cancer		☐	☐
Anemia		☐	☐	Other (*Type* ____)		☐	☐

Pulmonary
☐ Asbestos Exposure/Asbestosis ☐ Asthma ☐ COPD
☐ Emphysema ☐ Pulmonary Nodules ☐ Other _____

Rheumatologic/ Joint Disease
☐ Cervical Disc Disease ☐ Gout ☐ Lumbar Disc Disease
☐ Osteoarthritis ☐ Rheumatoid Arthritis

SURGICAL HISTORY *Please provide dates in the space below.*

	YEAR OF SURGERY		YEAR OF SURGERY
Appendix Removal		Hernia Repair	
Breast Biopsy/Breast Surgery		Hysterectomy	
Cardiac Bypass		Ovarian Removal *(one or both)*	
Carotid Artery Surgery		Other *(Type ____)*	
Cataract Surgery		Other *(Type ____)*	
Gallbladder Surgery		Other *(Type ____)*	

HOSPITALIZATIONS *Please list all dates, reasons and complications for hospitalizations below.*

DATE OF HOSPITALIZATION	REASON FOR HOSPITALIZATION	COMPLICATIONS
/ /		
/ /		
/ /		
/ /		

IMMUNIZATIONS *Please indicate month, day and year last received.*

INFLUENZA VACCINE	PNEUMONIA VACCINE	PREVNAR VACCINE	TETANUS BOOSTER	TDAP	ZOSTAVAX (SHINGLES) VACCINE
/ /	/ /	/ /	/ /	/ /	/ /

Person completing this medical history is ☐ Patient ☐ Other _____
PRINT NAME

Relationship to patient _____

SPECIALIST PHYSICIANS AND OTHER CURRENT PHYSICIANS

Please fill in the following medical information. Please **PRINT**. If in doubt, leave blank.

Current or Previous Primary Care Physician

NAME	CITY/STATE	( ) PHONE

Current or Previous Specialists

NAME	SPECIALTY	CITY/STATE	( ) PHONE

FAMILY HISTORY

	Alive?	Deceased?	Age at Death	Major medical problems or cause of death
Father	☐	☐		
Mother	☐	☐		
Brother 1	☐	☐		
Brother 2	☐	☐		
Sister 1	☐	☐		
Sister 2	☐	☐		
Other siblings	☐	☐		
Children - 1 M or F	☐	☐		
Children - 2 M or F	☐	☐		
Children - 3 M or F	☐	☐		
Children - 4 M or F	☐	☐		
Paternal Grandfather	☐	☐		
Paternal Grandmother	☐	☐		
Maternal Grandfather	☐	☐		
Maternal Grandmother	☐	☐		

Parent or Sibling with a History of ***(Please define who had history and what age if applicable)***

☐ Abdominal Aortic Aneurysm _____ ☐ Hypertension _____

☐ Breast Cancer _____ ☐ Mental Illness _____

☐ Colon Cancer _____ ☐ Ovarian Cancer _____

☐ Coronary Artery Disease _____ ☐ Prostate Cancer _____

☐ Diabetes Mellitus _____ ☐ Stroke _____

SOCIAL HISTORY

Please complete the following social history information. Please **PRINT** and check all that apply. If in doubt, leave blank.

Tobacco Use ☐ Current smoker ☐ Former smoker ☐ Nonsmoker

Are you ☐ Interested in quitting ☐ Ready to quit ☐ Not ready to quit

If you smoke or did smoke, how many years? _____ How many packs per day? _____

If you have quit smoking, when? *(Date)* ____/____/____

Do you or have you used other forms of tobacco? ☐ Yes ☐ No

Medication Adherence

Do you understand all the medications as you are taking them? ☐ Yes ☐ No

Do you have any financial concerns related to the medications you are taking? ☐ Yes ☐ No

Do you have any other barriers related to the medications you are taking? ☐ Yes ☐ No

Advance Directives

Note: Please bring a copy of these documents to your **FIRST** appointment.

☐ Living Will ☐ Health Care Surrogate ☐ Power of Attorney ☐ None

If none, would you like additional information explaining what these mean? ☐ Yes ☐ No

Communication

Do you have any communication barriers?

☐ None ☐ Cognitive ☐ Vision ☐ Language ☐ Hearing

Does the family or caregiver have any communication barriers?

☐ None ☐ Cognitive ☐ Vision ☐ Language ☐ Hearing

General

Guardian/Caregiver ☐ Self ☐ Spouse ☐ Significant Other ☐ Child ☐ Other

Total number in household ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ More than 6

Do you have a support system plan in the event of a medical crisis?

☐ None ☐ Family ☐ Friends ☐ Paid Caregiver(s)

Do you have local family? ☐ Yes ☐ No Where are you from? _____

Religious preference _____

Exercise ☐ None ☐ Occasional ☐ 1-2 times/week ☐ 3-4 times/week ☐ Daily

Type of exercise _____

Drugs/Alcohol

Recreational drug use (marijuana, cocaine, etc.)? ☐ Yes ☐ No

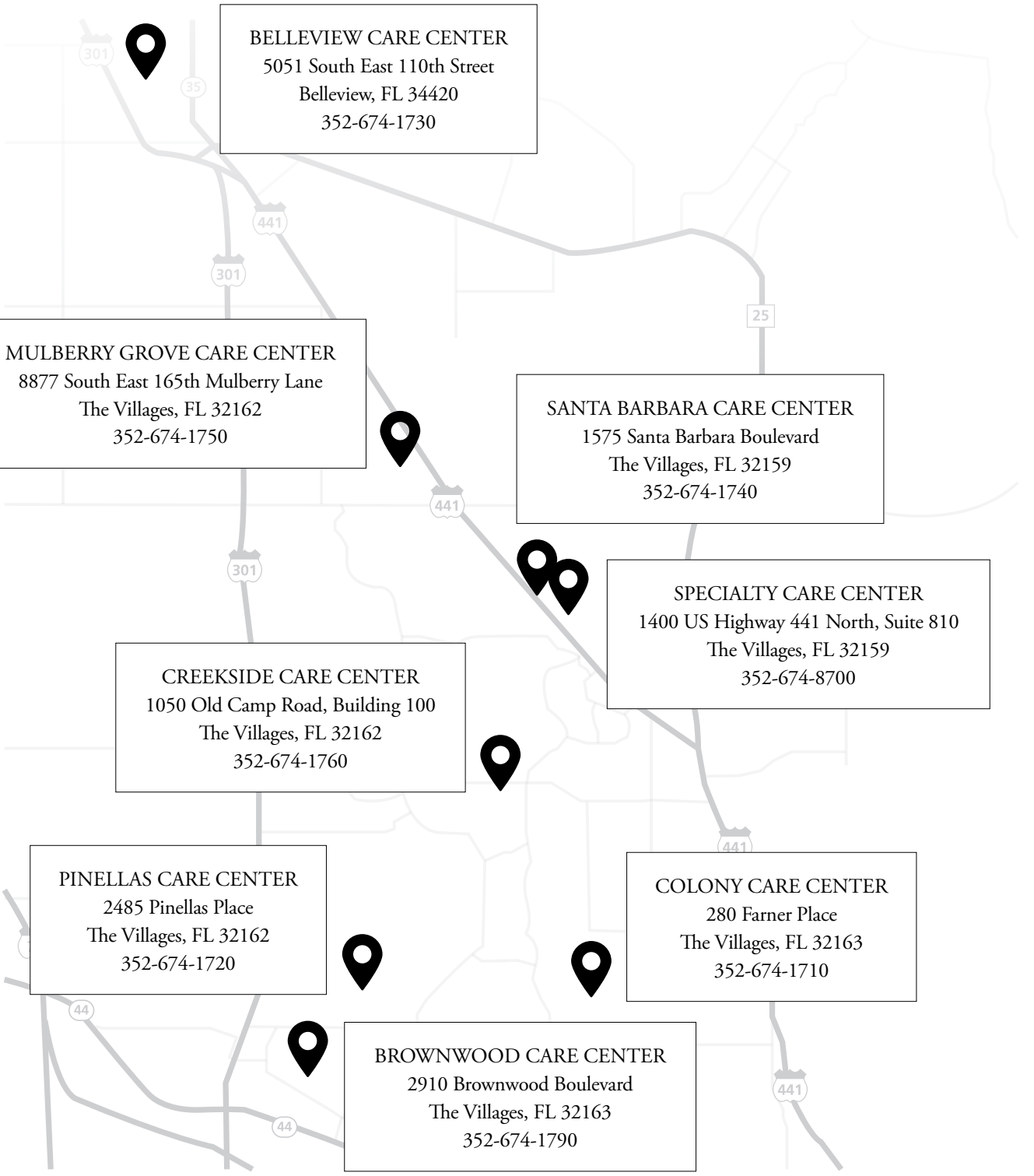
During the past 4 weeks, how many drinks of wine, beer or other alcoholic beverages have you consumed?

☐ No alcohol at all ☐ 1 Drink/week ☐ 2-5 drinks/week ☐ 6-9 drinks/week ☐ 10+ drinks/week

Miscellaneous

Hobbies or other interests _____

The Villages Health



BELLEVIEW CARE CENTER
5051 South East 110th Street
Belleview, FL 34420
352-674-1730

MULBERRY GROVE CARE CENTER
8877 South East 165th Mulberry Lane
The Villages, FL 32162
352-674-1750

SANTA BARBARA CARE CENTER
1575 Santa Barbara Boulevard
The Villages, FL 32159
352-674-1740

SPECIALTY CARE CENTER
1400 US Highway 441 North, Suite 810
The Villages, FL 32159
352-674-8700

CREEKSIDE CARE CENTER
1050 Old Camp Road, Building 100
The Villages, FL 32162
352-674-1760

PINELLAS CARE CENTER
2485 Pinellas Place
The Villages, FL 32162
352-674-1720

COLONY CARE CENTER
280 Farner Place
The Villages, FL 32163
352-674-1710

BROWNWOOD CARE CENTER
2910 Brownwood Boulevard
The Villages, FL 32163
352-674-1790

For the latest information, please visit www.TheVillagesHealth.com