JOHN W. COOKE, D.O., P.A.
633 North Bay Street—Eustis, FL 32726—352-357-3107—Fax 352-414-5939

Patient Information

Today's Date:_____ Social Security #:_____-_____-_____ Home Phone:_____

Patient Name:_____ Age:_____ Date of Birth:_____/_____/_____

Marital Status: M S W D Cell Phone: _____ Work:_____

Mailing Adress:_____

City:_____ State:_____ Zip Code:_____

Physical Address(If different from mailing address):_____

City:_____ State:_____ Zip Code:_____

Do you have a Medical Power of Attorney: Y N Do you have a DNR (Do Not Resuscitate): Y N

In Case of Emergency Notify:_____Phone:_____Relationship:_____

Name of Nearest Relative NOT living with you:_____

Address:_____ Phone:_____ Relationship:_____

Insurance Information: It is your responsibility to inform the office of any changes in **Insurance Information**

1)Primary Insurance:_____ **Name of Insured**:_____

Insured relationship to patient:_____ **Insured SS#:** _____/_____/_____**DOB**:_____

2)Supplemental Insurance:_____ **Name of Insured**:_____

Insured relationship to patient:_____ **Insured SS#:** _____/_____/_____**DOB**:_____

PLEASE NOTE

Our policy is to collect for services at the time they are rendered unless other arrangements are made prior. By signing below , you acknowledge the following:

- I understand that my medical insurance is a contract between myself and my insurance company, not between John W. Cooke, D.O., and my insurance company. Therefore, I AM responsible for payment for services to John W. Cooke, D.O. **Initial**_____
- I authorize release of medical information necessary to process my insurance claims to and from John W. Cooke, D.O., and I authorize payment of medical benefits from my insurance carrier to go to John W. Cooke, D.O. for any charged filed on assignment. A photocopy of this authorization is valid as the original and shall not expire until the termination of my relationship with John W. Cooke, D.O. **Initial**_____
- I understand that I am responsible for any charges not covered by my Insurance carrier, be it Medicare of any other carrier when they are filed. A photocopy of this authorization shall be valid as an original. **Initial**_____
- I acknowledge that I have read the Terms & Conditions and agree to accept full responsibility and guarantee payment of any and all charges. **Initial**_____

Signature:_____ **Date Signed:**_____

Witness:_____ **Date Signed:**_____

JOHN W. COOKE, D.O., P.A.

633 North Bay Street, Eustis, FL 32726

Comprehensive Internal Medicine History Sheet

Patient Name:_____ Date of Birth:_____

Illness: Please indicate if you now or have ever had any of the following illnesses. Only check the box if the answer is yes; please indicate the year you had the illness or when it started to the best of your knowledge:

□ Anemia_____	□ Headache_____	□ Sinus Problems_____
□ Arthritis _____	□ Heart Disease/Murmur_____	□ Skin Disease_____
□ Asthma _____	□ Hearing Loss _____	□ Stroke_____
□ Back Problems _____	□ Hemorrhoids/Diarrhea_____	□ Thyroid Disease_____
□ Bronchitis/Emphysema_____	□Hepatitis/Liver Disease_____	□ Tuberculosis_____
□ Cataracts_____	□High Blood Pressure_____	□ Tumors_____
□ Cancer_____	□ Kidney/Renal Disease_____	□ Ulcers_____
□ Emotional Problems_____	□ Pneumonia_____	□ Vascular Disease_____
□ Hay Fever_____	□ Seizure/Epilepsy_____	□ Vision Problems_____

Other Significant Illnesses:_____

List any ABNORMAL tests (lab, x-rays, etc.):_____

Surgeries/Hospitalizations: Please indicate the year or your age at time of surgery and reason performed to the best of your knowledge

Appendectomy_____	□Colon/Rectal Surgery_____	□ Tonsillectomy_____
□ Breast Biopsy/Mastectomy_____	□ D & C_____	□ Tubal Ligation_____
□ C Section_____	□ Gall Bladder Removal_____	□ Tubes in Ears_____
□ Cardiac Surgery_____	□Hysterectomy_____	□Vasectomy_____
□Cataract Surgery_____	□Kidney/Bladder_____	□Other_____

Other Surgeries (back, hip, knee, shoulder, etc.): _____

_____

Accidents: Please list any significant accidents (work, auto, fall, etc):_____

_____

Adult Wellness & Preventative Care: Approximate date when last done.

_____Influenza Shot	_____EKG	_____Vision Exam	_____Urinalysis
_____Pneumonia Shot	_____Hem Occult	_____Chest X-ray	_____Sigmoid Scope
_____Hepatitis Shot	_____Cholesterol	_____TB Tine or PPD	_____Colonoscopy
_____Tetanus Shot	_____Last Complete Physical		

Name and address of last physician:_____

Medications: Please list **ALL** medications you are currently taking. Include all prescription and over the counter medications as well. (Include the dosage and how you take the medication.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Digestive:

Peptic Ulcer When?	NO	YES	
Heartburn or Indigestion	NO	YES	
Sour taste in mouth or throat often	NO	YES	
Often use TUMS, Rolaids, Maalox, etc, antacid	NO	YES	
Poor tolerance to spicy foods, coffee, alcohol	NO	YES	
Do foods stick in the throat while swallowing	NO	YES	
Gallbladder trouble	NO	YES	
Poor tolerance to greasy food or fat	NO	YES	
Liver trouble, jaundice, hepatitis	NO	YES	
Crampy abdominal pain often	NO	YES	
Chronic constipation	NO	YES	
Frequent constipation	NO	YES	
Change in bowel habits	NO	YES	
Hemorrhoids or piles	NO	YES	

Genitourinary:

Loss of urine when cough or sneeze	NO	YES	
Kidney or bladder infection	NO	YES	last_____
Burning or painful urination	NO	YES	
Frequent urination	NO	YES	
Do you have to get up at night to urinate	NO	YES	How often_____
Blood in urine	NO	YES	
Kidney stones	NO	YES	When?_____
Swelling of hands and feet	NO	YES	
Difficulty starting urinations, weak stream	NO	YES	

Musculoskeletal:

Bothersome arthritis	NO	YES
Weakness which is new or limits activity	NO	YES
Difficulty in walking	NO	YES
Have you experienced any gout in the past?	NO	YES

Skin:

Frequent infections	NO	YES
Skin disorders (what type?)	NO	YES
Skin cancers removed? Moles removed?	NO	YES

Emotional:

Do you have much trouble sleeping	NO	YES
Are you tired most of the time?	NO	YES
Are you often depressed or distracted?	NO	YES

Do you have trouble with temper, anger?	NO	YES	
Do you get physically sick when stressed?	NO	YES	

Hematologic:

Have you been anemic?	NO	YES	if yes, when?_____
Excessive bleeding or abnormal bruising	NO	YES	

OTHER:

Very poor tolerance to heat or cold, recent	NO	YES	
Major change in skin or hair	NO	YES	
Major voice change	NO	YES	
Crave large amounts of water recently	NO	YES	
Has osteoporosis ever been diagnosed?	NO	YES	if yes, when?_____

What other health concerns do you want to discuss?

_____

_____

_____

_____

_____

_____

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633 North Bay Street
Eustis, FL 32726
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CONSENT TO RELEASE INFORMATION

I, _____ hereby consent for the following persons to be able to receive information pertaining to my health as well as my health care.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Signature: _____

Printed Name: _____

Date: _____

Witness Signature: _____

Witness Printed Name:_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date: _____

I hereby authorize: _____

_____

to release to: Dr. John W. Cooke, D.O., P.A.
633 North Bay St.
Eustis, FL 32726
Phone: 352-357-3107
Fax: 352-414-5939

The following information from my records: Medical, Psychiatric, Drug and or Alcohol abuse, HIV testing, ARC, or AIDS information.

Patient: _____ D.O.B.: _____

Social Security Number: _____

Records covering period from _____ to _____

____ Copy of Progress Notes/ Office Notes
____ Discharge Summary
____ History and Physical
____ Lab/ X-ray reports
Other _____

The above information is released for the following purpose. Any other use is forbidden. _____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed from records whose confidentiality is protected under Federal Law. Federal Regulations (42 CFR Part 2) prohibit recipients from making any further disclosure of this information except with the specific written consent of the patient. A general authorization for the release of information if held by another party is not sufficient for this purpose.

Signed: _____ Date: _____

Witness: _____

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AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. Opioids, tranquilizers, barbituates, sleeping pills, muscle relaxers, etc.) are very useful but have a high potential for misuse and therefore are closely monitored and controlled by the local, state, and federal governments. They are intended to **relive pain,** to **improve function**, and/or ability to **work, *not*** to simply feel good. Because Dr.Cooke is prescribing such a medication for me to help manage pain, I agree to the following conditions:

1. **I AM RESPONSIBLE FOR MY CONTROLLED SUBSTANCE MEDICATIONS.** If the prescription of medication is lost, misplace, stolen, or if I use it up sooner then prescribed, I understand that it **will not** be replaced.
2. **I WILL NOT REQUEST OR ACCEPT CONTROLLED SUBSTANCE MEDICATIONS FROM ANY OTHER PHYSICIAN OR INDIVIDUAL WHILE I AM RECEIVING SUCH MEDICATION FROM DR. COOKE WHILE UNDER HIS CARE.** Besides being illegal to do so, it may endanger my health. The only exceptions being while admitted to the hospital or on direction of Dr. Cooke that I be treated by Pain Medicine.
3. **REFILLS** of controlled substance medication:
    a. **WILL BE MADE ONLY DURING REGULAR BUSINESS HOURS.** Monday thru Friday, in person, once a month.
    b. **WILL NOT BE MADE** If I "un out early" or "lose a prescription" or "spill or misplace" my medication. I am responsible for taking medication in the dose prescribed and for keeping track of the amount remaining.
    c. **WILL NOT BE MADE** as an **Emergency**
    d. **WILL ONLY BE MADE IN THE OFFICE WITH AN APPOINTMENT TO SEE DR. COOKE.**
4. Dr. Cooke may deem it necessary for me to see a Pain Management Doctor or a medication use specialist at any time while I am receiving a controlled substance. I understand that if I do not attend this appointment that my medications may not be continued or refilled. I understand that if it is determined by the medicine specialist or Dr. Cooke that I am at risk for psychological dependence (addiction) that my medications will no longer be refilled.
5. I understand that driving a motor vehicle may not be allowed at times while taking controlled substance medications and that it is my responsibility to comply with the laws of this state while taking the medication prescribed.
6. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment may be ended IMMEDIATELY. If the violation involves obtaining controlled substances from another individual, for another individual, or the concomitant use of non-prescribed illegal drugs, I may also be reported to the proper officials and authorities.
7. I understand that the main treatment goal is to improve my ability to function, work and/or reduce pain.
8. I understand that the long term advantages of chronic opioid use have yet to be scientifically determined and that the treatment may change throughout my time as a patient. I understand and accept that there may be unknown risks associated with long term use of controlled substance medications and that Dr. Cooke will advise and may alter or discontinue my medications as determined by both mental and physical examination.

9. I understand that failing to sign this agreement in turn allows Dr. Cooke to refuse to prescribe me any controlled substance medication and/or discharge me as a patient based on failure to comply to controlled substance medication provisions as set forth by the government and this office.

I have read this agreement and the same has been explained to me by either Dr. Cooke or a member of his staff. In addition, I also understand and submit to the consequences of violating this agreement.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

LIVING WILL and DURABLE POWER OF ATTORNEY FOR HEALTHCARE FORMS and INSTRUCTIONS

The **Designation of Durable Power of Attorney for Healthcare** and Living Will are legal documents you may complete to help ensure that your wishes are carried out when you are unable to speak for yourself. **It is very important that your wishes expressed in these documents be discussed with your physician and family / significant other.**

You may at sometime lose the ability to make sound judgments concerning medical treatment for reasons that may range from confusion caused by medication or coma following a major accident. When you cannot make decisions about your medical care, others, such as family members and physicians will need to take responsibility for these decisions. Often, it is difficult for them to know what your wishes are. The decision process in these complex situations is made easier when you have previously expressed wishes about your medical care, including the withholding and/or withdrawal of life prolonging procedures.

You must be an adult (age 18 or older) and of sound mind when completing these forms. **In order for these documents to be valid, they must be signed by you in the presence of two witnesses. Only one witness may be your spouse or a relative.** The person you designate as your Durable Power of Attorney for Healthcare **cannot** be a witness. These documents do **not** need to be notarized.

The **Durable Power of Attorney for Healthcare** document allows you to appoint another person to make healthcare decisions on your behalf when you are unable to do so. It is recommended that you appoint an adult who knows your wishes and will carry them out. It is suggested that you choose a person who has exhibited special care and concern for you and has maintained regular contact and is familiar with your personal, religious, moral and cultural beliefs. Your Durable Power of Attorney for Healthcare will have the authority to make all medical decisions on your behalf according to your wishes, including but not limited to the withholding / withdrawal of life prolonging procedures.

The **Living Will** document lets your physician(s) and others know your choices regarding the use of life prolonging procedures if you are unable to make decisions for yourself. Your physician and your Durable Power of Attorney for Healthcare are to follow the directives of the Living Will. Your physician is required to make a reasonable effort to transfer your care to another physician if he/she is unable or unwilling carry out your wishes specified in the Living will.

These documents are valid as long as you do not rescind them or declare them void. These documents will continue indefinitely unless you provide for an expiration date. These documents will become void at time of death. If you decide at any time to revoke any portion of these documents, **immediately tell** this to your attending/treating physician. Also, retrieve and destroy all copies given to others and complete a new document(s).

You should keep the original completed documents. Copies should be given to:

- individual designated as Durable Power of Attorney for Healthcare.
- family member(s), friends, as appropriate
- family physician or primary health care provider
- the hospital each time you are admitted
- nursing home or assisted living facility if this is your home
- clergy, and / or attorney (optional)

The Durable Power of Attorney for Healthcare Living Will and these instructions are based on Florida Law. These instructions are intended to be general guidelines only. If further guidance is needed or questions arise regarding these documents, your physician, clergy or attorney should be contacted.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE
(DESIGNATION OF HEALTH CARE SURROGATE)

In the event that I, Name_____ Age _____ have been determined by my physician(s) to be incompetent/incapacitated (lack the ability) to provide informed consent for medical treatment and surgical and diagnostic procedures including but not limited to the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate as my decision maker (surrogate) to make health care decisions:

Name: _____ / _____ Phone # (w) _____
relationship (h) _____
Address: _____ (c) _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate decision maker:

Name: _____ / _____ Phone # (w) _____
relationship (h) _____
Address: _____ (c) _____

I fully understand that this designation will permit my decision maker to make all health care decisions on my behalf until I regain the ability to make health care decisions. The healthcare decisions may also include if necessary the decisions to withhold, withdraw, or continue life prolonging procedures. My decision maker may also authorize my admission to or transfer from a health care facility and also apply for public assistance on my behalf. This designation is to remain in effect during any incapacity or in competency I may experience.

Additional instructions (optional): _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Witness: _____ Signature: _____

Witness: _____ Date: _____

LIVING WILL

I willfully and voluntarily make known my desire that my dying not be prolonged under the following circumstances. If at any time I have a terminal condition and/or am in persistent vegetative state, and if my attending/treating physician and a consulting physician have determined that there is no medical probability of my recovery from such condition(s), 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. I request to be permitted to die naturally with only the administration of medication or the performance of medical procedures deemed necessary to provide me with comfort care or to alleviate pain.

I also desire to have life prolonging procedures withheld/withdrawn when: (optional)

_____ Initial — Due to debilitating disease/condition in which I have no reasonable probability of recovering, I cannot communicate or interact purposely with others.

_____ Initial — Specify Other Condition: _____

In addition, I do _____ Initial or I do not _____ Initial want to be given nutrition (food) and/or hydration (water) artificially by a feeding tube or by intravenous feeding when it would serve only to prolong artificially the process of dying.

Additional instructions (optional): _____

I request that my Living Will be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. **If I am pregnant and this is known to my physician(s), this Living Will shall have no force or effect during the course of my pregnancy.**

I understand the full meaning of this Living Will, and I am emotionally and mentally competent to make these declarations.

Witness: _____ Signature: _____

Witness: _____ Date: _____