PATIENT INFORMATION SHEET

Last Name_____ **First Name**_____ **MI** _____

SSN#_____-_____-_____ **DOB**_____/_____/_____ **Age**_____

Address_____ **City**_____ **State**____ **Zip**_____

Phone #1 (_____)_____□Home □Cell □Work **Phone #2** (_____)_____ □Home □Cell □Work

Email_____ ___ **Preferred method of appt. reminder**: □ Text □ Email

Referred By:_____

Sex: □Male □Female|**Gender Identity:** □Male □Female □Transgender male □Transgender female □Non-binary □Other

Marital Status: □ Single □ Married □ Partner □ Divorced □ Widowed

Race: □ White □ African American □ Hispanic □ American Indian □ Asian □ Other _____

Ethnicity: □ Hispanic-Latino □ Non-Hispanic-Latino **Language:** □ English □ Spanish □ Other _____

Country of Origin: □ USA □ Other_____

Employment Status: □ Employed □ Unemployed □ Retired □ Student □ Disabled

Employer:_____ **Occupation:**_____

Emergency Contact_____ **Relationship:**_____

Address_____

Phone (_____)_____ **Cellular** (_____)_____

Primary Insurance_____ **Policy #**_____

Secondary Insurance_____ **Policy #**_____

- **ARE YOU *ELIGIBLE* UNDER ANY OTHER HEALTH INSURANCE, SUCH AS MEDICARE?** □ YES □ NO
- **If you are eligible for Medicare Part B, what is your effective date?** _____/ _____/ _____
- **Do you have a Living Will?** □ YES □ NO (If so, please provide us with a copy for your medical chart.)

I hereby authorize LifeWay, Inc. and/or its staff and affiliates to render medical treatment to me as necessary. I fully understand that I am ultimately responsible for payment for all services provided to me and request that payment from my insurance carrier be made directly to LifeWay, Inc. I also understand that by signing below, my insurance carrier has full access to my entire medical records that may include sensitive, personal and confidential information.

_____ _____

Patient's Signature **Date**

PATIENT MEDICAL HISTORY FORM

Today's Date:_____/ _____/ _____

Name:_____ DOB:_____/_____ /_____ Age:_____

Reason for Visit:_____

Last Routine/Well Exam: □ Less than 1 year □ Greater than 1 year (Date:_____)

DRUG ALLERGIES:
CURRENT MEDICATIONS:

FAMILY HISTORY						
(Indicate if deceased)	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITILIZATIONS OR SURGERIES

REASON	DATE	REASON	DATE

MEDICAL HISTORY

□ ADD/ADHD	□ Depression	□ Hepatitis (□ A □ B □ C)	□ Pneumonia
□ Allergies	□ Diabetes	□ Hernia	□ Prostate disease/BPH
□ Anemia	□ Epilepsy	□ Herpes	□ Sexual dysfunction
□ Anxiety	□ Gallbladder disease	□ HIV (Date _____)(State___)	□ Sinus issues
□ Arthritis/Joint pain	□ GI disorder/Acid reflux	□ Hypertension	□ Stroke
□ Asthma	□ Glaucoma	□ Insomnia	□ Syphilis
□ Bipolar disorder	□ Gout	□ Kidney disease	□ Thyroid disease
□ Bowel irregularity	□ Headache/Migraine	□ Neuropathy	□ Ulcer
□ Cancer_____	□ Heart disease/MI	□ Osteoporosis	□ Vascular disease/PVD
□ Cholesterol high	□ Heart murmur	□ Pain chronic _____	□ Other_____

IMMUNIZATIONS	HABITS	TESTS AND SCREENINGS
COVID vaccine:____|____|____	□ Smoker _____ packs daily	Colonoscopy: ____|____|____
Flu vaccine: ____|____|____	□ Former smoker	Pap Smear: ____|____|____
Pneumonia vacc: ___|____|____	□ Never smoked	Mammogram: ____|____|____
Tetanus vaccine: ___|____|____	□ Alcohol: Beer | Wine | Liquor	Bone density: ____|____|____
Hepatitis A: ____|____|____	□ Frequency: #_____ Day |Week	Eye exam:____|____|____
Hepatitis B: ____|____|____	□ No alcohol consumption	

LifeWay, Inc.

Notice of Privacy Practices
Consent Form

Patient Name:_____ Date of Birth:_____

LifeWay, Inc. is providing this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

Listed below are the individuals to whom I give permission to LifeWay, Inc., its physicians, staff members and/or representatives, to review and discuss my medical and/or financial issues:

1) Name:_____ **DOB:**____/____/____ □ **Medical** □ **Financial**

Phone: (_____)_____ **Alt. Phone:** (_____)_____

Relationship: □ Partner □ Spouse □ Mother □ Father □ Adult Child □ Sibling □ Other_____

2) Name:_____ **DOB:**____/____/____ □ **Medical** □ **Financial**

Phone: (_____)_____ **Alt. Phone:** (_____)_____

Relationship: □ Partner □ Spouse □ Mother □ Father □ Adult Child □ Sibling □ Other_____

3) Name:_____ **DOB:**____/____/____ □ **Medical** □ **Financial**

Phone: (_____)_____ **Alt. Phone:** (_____)_____

Relationship: □ Partner □ Spouse □ Mother □ Father □ Adult Child □ Sibling □ Other_____

By signing below, I acknowledge that I have read and understand the Patient Privacy Notice from LifeWay, Inc. and consent to the release of information as I have specified above.

_____
Patient's Signature

_____
Date

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Ft. Lauderdale. FL 33334

Office: (954) 772-8554
Fax: (954) 772-9662
Email: info@LifeWayMD.com

HEALTH RISK ASSESSMENT

PHYSICAL ACTIVITY

- **How many days per week do you exercise?**
  - ☐ More than 3 days per week
  - ☐ Less than 3 days per week
  - ☐ Currently not exercising *(Skip to next section)*

- **How long do you exercise (in minutes)? _____**

- **How intense is your typical exercise?**
  - ☐ Light (stretching or slow walking)
  - ☐ Moderate (brisk walking)
  - ☐ Heavy (jogging or swimming)
  - ☐ Very heavy (fast running or stair climbing)

TOBACCO USE

- Tobacco status:
  - ☐ Never used tobacco *(Skip to next section)*
  - ☐ Former tobacco user
    - How many years?_____
    - When did you quit? _____
  - ☐ Current tobacco user
    - When did you start? _____

- Tobacco product:
  □ Cigarettes □ Cigars □ Pipe □ Smokeless

- Tobacco usage daily:
  □ < ½ pack □ 1 pack □ > 1 pack □ 2 packs
  □ Other:_____

ALCOHOL USE

- Alcohol Intake:
  - ☐ No alcohol consumption *(Skip to next section)*
  - ☐ Beer _____ drinks per occasion
  - ☐ Wine _____ glasses per occasion
  - ☐ Liquor _____ drinks per occasion

- Alcohol Frequency:
  - ☐ Socially
  - ☐ Once per week
  - ☐ 2-3 times per week
  - ☐ More than 3 times per week

ILLICIT DRUG USE

- Illegal and prescription drugs:
  - ☐ No illicit drug use *(Skip to next section)*
  - ☐ History of: When did you stop? _____
  - ☐ Current use: When did you start? _____

- What type of drug(s)?
  - ☐ Cocaine
  - ☐ Crack cocaine
  - ☐ Crystal meth
  - ☐ Heroin
  - ☐ Marijuana
  - ☐ Prescription_____
  - ☐ Other _____

NUTRITION

- Fruits and vegetables:
  □ None □ Some □ Moderate □ A lot

- High fiber or whole grain:
  □ None □ Some □ Moderate □ A lot

- Fried or high-fat food:
  □ None □ Some □ Moderate □ A lot

- Sugar:
  □ None □ Some □ Moderate □ A lot

- Caffeine:
  □ None □ Some □ Moderate □ A lot

GENERAL HEALTH

- In general, would you say your health is:
  □ Excellent □ Very Good □ Good □ Fair □ Poor

- How would you describe your mouth and teeth?
  □ Excellent □ Very Good □ Good □ Fair □ Poor

- How would you describe your hearing?
  □ Excellent □ Very Good □ Good □ Fair □ Poor

- How would you describe your vision?
  □ Excellent □ Very Good □ Good □ Fair □ Poor

DEPRESSION/ANXIETY

- Do you feel down, depressed or hopeless?
  □ Almost always □ Often □ Sometimes □ Rarely
- Do you feel little interest or pleasure in doing things?
  □ Almost always □ Often □ Sometimes □ Rarely
- Have your feelings caused you distress or interfered with your ability to get along with family or friends?
  □ Yes □ No
- Do you feel nervous, anxious or on edge?
  □ Almost always □ Often □ Sometimes □ Rarely
- How often are you not able to stop or control your worrying?
  □ Almost always □ Often □ Sometimes □ Rarely
- Is stress a problem for you in handling things such as your health, finances, relationships or work?
  □ Almost always □ Often □ Sometimes □ Rarely
- Do you get the social and emotional support that you need?
  □ Almost always □ Often □ Sometimes □ Rarely

RELATIONSHIP

- Are you currently married or in a relationship with a significant other?
  □ Yes
  □ No

ABUSE

- Has anyone hurt or abused you in the last 6 months?
  □ Yes
  □ No

SEXUAL HEALTH

- How many sexual partners have you had in the past 12 months?
  □ Not sexually active
  □ 1
  □ 2 or more
- Are your sexual partners:
  □ Male
  □ Female
  □ Both
- Do you use protection against sexually transmitted diseases?
  □ Always
  □ Often
  □ Sometimes
  □ Rarely or Never

ACTIVITIES OF DAILY LIVING

- In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, using the toilet?
  □ Yes _____
  □ No
- In the past 7 days, did you need help from others to take care of such things as laundry, housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your medications?
  □ Yes _____
  □ No

COGNITIVE SCREENING A

1. Do you have forgetfulness or memory loss?
   □ Yes □ No
2. Do you forget important events/appointments?
   □ Yes □ No
3. Do you lose your train of thought?
   □ Yes □ No
4. Are you overwhelmed by tasks or instructions?
   □ Yes □ No
5. Do you have trouble navigating around familiar environments?
   □ Yes □ No
6. Are you more impulsive or have increasingly poor judgment? □ Yes □ No
7. Have family and friends noticed these changes?
   □ Yes □ No

SLEEP

- How many hours of sleep do you get each night?
  □ < 3 hrs □ 4-5 ◘ 6-7 □ 8-9 □ 10-11 □ > 12 hrs
- Do you snore or has anyone told you that you snore?
  □ Yes
  □ No
- Do you feel sleepy during the daytime?
  □ Almost always
  □ Often
  □ Sometimes
  □ Rarely or Never

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

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LifeWay, Inc.

American Urological Association BPH Symptom Score Index Questionnaire

Name _____ **Date** _____

Please fill out this short questionnaire to help us find out more about any urinary problems you might have; for questions 1 through 7, circle the number under the column that best describes your situation; for question 6, circle the number in the row which best describes your situation.

	Not at all	Less than 1 time in 5	Less than half the time	About half the time	More than half the time	Almost Always
1. INCOMPLETE EMPTYING: Over the past month, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
2. FREQUENCY: Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?	0	1	2	3	4	5
2. INTERMITTENCY: Over the past month, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
3. URGE TO URINATE: Over the past month, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
5. WEAK STREAM: Over the past month, how often have you had a weak urinary stream?	0	1	2	3	4	5
6. STRAINING: Over the past month, how often have you had to push or strain to begin urination?	0	1	2	3	4	5
	None	1 time	2 times	3 times	4 times	5+ times
7. URINATING AT NIGHT: Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Symptom Score:
1-7 Mild, 8-19 Moderate, 20-35 Severe Total: _____

BOTHERSOME SCORE DUE TO URINARY SYMPTOMS							
	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
QUALITY OF LIFE DUE TO URINARY SYMPTOMS: How would you feel if you had to live with your urinary condition the way it is now – no better, no worse – for the rest of your life?	0	1	2	3	4	5	6