



JOSE R. ANTUNES, M.D., P.A.
2400 FRUITVILLE ROAD SARASOTA, FLORIDA 34237
941-365-0333 FAX: 941-955-3181

NAME: _____

AGE: _____ SEX: _____ TODAY'S DATE: _____

PLEASE CHECK BOX IF YOU HAVE OR HAVE HAD EITHER: DIABETES THYROID DISEASE

- | | |
|--|--|
| <p>1. <input type="checkbox"/> FATIGUE <input type="checkbox"/> TIREDNESS</p> <p>2. <input type="checkbox"/> INTOLERANCE TO HEAT OR COLD</p> <p>3. <input type="checkbox"/> EXCESSIVE SWEATING</p> <p>4. <input type="checkbox"/> INCREASE <input type="checkbox"/> DECREASE - IN APPETITE</p> <p>5. <input type="checkbox"/> WEIGHT GAIN <input type="checkbox"/> LOSS</p> <p>6. <input type="checkbox"/> FAST HEART RATE</p> <p>7. <input type="checkbox"/> CHEST PAIN</p> <p>8. <input type="checkbox"/> HEART MURMUR</p> <p>9. <input type="checkbox"/> SWELLING OF LEGS</p> <p>10. <input type="checkbox"/> HIGH BLOOD PRESSURE</p> <p>11. <input type="checkbox"/> HEARTBURN</p> <p>12. <input type="checkbox"/> STOMACH OR DUODENAL ULCER</p> <p>13. <input type="checkbox"/> ABDOMINAL PAIN</p> <p>14. <input type="checkbox"/> NAUSEA <input type="checkbox"/> VOMITING</p> <p>15. <input type="checkbox"/> DIFFICULTY SWALLOWING</p> <p>16. <input type="checkbox"/> DIARRHEA / CONSTIPATION</p> <p>17. <input type="checkbox"/> BLACK AND TARRY STOOLS</p> <p>18. <input type="checkbox"/> YELLOW JAUNDICE</p> <p>19. <input type="checkbox"/> BLEEDING FROM RECTUM</p> <p>20. <input type="checkbox"/> PAINFUL URINATION</p> <p>21. <input type="checkbox"/> KIDNEY/BLADDER STONE</p> <p>22. <input type="checkbox"/> HAVE TO URINATE AT NIGHT</p> <p>23. <input type="checkbox"/> BLADDER OR KIDNEY INFECTION</p> <p>24. <input type="checkbox"/> DIFFICULT STARTING URINATION</p> <p>25. <input type="checkbox"/> DECREASE IN URINE STREAM</p> <p>26. <input type="checkbox"/> PROSTATE PROBLEMS</p> <p>27. <input type="checkbox"/> SEXUAL IMPOTENCE</p> <p>28. <input type="checkbox"/> LUMPS OR PAINS IN TESTES</p> <p>29. <input type="checkbox"/> CHANGES IN SKIN <input type="checkbox"/> DRY</p> <p><input type="checkbox"/> COARSE <input type="checkbox"/> CLAMMY</p> <p>30. <input type="checkbox"/> CHANGES IN HAIR</p> <p>31. <input type="checkbox"/> TREMOR OF HANDS/FINGERS</p> <p>32. <input type="checkbox"/> FREQUENT HEADACHES</p> <p>33. <input type="checkbox"/> MUSCLE WEAKNESS</p> <p>34. <input type="checkbox"/> DIZZY SPELLS</p> <p>35. <input type="checkbox"/> FAINTING OR BLACKOUTS</p> <p>36. <input type="checkbox"/> IRREGULAR PULSE</p> <p>37. <input type="checkbox"/> HEART ATTACK</p> <p>38. <input type="checkbox"/> VISUAL DISTURBANCE <input type="checkbox"/> DOUBLE <input type="checkbox"/> BLURRED</p> <p><input type="checkbox"/> DECREASED</p> <p>39. <input type="checkbox"/> PAINFUL EYES</p> <p>40. <input type="checkbox"/> COUGH</p> <p>41. <input type="checkbox"/> BLOOD IN SPUTUM</p> <p>42. <input type="checkbox"/> ASTHMA / WHEEZING</p> <p>43. <input type="checkbox"/> NUMBNESS COLD SENSATION - <input type="checkbox"/> FEET <input type="checkbox"/> LEGS</p> <p><input type="checkbox"/> HANDS</p> <p>44. <input type="checkbox"/> PAIN IN LEGS WHEN WALKING</p> | <p>45. <input type="checkbox"/> DECREASED HEARING</p> <p>46. <input type="checkbox"/> RINGING IN THE EARS</p> <p>47. <input type="checkbox"/> VOICE CHANGES</p> <p>48. <input type="checkbox"/> NICK PAIN</p> <p>49. <input type="checkbox"/> SWELLING / LUMPS IN NECK</p> <p>50. <input type="checkbox"/> FEELINGS OF DEPRESSION</p> <p>51. <input type="checkbox"/> FEELINGS OF ANXIETY</p> <p>52. <input type="checkbox"/> MOODINESS</p> <p>53. <input type="checkbox"/> NERVOUSNESS</p> <p>54. <input type="checkbox"/> MEMORY LOSS</p> <p>55. <input type="checkbox"/> MENTAL ILLNESS</p> <p>56. <input type="checkbox"/> PHOBIAS</p> <p>57. <input type="checkbox"/> SLEEP DISTURBANCES</p> <p>58. <input type="checkbox"/> ARTHRITIS / PAIN IN JOINTS</p> <p>59. <input type="checkbox"/> BACK PAINS</p> <p style="text-align: center;"><u>FEMALE - MENSTRUAL HISTORY</u></p> <p>60. <input type="checkbox"/> AGE OF ONSET _____</p> <p>61. <input type="checkbox"/> MENSTRUAL PERIODS: <input type="checkbox"/> REGULAR <input type="checkbox"/> HEAVY</p> <p><input type="checkbox"/> MODERATE <input type="checkbox"/> LIGHT</p> <p>62. <input type="checkbox"/> DAYS OF MENSTRUAL FLOW _____</p> <p>63. <input type="checkbox"/> LENGTH OF CYCLE _____ DAYS</p> <p>64. <input type="checkbox"/> PAIN / BLEEDING AFTER SEX</p> <p>65. <input type="checkbox"/> HOT FLASHES</p> <p>66. <input type="checkbox"/> NUMBER OF PREGNANCIES _____</p> <p>67. <input type="checkbox"/> MISCARRIAGES _____</p> <p>68. <input type="checkbox"/> DO YOU DO SELF BREAST EXAMS? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>69. <input type="checkbox"/> BREAST SECRETION <input type="checkbox"/> PAIN <input type="checkbox"/> LUMPS</p> <p>70. <input type="checkbox"/> DO YOU HAVE PMS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>71. <input type="checkbox"/> FAMILY HISTORY OF OSTEOPOROSIS <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>72. <input type="checkbox"/> AT WHAT AGE DID YOU GO INTO MENOPAUSE?</p> <p>_____</p> <p>73. <input type="checkbox"/> DID YOU TAKE HORMONES AFTER YOUR</p> <p>MENOPAUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, FOR HOW</p> <p><input type="checkbox"/> LONG? _____</p> <p style="text-align: center;"><u>DIETARY HISTORY</u></p> <p>74. <input type="checkbox"/> ARE YOU ON A SPECIAL DIET? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF YES, PLEASE SPECIFY: _____</p> <p>75. <input type="checkbox"/> DO YOU TAKE CALCIUM SUPPLEMENTS? <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO IF YES, HOW MUCH PER DAY? _____</p> <p>76. <input type="checkbox"/> DO YOU TAKE VITAMIN D SUPPLEMENTS? <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO IF YES, HOW MUCH PER DAY? _____</p> <p>77. PLEASE LIST ALL THE VITAMINS AND OVER</p> <p>THE COUNTER MEDICATIONS YOU TAKE ON A</p> <p>REGULAR BASIS (USE BACK OF PAGE IF</p> <p>NEEDED): _____</p> <p>_____</p> |
|--|--|



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NAME: _____

AGE: _____ SEX: _____ TODAY'S DATE: _____

FAMILY HISTORY:

	ALIVE	DECEASED	AGE	ILLNESSES
FATHER:	_____	_____	_____	_____
MOTHER:	_____	_____	_____	_____
BROTHERS/SISTERS:				
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
SPOUSE:	_____	_____	_____	_____

HABITS:

DO YOU/HAVE YOU EVER SMOKED? YES NO HOW MANY PER DAY? _____

DO YOU DRINK ALCOHOL? YES NO HOW MUCH PER WEEK? _____

DO YOU EXERCISE? YES NO WHAT DO YOU DO: _____

PLEASE LIST ANY OPERATIONS:

1. _____ YEAR: _____ 2. _____ YEAR: _____

3. _____ YEAR: _____ 4. _____ YEAR: _____

5. _____ YEAR: _____ 6. _____ YEAR: _____

PLEASE LIST ANY OTHER HOSPITALIZATIONS:

1. _____ YEAR: _____ 2. _____ YEAR: _____

3. _____ YEAR: _____ 4. _____ YEAR: _____

PLEASE LIST ALL CURRENT *OVER THE COUNTER* MEDICATIONS AND VITAMINS:

1. _____ YEAR: _____ 2. _____ YEAR: _____

3. _____ YEAR: _____ 4. _____ YEAR: _____

PLEASE LIST ANY ALLERGIES TO MEDICATIONS:



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**IF YOU HAVE DIABETES MELLITUS
PLEASE ANSWER THE FOLLOWING:**

1. I HAVE HAD DIABETES SINCE _____
2. MY WEIGHT IS _____ LBS. MY HEIGHT IS _____ FT. _____ IN.
3. I AM ON _____ CALORIES PER DAY.
4. I DO NO NOT STAY ON MY DIET MOST OF THE TIME.
5. I EXERCISE REGULARLY OCCASIONALLY NEVER
6. I MONITOR THE CONTROL OF MY DIABETES WITH:
 HOME BLOOD SUGARS
7. HAVE YOU EVER HAD DIABETES KETOACIDOSIS? YES NO
8. DO YOU KNOW THE SYMPTOMS OF HYPOGLYCEMIA? YES NO
9. DO YOU CARRY A SUGAR TABLET OR HARD CANDY TO USE IN CASE OF HYPOGLYCEMIA? YES NO
10. WERE YOU EVER HOSPITALIZED BECAUSE OF DIABETES? YES NO
IF YES, EXPLAIN WHY _____
11. DO YOU HAVE ANY OF THE LONG TERM COMPLICATIONS OF DIABETES?
 YES NO
12. DO YOU SEE YOUR EYE DR. ONCE A YEAR? YES NO
13. DO YOU SEE YOUR FOOD DR. REGULARLY? YES NO
DATE OF LAST EXAM _____
14. MY DIABETES WORSENS WHEN: I DO NOT EAT PROPERLY
 I AM UNDER STRESS I DO NOT TAKE MEDICATIONS PROPERLY
 OTHER _____
15. WHEN MY BLOOD SUGAR GOES UP, I HAVE THE FOLLOWING SYMPTOMS:
 BLURRED VISION THIRST WEAKNESS WEIGHT LOSS
 INCREASED URINATION NAUSEA VOMITING
 VAGINAL ITCHING OTHER _____
16. DO YOU KNOW WHAT HEMOGLOBIN A1C IS? YES NO
IF YES, DO YOU KNOW WHEN THE LAST ONE WAS DONE? _____
17. DID YOU EVER ATTEND CLASSES ABOUT DIABETES? YES NO
WHEN? _____
18. DOES DIABETES COMPLICATE YOUR HOME OR WORK SITUATION IN ANY WAY?
 YES NO IF YES, EXPLAIN _____

PATIENT NAME: _____ DATE: _____



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NAME: _____

TODAY'S DATE: _____

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGE

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____



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THESE QUESTIONS PERTAIN TO HOW YOUR MEDICAL INFORMATION MAY BE DISCLOSED.
PLEASE REVIEW CAREFULLY AND SIGN BELOW.

DO WE HAVE YOUR PERMISSION TO MAIL OR FAX YOUR PROGRESS NOTES AND LABORATORY RESULTS TO YOUR HOME? **YES NO**
 PLEASE PROVIDE MAILING ADDRESS AND/OR FAX NUMBER:

IDENTIFY THE DOCTORS NAME UPON CALLING FOR APPOINTMENT REMINDERS: **YES NO**
 CALL APPOINTMENT REMINDERS TO YOUR HOME? **YES NO**

DO WE HAVE PERMISSION TO LEAVE THE FOLLOWING INFORMATION ON YOUR HOME ANSWERING/VOICE MAIL:

- TEST RESULTS / MEDICAL INFORMATION **YES NO**
- APPOINTMENT INFORMATION **YES NO**
- BILLING INFORMATION **YES NO**
- MAY WE CONTACT YOU AT YOUR E-MAIL ADDRESS WITH THE TEST RESULTS, MEDICAL INFORMATION, APPOINTMENT INFORMATION? **YES NO**

MAY WE SENT BILLING STATEMENTS AND INSURANCE INFORMATION TO YOUR E-MAIL ADDRESS **YES NO**
 E-MAIL: _____@_____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

NAME: _____ DATE: _____

ADDRESS: _____

I AUTHORIZE PERMISSSION TO SHARE MY MEDICAL, BILLING AND APPOINTMENT INFORMATION WITH THE FOLLOWING INDIVIDUALS:

I HEREBY AUTHORIZE THE OFFICE OF JOSE R. ANTUNES, M.D., TO APPLY FOR BENEFITS ON MY HEHALF FOR COVERED SERVICES RENDERED. I REQUEST PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO THE DOCTOR IF ASSIGNMENT HAS BEEN TAKEN. I CERTIFY THAT THE INFORMATION I HAVE REPORTE3D WITH REGARD TO MY INSURANCE COVERAGE IS **CORRECT** AND FURTHER **AUTHORIZE THE RELEASE OF ANY NECESSARY MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIM TO THE INSURANCE COMPANY.** I HAVE LISTED OR IN THE CASE OF MEDICARE PART B TO THE SOCIAL SECURITY ADMINISTRATION AND PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY MYSELF OR THE ABOVE OFFICE AT ANYTIME. **I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.**

PRINT NAME _____ **SIGNATURE** _____



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**PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION**

With my consent, Jose R. Antunes, M.D., P.A. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Jose R. Antunes, M.D., P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent. Jose R. Antunes, M.D., P.A. reserves the right to revise it's Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager / Privacy Officer at 2400 Fruitville Road, Sarasota, FL 34237. With my consent, Jose R. Antunes, M.D., P.A. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Jose R. Antunes, M.D., P.A. may mail my appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Jose R. Antunes, M.D., P.A. may e-mail my appointment reminder cards and patient statements. I have the right to request that Jose R. Antunes, M.D., P.A restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreements.

With my consent, Jose R. Antunes, M.D., P.A. may fax to the designated Medical Doctor as noted on the front of my chart all progress notes and laboratory reports.

By signing this form, I am consenting to Jose R. Antunes, M.D., P.A.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Jose R. Antunes, M.D., P.A. may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date



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ADVANCED NOTICE TO BENEFICIARY

DATE: _____

Florida law requires me, as your physician, to accept Medicare assignment for any services provided to a Medicare beneficiary for an emergency medical condition. An emergency medical condition is defined as one which manifests “itself by acute symptoms of sufficient severity, which may include severe pain”, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the patients’ health
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part

By signing below, you agree that as your physician, Jose R. Antunes, M.D. will not accept assignment for treatment provided to you for any condition other than an emergency medical condition.

Patient Signature: _____