

PINNACLE MEDICAL GROUP

Bayshore Family Physicians

David P. DiVita, MD

6033 26th Street West, Bradenton, FL 34207

Phone (941) 752-2025 Fax (941) 752-3921

Home Phone () _____ Business/Cell Phone () _____

PATIENT

Last Name	First Name	Initial
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Gender Male Female Ethnicity _____ Preferred Language _____

Race American Indian or Alaska Native Asian
 Native Hawaiian or Other Pacific Islander Black or African American
 White Unreported/Refused to Report

Date of Birth _____ Social Security # _____

Street Address _____

City _____ State _____ Zip _____

Email _____ Employer or School _____

Out of State Address (if applicable) _____

City _____ State _____ Zip _____

Out of State Phone () _____

SPOUSE (or person responsible for payment) Name _____

Date of Birth _____ Social Security # _____

Relationship to Patient _____

Employer Name _____ Occupation _____

Employer Address _____

Business Phone () _____

Name of Primary Insurance _____

Name of Secondary Insurance (if any) _____

Is today's visit related to a Worker's Compensation claim? _____ No _____ Yes

Is today's visit related to an auto insurance claim? _____ No _____ Yes

Please list other doctors you have seen in the last 2 years:

1. _____ Specialty _____

2. _____ Specialty _____

3. _____ Specialty _____

4. _____ Specialty _____

How did you learn about our practice?

() Word of Mouth () Phonebook () Other Physician _____

() Advertisement () Insurance Company () Other _____

I hereby authorize Dr. DiVita to release all or part of my medical records to Medicare and/or any other insurance company(s), if requested, without any liability to Dr. DiVita. I hereby authorize Medicare and/or my insurance company(s) to pay directly to Dr. DiVita any payments, assignments, or benefits due me.

_____ Date _____
Patient signature, or (if a minor) Parent or Guardian Signature

_____ Date _____
Insurance Policyholder signature, or (if other than patient)

PINNACLE MEDICAL GROUP

BAYSHORE FAMILY PHYSICIANS

David P. DiVita, MD

PATIENT HISTORY

Patient _____ Birthdate _____
Last Name First Name Initial

Reason(s) for seeing Dr. DiVita today:

- 1)
- 2)
- 3)

MEDICAL HISTORY:

Please check (✓) if you have ever been diagnosed with any of the following conditions...

- | | |
|---|--|
| <input type="checkbox"/> alcoholism | <input type="checkbox"/> heart attack |
| <input type="checkbox"/> anemia | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> arthritis (osteoarthritis) | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> arthritis (rheumatoid) | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> asthma | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> atrial fibrillation | <input type="checkbox"/> leg wounds/ulcers |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> cancer | <input type="checkbox"/> mononucleosis ("mono") |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> pacemaker |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia |
| <input type="checkbox"/> coronary artery blockage | <input type="checkbox"/> prostate enlargement (BPH) |
| <input type="checkbox"/> depression | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> stroke |
| <input type="checkbox"/> drug dependence | <input type="checkbox"/> suicide attempt |
| <input type="checkbox"/> epilepsy (seizures) | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> esophageal reflux (GERD) | <input type="checkbox"/> TIA ("mini stroke") |
| <input type="checkbox"/> gout | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> headaches | <input type="checkbox"/> ulcers (stomach/intestinal) |

SURGICAL HISTORY:

Please list the type of surgery and date it was performed.

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS

It is our office policy to ask patients to bring their medication bottles or a list of their current medications to each and every doctor's appointment. This includes over the counter and herbal medicines. Our patients are encouraged to carry a list of their medications with them at all times. Please give the nurse your medication list so she may enter it into your medical chart. Thank you.

ALLERGIES

Please list any...

medication allergies _____
food allergies _____
environmental allergies _____

FAMILY MEDICAL HISTORY

	age, if living	if deceased, age at death	cause if death
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Sister	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

SOCIAL HISTORY

Marital status ---> single ____ married ____ widowed ____ divorced ____ separated ____

Children ---> number of sons _____
number of daughters _____

Occupation ---> Are you currently employed? yes ____ no ____ retired ____
What is your present (or past) occupation? _____

Smoking History ---> Do you currently smoke?
If yes, fill in all that apply...
cigarettes ____ cigars ____ smokeless tobacco ____
number per day _____ years smoking _____
If no, have you ever smoked? yes ____ no ____
if yes, when did you quit smoking? _____

Seatbelt ---> Do you always wear your seatbelt? yes ____ no ____

Exercise ---> Do you exercise regularly? yes ____ no ____

REVIEW OF SYSTEMS

Please check if you currently experience or have experienced the following symptoms in the past year:

GENERAL

- fever
- chills
- weight loss
- weight gain
- fatigue

EYES

- double vision
- loss of vision
- spots before eyes
- wear glasses or contacts
- cataracts
- glaucoma

EARS, NOSE, MOUTH, THROAT

- loss of hearing
- wear hearing aid(s)
- ringing in ears
- sinus problems
- nosebleeds
- sore throat
- dentures
- hoarseness

CARDIOVASCULAR

- chest pain
- easily out of breath
- leg swelling
- heart palpitations
- varicose veins

RESPIRATORY

- shortness of breath
- wheezing
- chronic cough
- coughing up blood
- on oxygen at home

GASTROINTESTINAL

- diarrhea
- constipation
- dark stools
- blood in stools
- nausea
- vomiting
- stomach pain
- hemorrhoids

GENITOURINARY

- blood in urine
- painful urination
- frequent urination
- urine incontinence
- kidney stones
- frequent UTI's

MUSCULOSKELETAL

- muscle weakness
- joint pain
 - neck
 - shoulders
 - back
 - hips
 - knees
 - hands
 - feet
- fibromyalgia

SKIN

- psoriasis
- eczema
- changing moles
- dry skin
- sunburn easily
- hives

NEUROLOGICAL

- dizziness
- tremor
- difficulty walking
- frequent falls

PSYCHIATRIC

- feel sad most of the time
- difficulty sleeping
- bipolar
- ADHD

HEMATOLOGIC

- bruise easily
- cuts do not stop bleeding

MEN ONLY

- erection problems
- decreased stream
- discharge
- STD in past

date of last colonoscopy

_____ never had one

WOMEN ONLY

- irregular periods
- breast lump
- painful intercourse
- hot flashes
- abnormal pap smear
- abnormal mammogram

date of last pap smear

_____ unknown
_____ never had one

date of last mammogram

_____ unknown
_____ never had one

lifetime number of

pregnancies _____
abortions or
miscarriages _____
deliveries _____

**THANK YOU VERY MUCH FOR COMPLETING THIS FORM!
IT WILL HELP US PROVIDE BETTER CARE TO YOU!**

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PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

DON'T LOSE YOUR RIGHT TO DECIDE

You cannot remove all uncertainty about your future health care needs, but by having an advance directive you can have peace of mind that comes from making your wishes known in advance.

Declaration to Decline Life Prolonging Procedures

- I have made a Living Will
- I do **NOT** have a Living Will

Health Care Surrogate

- I have designated a Health Care Surrogate
- I do **NOT** have a designated Health Care Surrogate

Durable Power of Attorney

- I have appointed a Durable Power of Attorney for health care decisions
- I do **NOT** have a Durable Power of Attorney for health care decisions

Print Name

Date

Signature of Patient or Representative

If you have any further questions, you can contact your family attorney, local hospital, or local medical association for additional information.

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**Patient Consent to Receive Mail, Telephone
and/or E-mail Message**

DOB: _____
Please print (Last Name) (First Name) (M.I.)

Do we have permission to?

Send a yearly appointment card to your home? Yes No

Send test results to your home? Yes No

Send test results to your email? Yes No

Email address: _____

Leave the following information on your home answering machine/voice mail/email:

Appointment information Yes No

Billing information Yes No

Medical information Yes No

Leave the following information on your work answering machine/voice mail:

Appointment information Yes No

Billing information Yes No

Medical information Yes No

I give permission to share appointment information with the person named below:

Name: _____

I give permission to share medical information (including biopsy/lab results, prescriptions, etc.) with the person(s) listed below:

Name: _____

Name: _____

I give permission to share billing information with the person listed below:

Name: _____

Signature of Patient: _____ Date: _____

For internal purposes only - Account No: