700 North Hiatus Rd Suite # 213
Pembroke Pines, FL 33026

222 S. Flamingo Rd.
Pembroke Pines, FL 33027

Phone: (954) 392-9026, Fax: (954) 357-2353

Patient Demographics

Date:

Last Name	**First Name**	**Middle Initial**	**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**	

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:
    - Instructions for preparing your advance directive, please read all the instructions.
    - 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 Initial** _____ **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**

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.

Quality of Life Questionnaire

First Name	Middle Initial	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 regylarly 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
- Past Nasal Drip
- Headaches
- Trouble Sleeping
- Fatigue

Patient Stress Questionnaire*

Date

_____

First Name _____ **Middle Initial** _____ **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

6. Feeling bad about yourself or tha tyou 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'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.

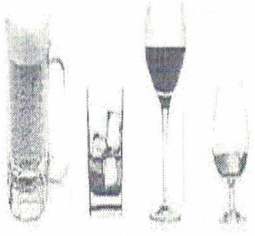
Standard serving of one drink:

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

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

FINANCIAL AGREEMENT

CLEOPATRA GORDON-PUSEY, MD

Life is Beautiful
700 North Hiatus Rd Suite # 213, Pembroke Pines FL 33026

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 Initial** _____ **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:

_____

700 North Hiatus Rd Suite # 213
Pembroke Pines, FL 33026

222 S. Flamingo Rd.
Pembroke Pines, FL 33027

Date: _____

HEALTH HISTORY QUESTIONNAIRE

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

First Name _____ **Middle Initial** _____ **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 feel depressed?
Yes No

Do you panic when stressed?
Yes No

Do you have problems with eating or your appetite?
Yes No

Do you cry frequently?
Yes No

Have you ever attempted suicide?
Yes No

Have you ever seriously thought about hurting yourself?
Yes No

Do you have trouble sleeping?
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:

_____

CLEOPATRA GORDON-PUSEY, M.D.

700 North Hiatus Rd Suite # 213
Pembroke Pines, FL 33026
222 S. Flamingo Rd.
Pembroke Pines, FL 33027
Phone: (954)-392-9026 Fax: (954)-357-2353
E-mail: lifeisbeautifulmd@gmail.com

Medication Form

First Name _____ **Middle Initial** _____ **Last Name** _____

Date of Birth _____ **Diagnosis:** _____ **Allergy:** _____

MEDICATION & DOSE	FREQUENCY	RATIONAL	NEW or RENEWAL or CHANGES

Date _____

(954) 392 9026

Dr. Cleopatra Gordon-Pusey
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