PLEASE .... PLEASE ...MAKE SURE THE PATIENT PACKAGE THAT YOU ARE FILLING OUT IS MAILED, FAXED OR EMAILED BACK TO THE DOCTORS OFFICE AT LEAST 5-7 DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT. IF WE HAVE NOT RECEIVED BEFORE YOUR APPOINTMENT DATE WE WILL HAVE TO RESCHEDULE YOUR APPT.....

THANK YOU FOR UNDERSTANDING.....

JORGE L. HERNANDEZ,M.D. WAGUIH EL MASRY, M.D.LESLIE GOMEZ, D.O. DR. SEAN NONNEMAKER, D.O.

250 2ND STREET EAST SUITE 3B

BRADENTON, FLORIDA 34208

PHONE: 941-746-4151 FAX: 941-746-4345

(PLEASE PRINT)

TODAY'S DATE: _____ HOME PHONE NUMBER:_____

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

IS THIS YOUR LEAGLE NAME (PLEASE CIRCLE): YES NO

IF NOT WHAT IS YOUR LEGAL NAME: _____ FORMER NAME: _____

DATE OF BIRTH (M/D/Y): _____ AGE: _____ SEX: _____

SOCIAL SECURITY NUMBER:_____

MARITAL STATUS (PLEASE CIRCLE ONE): SINGLE MARRIED DIVORCED SEPERATED WIDOWED

MAILING ADDRESS (PLEASE INCLUDE PO BOX,UNIT,APT. OR LOT NUMBER): _____

CITY: _____ STATE:_____ ZIP CODE: _____

SEASONAL ADDREE: _____

OCCUPATION:_____ EMPLOYER: _____

EMPLOYER TELEPHONE NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ POLICY NUMBER: _____

GROUP NUMBER: _____ SUBSCRIBER NAME: _____

RELATIONSHIP:_____ S.S.#: _____ D.O.B.:_____

IN CASE OF EMERGENCY WHO SHOULD WE NOTIFY: _____

CONTACT PHONE NUMBER: _____ RELATIONSHIP: _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO LESLIE GOMEZ, JORGE L HERNANDEZ, WAGUIH ELMASRY. I UNDERSTAND THAT I AM FINANCIALLY RESPONSBLE FOR ANY BALANCE. I ALSO AUTHORIZE LESLIE GOMES, JORGE L HERNANDEZ, WAGUIH ELMASRY OR MY INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

_____ _____

(PATIENT SIGNATURE) (DATE)

JORGE L. HERNANDEZ,M.D. WAGUIH EL MASRY, M.D.LESLIE GOMEZ, D.O.

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QUESTIONS CONATAINED IN THIS QUESTIONAIRE ARE STRICTLY CONFIDENTIAL AND WILL BECOME PART OF YYOUR MEDICAL RECORD.

FULL NAME: _____ DATE OF BIRTH: _____ M/F

PREVIOUS OR REFERRING DOCTOR: _____

DATE OF LAST PHYSICAL EXAM: _____

CHILDHOOD ILLNESS: (PLEASE CIRCLE) MEASLES MUMPS RUBELLA CHICKEN POX RHEUMATIC FEVER POLO

IMMUNIZATIONS AND LAST KNOWN DATE RECEIVED:

TETANUS _____ INFLUENZA _____ CHICKEN POX _____

HEPATITIS _____ (MEASLES,MUMPS,RUBELLA) _____ PNEUMONIA _____

LIST ANY KNOWN MEDICAL PROBLEMS:

_____

LIST PAST SURGERIES:	DATE:	HOSPITAL:

LIST ANY HOSPITALIZATIONS:	DATE:	REASON:

HAVE YOU EVER HAD A BLOOD TRANSFUSION (PLEASE CIRLCE ONE): YES NO

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(PLEASE PRINT)

ARE YOU CURRENTLY DIETING (PLEASE CIRCLE ONE): YES NO

IF YES, ARE YOU ON A PHYSICIAN PRESCRIBED MEDICAL DIET:_____

HOW MANY MEALS DO YOU EAT ON AN AVERAGE DAY:

_____

PLRSDR TSNK YOUT INTAKE OF THE FOLLOWING:

SALT INTAKE HIGH MEDIUM LOW

FAT INTAKE HIGH MEDIUM LOW

CAFFEINE INTAKE: NUMBER OF CUPS PER DAY _____ OF: COFFEE TEA SODA

DO YOU DRINK ALCOHOL:YES/ NO IF YES WHAT TYPE: _____ HOW MANY DRINKS

_____

ARE YOU CONCERNED ABOUT THE AMOUNT OF ALCOHOL YOU DRINK:

_____

HAVE YOU EVER EXPERIENCED BLACK OUT:_____ ARE YOU PRONE TO BINGE DRINKING:_____

DO YOU USE TOBACCO: _____ IF YES WHAT TYPE) CIGS, PIPE,CHEW)

_____

HOW MANY CIGARETTES,PIPE, CIGAR,PER DAY : _____ HOW LONG HAVE YOU USED:

_____

IF YOU QUIT, HOW LONG AGO DID YOU QUIT: _____

DO YOU CURRENTLY USE ANY RECREATIONAL OR STREET DRUGS: _____

IS THERE ANY OTHER PERTINENT MEDICAL INFORMATION YOU THINK YOUR DOCTOR SHOULD BE AWARE OF:

_____

_____

_____

HOW DID YOU HEAR ABOUT THIS MEDICAL PRACTICE:

_____

DO YOU HAVE ANY OTHER FAMILY MEMBERS THAT ARE SEEN HERE:_____

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(PLEASE PRINT)

PLEASE LIST YOUR PRESCRIPTION MEDICATIONS

NAME OF DRUG: STRENGTH: FREQUENCY TAKEN:

_____

_____

_____

_____

_____

PLEASE LIST ANY OVER THE COUNTER MEDICATIONS OF VITAMIN SUPPLEMENTS YOU TAKE

NAME OF DRUG: STRENGTH: FREQUENCY TAKEN:

_____

_____

_____

PLEASE LIST ALLERGIES/ INTOLERANCE TO ANY MEDICATIONS

NAME OF DRUG: REACTION YOU HAD:

_____

_____

_____

WHAT IS YOUR PHARMACY: _____ TELEPHONE NUMBER:

_____

HEALTH HABITS

EXERCISE: (PLEASE CHECK NEXT TO YOUR CHOICE)

_____ SEDENTARY (NO EXERCISE)

_____ MILD EXERCISE (CLIMB STAIRS, WALK SEVERAL BLOCKS, WALK A ROUND OF GOLF)

_____ OCCASIONAL VIGOROUS EXERCISE (DURATION OF AT LEAST 30 MINUTES < 4 X PER WEEK)

_____ REGULAR VIGOROUS EXERCISE (DURATION OF AT LEAST 30 MINUTES >/= 4X PER WEEK)

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(PLEASE PRINT)

PATIENT CONSENT FOR RELEASE OF PRIVATE HEALTH INFORMATION

AS A PATIENT OF JORGE L. HERNANDEZ, WAGUIH EL MASRY, AND LESLIE GOMEZ., I GIVE THE FOLLOWING CONSENT FOR THE STAFF OF THIS PRACTICE TO LEAVE WITH MEMBERS OF MY HOUSEHOLD OR ON VOICE MAIL:

PLEASE INDICATE YOUR CONSENT BY INITALING BELOW:

_____ CONFIRM APPOINTMENTS

_____ AUTHORIZATION / REFERRAL INFORMATION

_____ PRESCRIPTION REFILL INFORMATION

_____ OTHER MEDICAL INFORMATION THAT IS NECESSARY FOR MY TREATMENT

I GIVE THE PRACTICE PERSONNEL PERMISSION TO SHARE PERSONAL HEALTH INFORMATION WITH THE FOLLOWING PERSON:

_____

(PERSON NAME) (RELATIONSHIP)

_____

(PATIENT SIGN) (DATE)

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(PLEASE PRINT)

REQUEST FOR RELEASE OF MEDICAL RECORDS

DATE: _____

DOCTORS NAME: _____

DOCTORS PHONE NUMBER: _____

DOCTORS FAX NUMBER: _____

PLEASE PRINT CLEARLY

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

TO WHOM IT MAY CONCERN:

I AM REQUESTING THE RELEASE OF MY FULL MEDICAL RECORD TO THE OFFICE OF JORGE L. HERNANDEZ, WAGUIH EL MASRY, LESLIE GOMEZ. AS SOON AS POSSIBLE.

THANK YOU,

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

Patient Name _____ Patient DOB _____

Date of Visit _____ Provider Name _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use check mark to indicate your answer)	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)	TOTAL:			

10. If you checked off any problems, 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?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at http://www.pfizer.com.