

Confidentiality Notice: This form and its attachments may contain privileged and confidential information and/or protected health information (PHI) intended solely for the recipient(s) named above. If you are not the recipient, or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any review, dissemination, distribution, printing or copying of this email message and/or any attachments is strictly prohibited. If you have received this transmission in error, please notify the sender immediately at (352)746-2200 or (352)873-1500 and permanently delete this email and any attachments.

# UPDATE

Hospice Patient

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Phone (other than your own): \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email Address: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Please list your current medications, including OTC medications/vitamins/herbs. Please include prescription, over-the-counter, herbs, vitamins/supplements):

Name	Dosage	Directions	Route of Administration

Are you allergic to any medications?  Yes  No If yes, please list: \_\_\_\_\_

Do you have now or have you ever had the following diseases or conditions:

	Yes	No		Yes	No		Yes	No
<b>Lungs:</b>			<b>Other Systemic:</b>			<b>Artificial/Implanted Devices:</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Pins or Screws	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis or Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve(s)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vascular:</b>			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Stent(s)	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint	<input type="checkbox"/>	<input type="checkbox"/>	Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker with Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker w/o Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	Implanted Brain Devices	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Healing	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
			HIV+	<input type="checkbox"/>	<input type="checkbox"/>			

Are you currently pregnant, planning a pregnancy, or breastfeeding?  Yes  No

Do you have a history of cancer?  Yes  No If yes, please list: \_\_\_\_\_

Do you have a family history of malignant melanoma?  Yes  No If yes, whom?: \_\_\_\_\_

Have you had a flu shot this season? (October thru March)  Yes  No

For patients 65 and over, have you received the pneumococcal vaccine?  Yes  No

Are you under the care of Hospice?  Yes  No

Do you bleed easily?  Yes  No

Do you use tobacco products?  Yes  No Type/frequency \_\_\_\_\_ Are you interested in cessation counseling?  Yes  No

Do you drink alcohol?  Yes  No If yes, amount per week: \_\_\_\_\_

**Have you had any changes in your health insurance?**  Yes  No *\*If yes, please present cards to our receptionist so she may make a copy and update your account.*

(Updated July 2017)