GENERAL INFORMATION

Patient Last Name _____ First Name _____ MI _____ DOB _____

(_____) _____ Home # (_____) _____ Cell Phone #

Home Address _____ City _____ State _____ Zip _____

SS# _____-_____-_____ ☐ Male ☐ Female
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email Address _____

Employer _____

Primary Insurance Carrier _____ Policy ID _____

☐ HMO ☐ PPO ☐ POS ☐ Other _____ (_____) _____
(Type of Plan) Insurance Carrier Phone #

Secondary Insurance Carrier _____ Policy ID _____

☐ HMO ☐ PPO ☐ POS ☐ Other _____ (_____) _____
(Type of Plan) Insurance Carrier Phone #

IMPORTANT: In case of emergency, who would we contact?

Name _____ Relationship _____

Address (Street/City/ZIP) _____ (_____) _____ Home Phone #

Cell Phone # _____ (_____) _____ Work #

"I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services. By signing this form, I hereby give the clinic Medical Group) consent to perform medical treatment."

Patient/Guardian Signature _____ Date _____

Patient Last Name: _____ First Name: _____ DOB: _____

Family History	Circle Sex		If Living		If Deceased	
			Age	Health	Age at Death	Cause
Father	M	F				
Mother	M	F				
Brothers/Sisters	M	F				
	M	F				
	M	F				
Husband/Wife	M	F				
Sons/Daughters	M	F				
	M	F				

Check if any blood relative has or had any of the following and enter their relationship:

	Yes	No	Relationship to you
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding Tendency	☐	☐	_____
Cancer	☐	☐	_____
Colitis	☐	☐	_____
Congenital Heart Disease	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Epilepsy	☐	☐	_____
Goiter	☐	☐	_____
Gout	☐	☐	_____
Hay Fever	☐	☐	_____
Heart Attack	☐	☐	_____

	Yes	No	Relationship to you
High Blood Pressure	☐	☐	_____
Intestinal Polyps	☐	☐	_____
Kidney Disease	☐	☐	_____
Leukemia	☐	☐	_____
Migraine	☐	☐	_____
Nervous Breakdown	☐	☐	_____
Rheumatic Fever	☐	☐	_____
Sickle Cell Anemia	☐	☐	_____
Stomach Ulcers	☐	☐	_____
Stroke	☐	☐	_____
Suicide	☐	☐	_____
Tuberculosis	☐	☐	_____
Other	☐	☐	_____

MEDICATIONS:

- ☐ Asthma Wheezing Medicine
- ☐ Aspirin, Bufferin, Anacin, Tylenol or Similar Products
- ☐ Blood Pressure Pills
- ☐ Cortisone, Prednisone
- ☐ Cough Medicine
- ☐ Digitalis or Heart Medicine
- ☐ Hormones
- ☐ Insulin or Diabetic Pills
- ☐ Anemia Medications
- ☐ Laxatives
- ☐ Sleeping Pills/Tranquilizers
- ☐ Thyroid Medicine
- ☐ Stomach/Digestive Medicine
- ☐ Weight-Reducing Pills
- ☐ Blood Thinners or Coumadin
- ☐ Dilantin or Seizure Medications
- ☐ Water Pills or Diuretics
- ☐ Antibiotics
- ☐ Phenobarbital/Barbiturates
- ☐ Vitamins
- ☐ Other Prescription or Over-the-Counter Drugs

PATIENT MEDICAL HISTORY

Patient Last Name: _____ First Name: _____ DOB: _____

Date of Last Physical Exam: _____ Previous Provider Name: _____

Provider Address: _____

PAST HISTORY (Personal and Allergies): Have you had any of the following illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	CVA/TIA	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Nervous Breakdown	☐	☐
Alcohol Overuse	☐	☐	Emphysema/COPD	☐	☐	Ostomies _____	☐	☐
Allergies (other than medications)	☐	☐	Falls	☐	☐	Paralysis	☐	☐
			Gallbladder Disease	☐	☐	Rheumatic Fever	☐	☐
Arthritis	☐	☐	Gout	☐	☐	Seizures	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐	Sexually		
Bleeding Disorder	☐	☐	Heart Attack/MI	☐	☐	Transmitted Diseases	☐	☐
Cancer	☐	☐	Other Heart Disease	☐	☐	Sickle Cell Anemia	☐	☐
location: _____			(CHF/CAD)			Sleep Disorder	☐	☐
Cardiac Arrhythmias	☐	☐	Hepatitis	☐	☐	Stomach Ulcers	☐	☐
Pacemaker: _____			High Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Chicken Pox	☐	☐	Jaundice	☐	☐	Vascular Disease	☐	☐
Colitis	☐	☐	Kidney Disease	☐	☐			
Depression	☐	☐	Measles/Mumps	☐	☐			

PERSONAL HABITS:

1) Have you ever smoked? ☐ Yes ☐ No If yes, are you are regular smoker now? ☐ Yes ☐ No

Have you used chewing tobacco? ☐ Yes ☐ No If yes, number of years _____ If no, when did you quit? _____

2) Do you regularly drink alcohol? ☐ Yes ☐ No If yes, how often _____

3) Have you ever used any of the following? ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Speed ☐ Other

OPERATIONS: List and indicate approximate year.

_____

_____

_____

SERIOUS INJURIES: List injuries and give approximate dates.

_____

_____

_____

HOSPITALIZATIONS: (Other than operations)
List reasons and approximate dates

_____

_____

_____

DIAGNOSTIC TESTS/EXAMS:

Last Test/Exam	Date	Location/Provider
Eye Exam:		
Foot Exam:		

IMMUNIZATIONS: (Please give date) Hepatitis B _____ Flu _____ Polio _____

Typhoid _____ Smallpox _____ Tetanus _____ Pneumococcal _____ Chicken Pox _____

Patient Last Name: _____ First Name: _____ DOB: _____

List each medication; its dosage and how often you take it, including vitamins and herbal supplements.

Medication	Dosage	How Often?	When Started?

Are you allergic to any medications: ☐ Yes ☐ No If yes, please list medications and the reactions.

Medication	Reaction

Patient Last Name: _____ First Name: _____ DOB: _____

SOCIAL / LIFESTYLE HISTORY:		Primary Language: _____
Is there someone that lives in your residence?	☐ Yes ☐ No	If yes, please list name and relationship:
Type of Residence		☐ Apartment ☐ Mobile Home ☐ House ☐ One Story ☐ Two Story ☐ Assisted Living Facility Facility Name _____ ☐ Other _____
Durable Medical Equipment	☐ Yes ☐ No	Wheelchair _____ Oxygen _____ Walker _____ Nebulizer _____ Cane _____ CPAP/BIPAP _____ Other _____
Can you afford medicines?	☐ Yes ☐ No	Potential Referral to Patient Assistance Program
Transportation provided by?		

NUTRITIONAL HISTORY:		
Current Weight: _____ Lbs		Current Height: _____ Ft _____ In Weight Changes in the past 6 months? ☐ Yes ☐ No
Current Diet Plan:		
EXERCISE/ACTIVITY:		
Current Activity:		How Often:
Physical Limitations:		
ACTIVITIES OF DAILY LIVING:		
Do you require assistance to bathe or groom?	☐ Yes ☐ No	If yes, Explain: _____
Do you require assistance for your toilet needs?	☐ Yes ☐ No	If yes, Explain: _____
Do you require assistance to eat?	☐ Yes ☐ No	If yes, Explain: _____
Do you have hearing loss?	☐ Yes ☐ No	Do you wear hearing aids? ☐ Yes ☐ No Last hearing exam date: _____

Additional Comments and Notes: _____

_____

MARKOU MEDICAL CENTER
MICHAEL MARKOU, D.O.

1266 TURNER ST.
CLEARWATER, FL 33756
TELEPHONE: (727)446-0176
FAX: (727)442-0696

WHAT ARE ADVANCE DIRECTIVES?

What are Advance Directives?

"Advance Directive" is a general term that refers to your oral and written instructions about your future medical care, in the event you become unable to speak for yourself.

What is a living will?

A living will is a type of advance directive in which you put in writing your wishes about medical treatment should you be unable to communicate your wishes.

What is a medical power of attorney?

A medical power of attorney is a document that lets you appoint someone you trust to make decisions about your medical care if you cannot make those decisions yourself.

Why do I need an Advance Directive?

Advance directives give you a voice in decisions about your medical care when you are unconscious or too ill to communicate. As long as you are able to express your own decisions your advance directives will not be used and you can accept or refuse any medical treatment. But if you become seriously ill, you may lose the ability to participate in decisions about your own treatment.

What happens if I don't have an Advance Directive (or Living Will)?

In the event that you cannot speak for yourself, health and medical decisions may be made by someone not of your choosing or by the court.

Once I make an Advance Directive can I cancel it?

Yes. Your advance directive can be canceled or revoked by you at any time.

Who should I talk to about an Advance Directive?

Your JSA Primary Care Physician is the best person to answer your questions. He or she has the knowledge and caring about you to put your concerns at ease.

What about the paperwork?

All of the necessary paperwork and information is available at your JSA Primary Care Center. Ask your doctor or see the receptionist.

Patient Self Determination Questionnaire

In order to comply with the Omnibus Budget Reconciliation Act (OBRA) of 1990 and Chapter 765 of the Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

[ ] I have made such a declaration

[ ] I have NOT made such a declaration

Health Care Surrogate

[ ] I have designated a Health Care Surrogate

[ ] I have NOT designated a Health Care Surrogate

Durable Power of Attorney

[ ] I have appointed a Durable Power of Attorney for Health Care Decisions

[ ] I have NOT appointed a Durable Power of Attorney for Health Care Decisions

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

PLEASE PRINT FULL NAME _____ SOCIAL SECURITY NUMBER _____

Signature: _____ Date: _____
Patient or Patient Representative

Relationship of Patient Representative (If applicable): _____

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate

Signature of Patient or Patient Rep _____ Date _____

Signature of Patient or Patient Rep _____ Date _____

Signature of Patient or Patient Rep _____ Date _____

Signature of Patient or Patient Rep _____ Date _____

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Patient Rep: _____ Date _____

Relationship of Patient Representative (If applicable): _____

Dr. Michael Markou

CONSENT FOR RELEASE of CONFIDENTIAL MEDICAL INFORMATION

I _____hereby authorize Dr. Michael Markou to release my healthcare information to:

1. _____ _____
Print name of party authorized to receive information | Relationship to patient

_____ _____
Address of party listed above | Telephone number of party listed above

2. _____ _____
Print name of party authorized to receive information | Relationship to patient

_____ _____
Address of party listed above | Telephone number of party listed above

3. _____ _____
Print name of party authorized to receive information | Relationship to patient

_____ _____
Address of party listed above | Telephone number of party listed above

I authorize the release of my entire medical record via either telephonic, face-to-face, or written communications to the above named individual(s). Unless otherwise indicated, my authorization includes the release of the following, please strike through those you wish to **exclude**, if any:

- My diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.
- My diagnosis and/or treatment regarding mental health issues.
- HIV antibody test results and/or AIDS diagnosis and treatment.
- Genetic test results an/or related treatment.
- Other: _____

I further release and indemnify JSA Healthcare its affiliates, employees, officers and directors from any and all liability, which in any way results from the disclosure of this information pursuant to the above instruction. This authorization shall remain in effect from the date signed until written revocation is received. I understand that I am under no obligation to sign this release of information and that it is my right to inspect all information disclosed, if I so request.

_____ _____
Signature of Patient | ID or SS#

_____ _____
Date of Birth | Date

MARKOU MEDICAL CENTER
MICHAEL MARKOU, D.O.

1266 TURNER ST.
CLEARWATER, FL 33756
TELEPHONE: (727)446-0176

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____ have received a copy of
Patient Name

MARKOU MEDICAL CENTER'S Notice of Privacy Practices.
Practice Name

_____
Signature of Patient

_____
Date

MARKOU MEDICAL CENTER
Michael Markou, D.O.
Matthew Deachin, PA-C
Kaitlyn Wagner, PA-C
1266 Turner Street
Clearwater, Florida 33756
P: 727-446-0176 F: 727-446-4906

AUTHORIZATION FOR DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Name: _____ Date of Birth: _____
Address: _____
Home Phone: _____ SS#: _____

I authorize _____ Phone# _____ Fax _____
to release the following information for the purpose of continuing health care. Please forward the following health information to Markou Medical Center:

_____ Entire medical record to the above named recipient
_____ This authorization is limited to the following treatment or time period: _____
_____ Other (describe) _____
_____ DO NOT FAX MEDICAL RECORDS; PLEASE MAIL THEM TO OUR OFFICE

The information will be used on my behalf for the following purpose(s): Continuation of care/Treatment
Please send my protected health information to:

Markou Medical Center
1266 Turner Street
Clearwater, FL 33756

If the information to be used/disclosed contains any types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I **PLACE MY INITIALS** in the applicable space next to the type of information.

_____ Drug/Alcohol diagnosis, treatment or referral information
_____ Mental Health information
_____ HIV/AIDS information
_____ Genetic testing information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclossure or drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing.

This authorization may be revoked in writing at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier this consent will expire 18days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. To revoke this authorization, please send a written statement to Markou Medical Center, 1266 Turner Street, Clearwater, FL 33756.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

_____ _____
Signature: Patient or Legal Representative Date

FUNCTIONAL STATUS & PAIN ASSESSMENT

Patient:	Center:
Date of Birth:	Physician:
MemberID:	Health Plan:

1. Are you able to walk on your own or do you require assistance?

   Independently _____ Requires Assistance _____

2. Do you have any problems with your hearing, vision or speech?

   Hearing: Yes _____ No _____

   Vision: Yes _____ No _____

   Speech: Yes _____ No _____

3. Are you able to exercise?

   Yes _____ No _____

CODE BOTH CPT & V CODE:

CPT Category II: 1170f – functional assessment

AND ALSO CODE:

ICD-10 code Z13.9 - screening for unspecified condition (if done by telephone without office visit)

---

4. Do you have ongoing pain? Yes_____ No _____ Location _____

   If yes: Please rate on a scale of 1 – 10

CODE BOTH CPT & V CODE:

CPT Category II: 1125f – pain present **- OR -** **1126f** – no pain

AND ALSO CODE:

ICD-10 code Z13.9 - screening for unspecified condition (if done by telephone without office visit)

MA/Nurse Signature:_____ Physician Signature:_____

Assessment Date: _____

Revisions: May 2012, 6/12, 3/7/13, 9/10/13, 4/15/2014, 8/6/2014, 10/17/2015, 11/18/2015, 6/6/17

"Get Up & Go" "Levantese y Muevase"

Name/Nombre _____ Age/Edad _____

Date of Birth/Fecha de Nacimeiento_____ Date/Fecha _____

Questions 1-2 to be completed by the Patient

1. Have you fallen or had problems with balance or walking in the last 12 months? Y / N *(Circle one)* Pt Ed ____
   a. How many times have you fallen?_____
   b. Date last fall occurred:_____
   c. Were any medications started or medications changed around the time of this fall? Y / N *(Circle one)*
      If yes, please list: _____
      _____
   d. Circumstances of fall (tripped, dizzy, rushing to bathroom, etc.): _____
      _____
   e. Needed assistance to get up? Y / N *(Circle one)*
2. a. Do you have any assistive devices? (Cane, walker, wheelchair, other) Y / N *(Circle one)*
      Please specify:_____
   b. Were you using it when you fell? Y / N *(Circle one)*

Preguntas 1-2 para ser completado por el Paciente

1. ¿Se ha caido o ha tenido problemas con su balance en los ultimos 12 meses? Y / N (Encierre en un círculo) Pt Ed ____
   a. ¿Cuantas veces se ha caido? _____
   b. ¿Fecha de la ultima caida?_____
   c. ¿A cambiado o empezado medicamentos alrededor del tiempo de su caida? Y / N (Encierre en un círculo)
      En caso afirmativo, liste los medicamentos: _____
      _____
   d. Circunstancias de la caida - (tropezó, mareo, deprisa hacia el baño, etc.)_____
   e. _____
      ¿Necesito ayuda para levantarse? Y / N (Encierre en un círculo)
2. a. ¿Utiliza equipo para ayudarse a caminar? (Baston, caminador, silla de rueda, otra cosa?) Y / N (Encierre en un círculo)
      ¿Cual utiliza?_____
   b. ¿Lo estaba usando cuando se cayo? Y / N (Encierre en un círculo)

Preguntas 3-5 completado por el Asistente del Medico
Questions 3-5 to be completed by the Medical Assistant:

*Note: If answers to questions 1-2 are "NO", complete question 3 ONLY.

3. Get Up and Go Test: # Seconds_____

(Person may wear their usual footwear and use any assistive device normally used)

--Have Patient sit in standard chair with their back to the chair and arms resting on arm rests.
--Ask patient to stand up and walk 10 ft., turn around, walk back to the chair and sit down again.
--Timing begins when patient starts to rise from chair and ends when they return to chair and sit down.
The patient should complete this one time.

Seconds Rating

<10 Freely mobile
<20 Mostly independent
20-29 Variable mobility
>30 Impaired mobility

4. Eye Exam: a. Is eye exam in the chart in the past year? Y / N (Circle one)
b. If not in the chart or patient had recent vision changes, schedule eye appointment for patient.

5. Blood Pressure:
If pt. complains of lightheadedness or loss of consciousness, take orthostatic BP & record results.

PHQ-9 NINE SYMPTOM CHECKLIST

PATIENT NAME_____ DATE:_____

Over the past two (2) weeks, how often have you been bothered by any of the following problems?
Read each item carefully, and select your response.

1		NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
a	Little or no interest or pleasure in doing things.				
b	Feeling down, depressed, or hopeless.				
c	Trouble falling asleep, staying asleep, or sleeping too much.				
d	Feeling tired or having little energy.				
e	Poor appetite or overeating.				
f	Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down.				
g	Trouble concentrating on things such as reading the newspaper or watching television.				
h	Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.				
i	Thinking that you would be better off dead or that you want to hurt yourself in some way.				
		Not Difficult At All	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**
2	If you checked off any problem on this questionnaire so far, 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?				