HCA Florida
North Florida Hospital

Crown Pointe
2205 NW 40th Terrace
Suite B
Gainesville, FL 32605
(352) 375-1999

Springhill
3720 NW 83rd Street
Gainesville, FL 32606
(352) 336-3050

Melrose
5818 Centre Street
Melrose, FL 32666
(352) 475-3792

The Village
8000 NW 27th Blvd
The Village Commons
Gainesville, FL 32606
(352) 872-5332

Patient Information

Last Name _____ First Name _____ MI ____

Date of Birth _____ Gender _____ Social Security Number _____

Previous name/Nickname _____

Physical Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status ☐Divorced ☐Married ☐Partner ☐Single ☐Widowed ☐Legally Separated

Employer Information

Employer Name _____

Employment Status ☐Employed full-time ☐Employed part-time ☐Not employed ☐Self-employed ☐Retired ☐Other _____

Emergency Contact

This person will be contacted by the MD and/or office staff in the event you experience an emergency. The MD and/or office staff may speak to this person regarding your medical care if they were to call our office for information.

Last Name _____ First Name _____ MI ____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work/Other Phone _____

Relationship _____

Primary Insurance Information

Primary Insurance _____

Policy Number _____ Group Number _____

Office Use Only ____RN ____FO ____CM ____PAS

Patient Information (cont)

Primary Insurance Policy Holder Information (if different from patient)

Please fill out this section only if the primary insurance policy holder is NOT the patient

Policy Holder Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Gender _____ Social Security Number _____

Relationship to Patient _____

Employment Status ☐Employed full-time ☐Not employed ☐Retired
☐Employed part-time ☐Self-employed ☐Other _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

Secondary Insurance Information

Secondary Insurance _____

Policy Number _____ Group Number _____

Additional Patient Information

Patient Mailing Address (if different than physical address)

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____

Ok to leave message at home? Yes No

Residence Type
☐ Independent Living Facility
☐ Assisted Living Facility
☐ Nursing Home
☐ Hospice Care Center
☐ Group Housing
☐ Home
☐ Homeless

Race and Ethnicity

Which categories best

☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ White
☐ Hispanic
☐ Other Race
☐ Other Pacific Islander
☐ Decline to report race

Which categories best describe your ethnici-
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to report ethnicity

Additional Patient Information (cont)

Language Information

What language do you prefer to discuss your healthcare? ☐ English ☐ Spanish ☐ Indian ☐ American Sign Language ☐ Russian ☐ Other _____

Language translation services are available for patients who are not comfortable discussing their healthcare in English during office visits or phone calls. Would you like to use a translator? Yes No

Pharmacy Information

Local Pharmacy Name _____

Local Pharmacy Address/Phone Number _____

Mail Order Pharmacy Name _____

Mail Order Pharmacy Address/Phone Number _____

Additional Contacts

The MD and/or office staff may speak to these contacts regarding your medical care if they were to call our office for information.

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Other Phone _____

Relationship _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Other Phone _____

Relationship _____

Patient Care Team

Your care team is defined as the list of all physicians, specialists and healthcare companies providing care to the patient. Your care team can include any specialists, case managers, assisted living facilities, nursing homes, home care services, and durable medical equipment companies that provide you with health care services.

Patient Care Team		
Please include any current providers, specialists, assisted living facilities, nursing homes, home care services, or durable medical equipment companies		
Name	Specialty/Service Provided	Phone

Additional Information (Structured)

Advance directives:
- ☐ Living will
- ☐ Power of attorney
- ☐ Durable Power of attorney
- ☐ Do Not Resuscitate order
- ☐ Healthcare surrogate
- ☐ Healthcare proxy

Please bring a copy of your advance directives with you to your visit.

Are you an organ donor? Yes No

Name of current living facility/residence? _____

Please indicate which prescription insurance plan you are currently enrolled in (i.e. Med D):

Plan Name _____ ID# _____

How did you hear about the Senior Healthcare Center?

- ☐ Community agency
- ☐ Senior Healthcare Center brochure
- ☐ Newspaper
- ☐ Relative / friend
- ☐ Hospital / referral line
- ☐ Yellow pages
- ☐ Walked / drove by
- ☐ Physician
- ☐ Other _____

Primary person to contact regarding your care:
- ☐ Self
- ☐ Next of kin
- ☐ Emergency contact
- ☐ Additional contact

History (HPI) & Assessment

Chief Complaints

What concerns do you have which you would like discussed during your visit?

Activities of Daily Living

Please identify which of the following activities you have difficulty completing and would like further information on regarding available resources for assistance:

- ☐Bathing
- ☐Eating
- ☐Dressing
- ☐Grooming
- ☐Oral Care
- ☐Toileting
- ☐Walking
- ☐Use a cane
- ☐Use a scooter
- ☐Use a walker
- ☐Use crutches
- ☐Use a wheelchair
- ☐Other _____

Instrumental Activities of Daily Living

Please identify which of the following activities you have difficulty completing and would like further information on regarding available resources for assistance:

- ☐Driving
- ☐Housekeeping
- ☐Laundry
- ☐Managing Money
- ☐Preparing Meals
- ☐Shopping
- ☐Taking Medications
- ☐Using a Telephone
- ☐Other _____

Cognitive

Please mark Yes or No to the following question:

Difficulty remembering things? Yes No

Major Life Changes – Please indicate any major life changes you have recently experienced:

- ☐ Death of a child
- ☐ Death of a parent
- ☐ Death of a pet
- ☐ Death of spouse/significant other
- ☐ Inability to work
- ☐ Recent job loss
- ☐ Divorce
- ☐ Marriage
- ☐ Separation
- ☐ Newly diagnosed with diabetes
- ☐ Newly diagnosed with cancer
- ☐ Relocated

Fall Assessment - Please select all that apply**:**

- ☐Had a fall in the last six months
- ☐Difficulty walking or standing

Nutrition

Have you experienced any recent changes in your appetite?

☐ No changes ☐ Increase ☐ Decrease

Please select any issues that are affecting your ability to eat.

- ☐Difficulty chewing
- ☐Difficulty swallowing
- ☐Coughing after drinking
- ☐Coughing after eating
- ☐Problems with dentures
- ☐Heartburn
- ☐Inability to taste food
- ☐Changes to bowel movements
- ☐Difficulty complying or understanding prescribed diet

Sleep Patterns

Please select the answer(s) which best describe your sleep pattern:

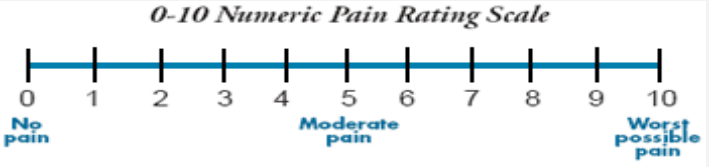
☐ Sleeping through the night
☐ Taking frequent naps
☐ Sleeping through the day
☐ Sleeping less than 8 hours

Do you experience any of the following sleep disturbances?

☐ Difficulty falling asleep
☐ Continuity disturbances
☐ Waking up early
☐ Daytime drowsiness
☐ Snoring
☐ Waking with a sudden jolt
☐ Waking for frequent urination
☐ Restlessness throughout sleep

Pain - Please complete if you are currently suffering from chronic pain:

Pain level on a **scale of 1 to 10:**



Pain Location: _____

Pain characteristics:

☐Aching
☐Piercing
☐Sharp
☐Stabbing
☐Throbbing
☐Episodic
☐Other _____

Modifying Factors:

☐Advil
☐Aspirin
☐Elevation
☐Heat
☐Ice
☐Prescribed pain medications
☐Rest
☐Tylenol
☐Other _____

Pain Duration:

☐Less than a week
☐One week
☐Two weeks
☐Three weeks
☐One month
☐Over a month

Episode Frequency:

☐ All Day
☐ In the morning
☐ In the evening
☐ Other_____

OB/GYN (for female patients only)

Have you ever taken hormone replacement therapy?	Yes	No
Do you lose control of your urine when you laugh or sneeze?	Yes	No
Have you had bleeding since the stop of your menstrual?	Yes	No

Current Medications

List all medications you use regularly and how often you take them. **Please include all non-prescription medications such as laxatives, cold tablets, vitamins, herbals, and dietary supplements.** Note: This facility uses an electronic medical record which allows physicians to access a list of prescriptions filled by their patients within the last two years.

PLEASE BRING ALL MEDICATION BOTTLES WITH YOU TO EACH VISIT

Medication Name	Dose	Instructions	How long you've been on it

Are you currently receiving Oxygen therapy? Yes No

If yes, how is it prescribed? _____ liters/minute ☐ continuous ☐ intermittent

Which company currently supplies your oxygen? _____

Medical History

Please select any conditions you currently have or have had in the past. Indicate the approximate year next to each.

Condition	Year	Condition	Year	Condition	Year
☐ Anemia		☐ Diverticulosis		☐ High blood pressure	
☐ Anxiety		☐ Drug Addiction		☐ Kidney stones	
☐ Appetite Change		☐ Emphysema		☐ Kidney trouble	
☐ Arthritis		☐ Epilepsy		☐ Liver disease	
☐ Asthma		☐ Gallstones		☐ Osteoporosis	
☐ Bleeding tendency		☐ Glaucoma		☐ Phlebitis / Blood clots	
☐ Blood transfusion		☐ Gonorrhea		☐ Rheumatic fever	
☐ Cancer		☐ Gout		☐ Syphilis	
☐ Chest pain		☐ Heart murmur		☐ Thyroid disease	
☐ Colitis		☐ Heart trouble		☐ Tuberculosis	
☐ Depression		☐ Hemorrhoids		☐ Yellow jaundice	
☐ Diabetes		☐ Hepatitis			

Procedure History

Please select any procedures you have had in the past and indicate the approximate year:

Procedure	Year	Procedure	Year
☐ Chest x-ray		☐ Bone density scan	
☐ Other x-ray		☐ Pap smear / pelvic exam	
☐ Mammogram		☐ Breast exam	
☐ Echocardiogram		☐ Flexible sigmoidoscopy	
☐ EKG		☐ Colonoscopy	
☐ Nuclear stress test		☐ Prostate exam	

Allergy History

List allergies and the type of reaction you had when exposed to the allergen. Please include allergies to medications and non-medication allergies including foods, iodine, radiology IV dyes and contrast, and latex products.

Medication/Food/Misc agent/Substance	Reaction

Surgical History and Hospitalizations

List any surgeries and hospitalizations you have had in the past starting with the most recent

Year	Operation or Illness	Hospital	City/State

Family History

Relation	Age	Diabetes	Hypertension	Heart Disease	Stroke	Cancer	Cause of death
Father		☐	☐	☐	☐	☐	
Mother		☐	☐	☐	☐	☐	
Brother(s)		☐	☐	☐	☐	☐	
Sisters(s)		☐	☐	☐	☐	☐	
Spouse		☐	☐	☐	☐	☐	
Son(s)		☐	☐	☐	☐	☐	
Daughter(s)		☐	☐	☐	☐	☐	

Social History

Veteran Status

Are you a veteran? Yes No

Are you a surviving spouse of a veteran? Yes No

Occupation

Occupation/Type of Work _____ Date last worked _____

Illicit Drug Use

Have you ever used illicit drugs? Yes No

Learning Status

What is your preferred method of learning?
☐Demonstration ☐Written instructions
☐Verbal instructions ☐Other _____
☐Self-study pamphlet

Highest grade completed in school:
☐Did not finish high school ☐Did not finish college
☐GED ☐College
☐High school ☐Masters/PhD

Persons required during education:
☐No other person required ☐Caregiver
☐Significant other ☐friend
☐Family member

Check if you are: ☐Hearing impaired ☐Visually impaired

Social History (cont)

Do you have any medical conditions and/or memory difficulties which may affect your ability to learn? Yes No

If yes, please explain _____

Do you have any religious or cultural restrictions which may affect your ability to learn or treatment? Yes No

If yes, please explain _____

Literary Status ☐Able to read/write ☐Unable to read/

Household

Number of adults in your current household _____

You are a caregiver for
☐Spouse ☐Child
☐Parent ☐Oth-

You currently live with
☐Child/children ☐Parents
☐Family ☐Self
☐Father ☐Sibling
☐Friend ☐Spouse
☐Mother ☐Other_____

Please select which services you are currently receiving

☐Hospice care ☐Medical alert service ☐Transportation assistance
☐Home care ☐Meals on wheels ☐Other_____

Please list the name(s) of the company providing services _____

Please indicate if you are
☐Bedridden ☐Using a prosthesis
☐Using a cane ☐Using a walker
☐Using a crutch ☐Using a wheelchair

Social History

History

Please select if you have a history of or been diagnosed with/as

- ☐ Anorexia
- ☐ Anxiety
- ☐ Bipolar
- ☐ Bulimia
- ☐ Clinical depression
- ☐ Depression
- ☐ Drug addiction
- ☐ Emotional disorder
- ☐ Alcohol addiction
- ☐ Schizophrenia
- ☐ Sleeping disorder
- ☐ Suicidal
- ☐ Suicide attempt
- ☐ Other_____

Previously under the treatment of ☐ Counselor ☐ Psychiatrist ☐ Psychologist

Currently under the treatment of ☐ Counselor ☐ Psychiatrist ☐ Psychologist

Dietary Assessment

Please indicate any special diets you are currently on. Select all that apply.

- ☐ Regular
- ☐ ADA
- ☐ Enteral tube feeding
- ☐ Kosher
- ☐ Liquid
- ☐ Low calorie
- ☐ Low cholesterol
- ☐ Low fat
- ☐ Low/no carbohydrates
- ☐ Low salt
- ☐ Mechanical soft
- ☐ No dairy
- ☐ No red meats
- ☐ No seeds
- ☐ No shellfish
- ☐ No strawberries
- ☐ No tomatoes
- ☐ Pureed foods
- ☐ TPN
- ☐ Vegetarian

Length of time on diet(s) selected above _____

What was your weight at age 20? _____ lbs

What was your weight one year ago? _____ lbs

What is your normal eating pattern? ☐ Eat three meals per day ☐ Snack throughout the day ☐ Skip a meal every day ☐ Other_____

Tobacco Product Screening

Are you a ☐ Current smoker ☐ Current everyday smoker ☐ Former smoker ☐ Occasional smoker ☐ Never smoker

Current and Former Smokers Only

Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

How many cigarettes a day do you smoke? ☐ 5 or less ☐ 6 - 10 ☐ 11 - 20 ☐ 21 - 30 ☐ 31 or more

How soon after you wake up do you smoke your first cigarette? ☐ Within 5 min ☐ 6 - 30 min ☐ 31 - 60 min ☐ After 60 min

If you are a former smoker, how long has it been since you last smoked?

- ☐ Less than 1 month
- ☐ 1 - 3 months
- ☐ 3 - 6 months
- ☐ 6 - 12 months
- ☐ 1 - 5 years
- ☐ 5 - 10 years
- ☐ More than 10 years

What type of tobacco products? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless tobacco

How long have you used tobacco products? _____

Social History (cont)

Alcohol Screening

Have you had a drink containing alcohol in the past year? Yes No

If you've had a drink containing alcohol in the past year, please answer the following questions.

How often did you have a drink containing alcohol in the past year?

☐Never ☐Monthly or less ☐2 to 4 times a month
☐2-3 times a week ☐4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

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

How often did you have six or more drinks on one occasion in the past year?

☐Never ☐Monthly ☐Daily or almost daily
☐Less than monthly ☐Weekly

What is the most common type of alcoholic beverage you drink? _____

Caffeine

Please check the appropriate answer regarding your caffeine intake

☐Do not use ☐4 cups/glasses per day
☐1 cup/glass per day ☐5 cups/glasses per day
☐2 cups/glasses per day ☐> 5 cups/glasses per day
☐3 cups/glasses per day

Exercise

Please check the appropriate answer(s) regarding your exercise activity

☐Do not exercise regularly ☐Yoga
☐Cycle ☐Walk
☐Run ☐Weight lift
☐Tai chi ☐Other_____

I exercise: ☐1 ☐2 ☐3 ☐4 ☐5 ☐>5 time(s) per ☐Day ☐Week ☐Month

Immunizations

Please enter the date of the last immunization

Immunization	Date	Immunization	Date
Influenza		TD Tetanus Diphtheria	
Prevnar-13 (Pneumococcal)		TDap Tetanus (Pertussis)	
Pneumovax-23 (Pneumococcal)		Zostavax (Shingles)	
Covid-19		Shingrix (Shingles)	

_____

Patient/Representative Signature Date