MARKOU MEDICAL

Welcome to Markou Medical! Always here, always available! Thank you for trusting us with your health care! This welcome packet includes your new patient paperwork to fill out and bring with you to your first visit as other information about our providers, locations, and services.

We will provide you with same-day office visits for any acute needs during normal office hours and provide one of our own highly trained providers on call 24/7 to meet any acute needs that might come up.

In the coming days, one of our staff members will be reaching out to you to give you information, answer any questions and schedule your new patient appointment. In the meantime, please take the time to review the information contained in this packet.

I am excited for the opportunity for us to meet you and to help meet your healthcare needs!

Respectfully,

Michael Markou, DO, FACOFP
Markou Medical

Markou Medical - Clearwater
1266 Turner St. Suite A
Clearwater, FL 33756
727-446-0176
MarkouMedical.Com

Markou Medical - Tarpon Springs
1501 Pinellas Ave. Suite B
Tarpon Springs, FL 34689
727-940-2099
MarkouMedical.Com

MARKOU MEDICAL

Welcome To Our Practice!

Please keep this form so that you have access to this information when needed.

Our physicians are available 24 hours a day, after hours, for your urgent healthcare needs. Upon contacting our office after hours, one of our providers will personally return your call. Avoid expensive emergency room co-pays, long wait times, and physicians who are not familiar with your specific healthcare history.

Please contact our office

- If you have an urgent healthcare need during business hours, Monday – Friday 8:00 – 5:00, our staff will make necessary arrangements to see you in the office.

- Preferred Hospitals – Our providers have selected the following hospital because of their confidence and professional relationship with the hospital and the specialists.
    - Mease Countryside, Morton Plant, Largo Medical and we work with various skilled nursing facilities.

- Preferred Laboratory
    - Lab Corp or Quest Diagnostics

- After a hospital stay or emergency room visit, please contact our office immediately after discharge. Your provider will need to see you in the office for a follow up visit within 24 to 48 hours after discharge to assure your continued recovery.

- Medicare patients – Your provider encourages you to be seen at least every six (6) months. This will help both you and your provider maximize preventative care.

- Scheduling Appointments – Call our office to schedule your appointment and be sure to always bring a current list of medications with you to each appointment. If you are unable to keep your appointment, please contact our office at least 24 hours in advance so we may offer that opening to someone else with a healthcare need.

- To Avoid Receiving a Bill – Call the office prior to seeing a specialist or undergoing any procedure, as your Humana insurance requires a referral. DO NOT go for lab tests, x- rays, physical therapy, etc. until our office is notified.

MARKOU MEDICAL

Understanding Your Insurance & the Referral Process

The insurance plan you have selected is a HMO/managed care plan.

1. Your Primary Care Provider (PCP) will be able to see the total picture of your overall health. This allows your provider to make the best decisions in managing your health and well-being.

2. While your Primary Care Provider (PCP) can provide most of your care, if you need a specialist, your PCP manages the care you receive from these healthcare specialists within the network.

3. Your Primary Care Provider (PCP) needs to issue a referral for you before you see any specialists.

4. Your Primary Care Provider (PCP) will choose a specialist that will best suit your needs within your HMO Network.

5. Within the HMO, there are a select number of Providers that have demonstrated outstanding care and improved outcomes.

6. Unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network.

7. The referral process serves as a way for your PCP and your specialist to communicate with each other. When a referral is issued for you to see a specialist, your PCP will inform the specialist of the reason(s) for the referral, as well as the goal(s) for the visit. In other words, your PCP will help coordinate your visit; the referral helps ensure you receive the proper care when seeing a specialist.

Thank you for joining our Practice!

How Did You Hear About Us?

- [ ] Friend or Relative **Name:**
- [ ] Newspaper/ Newsletter
- [ ] Online Advertisement
- [ ] Social Media
- [ ] Humana.com or Medicare.gov
- [ ] Google
- [ ] Insurance Agent **Name**:
- [ ] Other, Please specify:

MARKOU MEDICAL

<u>Please bring the following to your first appointment:</u>

<u>ALL Prescriptions</u> and

<u>Over the Counter Medication bottles</u>

that you are currently taking.

PLEASE ARRIVE 15 – 20 MINUTES EARLY FOR YOUR FIRST APPOINTMENT TO AVOID DELAYS

MARKOU MEDICAL

New Patient Verification

Welcome to Markou Medical. If you need any assistance, please let the receptionist know.

Patient_____

Last Name First Name Middle initial

SS#_____ Birth date_____

Home Phone #_____ Cell #_____

E-mail:_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐M ☐F Age_____ Significant other ☐Yes ☐No Name: _____

Emergency Contact: _____

Name(s) Phone #

Do you have any specialist appointments scheduled? Yes No

- Where & When _____

Prior Doctor and Phone Number:

_____

_____

_____

Insurance:_____

_____

Office Use Only: Availity Done ☐ Yes ☐ No

ID/License Scanned ☐ Yes ☐ No

Med Records Requested ☐ Yes ☐ No

Labs: _____

Dr:_____

MARKOU MEDICAL

Patient Consent

I hereby give my consent for Markou Medical to use and disclose protected health information (PHI) about me, to include HIV/Aids testing/status, to carry out treatment, payment and healthcare operations (TPO). (Markou Medical "Notice of Privacy Practices" provides 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, Markou Medical reserves the right to review its "Notice of Privacy Practices" at any time. A revised "Notice of Privacy Practices" may be obtained by forwarding a written request to Markou Medical, Attn: Privacy Officer, 1266 Turner St. Suite A Clearwater, Fl 33756.

With this consent, Markou Medical may mail to my home or other alternative 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 calls pertaining to my clinical care, including laboratory results among others.

With this consent, Markou Medical may mail to my home or other alternative location, any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal & Confidential".

With this consent, Markou Medical may email to my home or alternate location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Markou Medical 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 agreement.

By signing this form, I am consenting to Markou Medical use and disclosure of my PHI to carry out TPO, including third party payors.

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, or later revoke consent, Markou Medical may decline to provide treatment to me.

Patient Signature:_____Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative:

_____

MARKOU MEDICAL

Prescription Renewal, Patient Conduct, Exam Room Escort & Health Policy

Prescription Renewal Policy

Markou Medical physicians are available for emergencies twenty-four hours a day. Prescription renewals, however, should not be considered medical emergencies. Prescription renewals should be discussed with your doctor during your office visit or by phone with the medical assistants between the hours of 8am to 5pm, Monday through Friday. We will get back to you within twenty-four hours. By following this policy, we can assure you the highest quality of medical care.

Patient Conduct and Examination Room Escort Policy

If at any time a patient is physically threating, verbally abusive, or demeaning to staff (or other patients) whether it is in person or other means of communication, we at Markou Medical have the right to refuse treatment to the patient and dismiss them from the practice.

To ensure your comfort, at your request, you may have an escort present with you during your examination. Escorts may be a friend or a family member, or we can furnish a member of our staff to be present during your examination. At the physician's discretion, an escort may also be asked to be present at the time of the examination.

Health Maintenance

To maintain your good health, it is important to us that you, our patient adhere to the following:

- Not smoke
- Lose weight, if necessary. Maintain your optimum weight
- Exercise daily – walk, swim, etc.
- Follow a healthy diet: Decrease – cholesterol, calories, saturated fats, use salt substitutes
- Do not use alcohol or use in moderate amounts only
- Use your safety belts
- Wear your bicycle helmet
- Get regular mammograms and pap smears (start pap with onset of sexual activity or at 18 years)
- Have yearly eye exams
- Stop use of illegal drugs, marijuana, designer drugs
- Use safe sexual practices; HIV protection, venereal diseases
- Regular prostate exams for the older male

Patient Signature:_____ Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

Advance Directive

What is an Advance Directive?

It is a statement which tells your doctor and family what care you would like to have when you are not able to make those decisions because of the seriousness of your injury or illness.

There are two kinds of advance directives:

- A Living Will
- Durable Power of Attorney for Health Care

A Living Will – What is it?

It is a statement that lets you tell your doctor and family your wishes if there were no hope for your recovery and you become unable to make your own decisions. An example of this would be whether to continue to use a breathing machine to keep you alive if you were in a permanent coma following an automobile accident.

Durable Power of Attorney for Health Care – What is it?

It is a statement in which you appoint a person to make medical judgement(s) for you if you become unable to make those decisions for yourself. That person should be someone you trust to make health decisions like the ones you would make yourself if you were able. Usually that person would be a close relative or close friend.

Is one better than the other?

They are different and are used for different things so they both are good. These statements are to help your family and your doctor make decisions concerning your healthcare at a time when you are not able to. You may use one, or both of these forms of advance directives to provide direction for your medical care. You may combine them into a single statement that appoints a person to make medical decisions for you but also tells that person of your wishes if there is no expectation for reasonable survival.

Can I change my mind?

Yes! You can change your mind or cancel your statement at any time. Changes should be written, signed and dated. You can also make your change of opinion by telling someone (an oral statement).

Who should make out an Advance Directive?

Because we may have a serious illness or injury at any age, all adults should have an advance directive.

MARKOU MEDICAL

YEARLY INSURANCE AUTHORIZATION, ASSIGNMENT AND GUARANTEE OF PAYMENT

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Markou Medical or any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries of carriers any information needed for this or a related Medicare claim/other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.

I request that payment under the Medicare or other medical insurance program(s) be made to Markou Medical for as long as I continue to receive services from them. If I were to receive any checks (payments) intended as payment for services rendered by Markou Medical from Medicare and/or other insurance company(ies), I will immediately endorse it and turn it over to Markou Medical for services rendered.

I understand that I am responsible for payment of all charges and fees to Markou Medical that they are entitled to collect that which are not paid for by Medicare or other insurance.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original.

A charge of $35 will be billed to your account for any missed appointments. This is <u>not</u> billable to your insurance company.

Patient Signature:_____ Date: _____

CONSENT FOR DIAGNOSTIC AND/OR THERAPEUTIC PROCEDURES

I hereby consent to and authorize my physician and any other health professional as designated to perform any physical examination and routine diagnostic procedures upon me. I also consent to and authorize my physician to prescribe a therapeutic regime, which I shall follow. Unless I explicitly refuse, I consent that the diagnostic procedure(s) and immunization(s) ordered by my physician be performed on me despite the risks involved and complications that might be involved, which will be explained to me at the time they are ordered.

Patient Signature:_____Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have received a copy of
(Print Patient Name)

Markou Medical Notice of Privacy Practices.

Patient Signature:_____Date: _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I hereby give my permission to (list physician / facility name, address & phone number):

_____ _____

_____ _____

_____ _____

_____ _____

To release a copy of my Protected Health Information (PHI) to: **Markou Medical** I instruct the above named entity to produce the following information (check ONE only):

☐ Release Entire Record
☐ I would like specific records released: _____

My PHI is to be disclosed for: ☐ Continuation of Care ☐ Other: _____

Please forward records to the following location (Circle One):

1266 Turner St. Suite A Phone: (727) 446-0176
Clearwater, FL 33756 Fax: (727) 446-4906

OR

1501 Pinellas Ave. Suite B Phone: (727) 940-2099
Tarpon Springs, Fl 34689 Fax: (727) 940-2459

Unless otherwise noted, this authorization expires one year from date signed.

I authorize Markou Medical or an authorized representative of the patient and requests that the above named facility to release any and all information which the named facility may possess in regard to the patient's examinations and treatments, including, but not limited to, alcohol abuse or drug abuse information, HIV antibody testing information, psychiatric and/or psychological information, communicable disease information, or any other information related to the patient's total treatment, unless specified below which may be a part of the medical records. I may revoke this authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on the Authorization. I am entitled to a copy of this authorization upon request. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits. This recipient of this protected health information is prohibited from re-disclosing the information unless the recipient obtains another authorization from me or unless the discloser is specifically required by law. Where permitted, the information I am requesting to be disclosed may sometimes be re-disclosed by the recipient and may no longer be protected by law. I am entitled to notice if my protected health information is used for marketing and results in remuneration to the provider. I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Patient Name (Print) :_____ DOB : _____

Patient Signature :_____ Date : _____

If signed by someone other than the patient, please indicate the relationship to the patient:

☐ Parent ☐ Legal Guardian ☐ Legal Representative

Printed Name of Parent/Legal Guardian/Legal Representative: _____

MARKOU MEDICAL

Personal Health Risk Assessment

Please complete the following packet and bring with you to your first appointment.

This information is extremely important as your doctor will need to review your health risk assessment.

MARKOU MEDICAL

Patient Last Name: _____ Patient First Name: _____ DOB: _____

Choose One: [ ] Male [ ] Female

Past Medical History: Have you ever had one of the follow illnesses?

	Yes	No		Yes	No		Yes	No
Amputation	☐	☐	Diabetes	☐	☐	Migraine Headache	☐	☐
Anemia	☐	☐	Falls	☐	☐	Ostomy	☐	☐
Alcohol Overuse	☐	☐	Gout	☐	☐	Paralysis	☐	☐
Arthritis	☐	☐	HIV/AIDS	☐	☐	Sexually	☐	☐
Asthma	☐	☐	Heart Attack	☐	☐	Transmitted Disease		
Bleeding Disorders	☐	☐	Heart Disease	☐	☐	Sickle Cell Anemia	☐	☐
Cancer	☐	☐	(CHF/CAD)			Sleep Disorder	☐	☐
Location: _____			Hepatitis	☐	☐	Stomach Ulcer	☐	☐
Cardiac Arrhymias	☐	☐	High Blood Pressure	☐	☐	Stroke, CVA/TIA	☐	☐
Pacemaker: _____			Kidney Disease	☐	☐	Thyroid Disease	☐	☐
Colitis	☐	☐	Mental Illness	☐	☐	Vascular Disease	☐	☐
COPD/Emphysema	☐	☐	Other Medical History: _____					

Symptoms you would like to discuss: _____

Personal Habits: Have you ever?

Smoked tobacco? ☐ Yes ☐ No If yes, packs per day____#of years_____ Year quit _____

Used chewing tobacco? ☐ Yes ☐ No If yes, # of cans_____# of years_____Year quit_____

Do you drink alcohol regularly? ☐ Yes ☐ No If yes, how often_____# of drinks per day_____

Have you ever used? ☐ Marijuana ☐ LSD ☐ Heroin ☐ Cocaine ☐ Meth ☐ Other

Operations: List with approximate year

_____ _____

_____ _____

_____ _____

_____ _____

Serious Injuries: List with approximate year

_____ _____

_____ _____

_____ _____

_____ _____

Hospitalization (Other than operations with approximate date):_____

_____

_____

Immunizations (please include the date):		Covid-19 _____	Prevnar 13 _____
Tetanus _____	Shingles _____	Flu _____	Prevnar 20 _____
Other _____	MMR _____	Hep _____	Pneumovax 23 _____

MARKOU MEDICAL

FAMILY HISTORY

FAMILY MEMBER	CIRCLE SEX	IF LIVING		IF DECEASED	
		AGE	HEALTH	AGE AT DEATH	CAUSE
Father					
Mother					
Brother(s) / Sister(s)	M F				
	M F				
	M F				
Husband / Wife					
Son(s) / Daughter(s)	M F				
	M F				
	M F				
	M F				

Check if any blood relative has or had any of the following and enter their relationship to you:

	Yes	No	Relationship to you	Comments
Bleeding Tendency	☐	☐		
Cancer	☐	☐		
Colitis	☐	☐		
COPD	☐	☐		
Diabetes	☐	☐		
Epilepsy	☐	☐		
Heart Attack	☐	☐		
High Blood Pressure	☐	☐		
Kidney Disease	☐	☐		
Sickle Cell Anemia	☐	☐		
Stroke	☐	☐		
Suicide	☐	☐		
Tuberculosis	☐	☐		
Other:	☐	☐		

MARKOU MEDICAL

Preventative Service History

This form needs to be completed to the best of your ability.

We need to know if the below listed testing has: Never Been Done (NO), Has Been Done (YES). If yes, your best estimate as to the month/year the test was performed, and the result.

Preventative Service	NO	YES	Month/Year Testing Performed	Findings & Recommendations
Bone Mass Measurement (Bone Density)	☐	☐		
Bloodwork	☐	☐		
Colorectal Cancer Screening Colonoscopy –	☐	☐		
Fecal Occult Blood Test (Stool Card)	☐	☐		
Vision Screening Eye Exam	☐	☐		
Female Screening PAP & Pelvic Examination	☐	☐		
Mammogram	☐	☐		
Male Screening PSA – Prostate Specific Antigen (Blood Test)	☐	☐		

FOR PHYSICIAN USE

Physician Signature **Date Reviewed**

MARKOU MEDICAL

SOCIAL / LIFESTYLE HISTORY: Primary Language: _____

Interpreter Required: ☐ Yes ☐ No

Is there someone that lives with you in your residence? ☐ Yes ☐ No

If yes, please list name & relationship: _____

Type of Residence: ☐ Apartment ☐ Mobile Home ☐ House ☐ One Story ☐ Two Story

☐ Independent Living Facility Facility Name: _____

☐ Assisted Living Facility Facility Name: _____

Durable Medical Equipment? ☐ Yes ☐ No ☐ Wheelchair ☐ Walker ☐ Cane

☐ Oxygen ☐ Nebulizer ☐ CPAP/BIPAP

Other: _____

Can you afford medicine? ☐ Yes ☐ No Potential Referral to Patient Assistance Program: _____

Transportation provided by? _____

EXERCISE / ACTIVITY:

Current Activity: _____ How Often: _____

Physical Limitations: _____

ACTIVITIES OF DAILY LIVING:

Do you require assistance to bathe or groom? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance for your toilet needs? ☐ Yes ☐ No

If yes, explain: _____

Do you require assistance to eat? ☐ Yes ☐ No

If yes, explain: _____

Do you have hearing loss? ☐ Yes ☐ No

Do you wear hearing aids? ☐ Yes ☐ No

Date of last hearing exam: _____

Additional Comments & Notes: _____

MARKOU MEDICAL

REVIEW OF SYSTEMS

Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Feeling Poorly
- ☐ Feeling Tired
- ☐ Recent Weight Gain _____ lbs.
- ☐ Recent Weight Loss _____ lbs.

Eyes

- ☐ Blurry Vision
- ☐ Glaucoma
- ☐ Eye Infection
- ☐ Dry Eyes
- ☐ Red Eyes

ENT

- ☐ Ringing in the Ears
- ☐ Throat Clearing
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Mouth Sores

Cardiovascular

- ☐ Heart Rate Slow
- ☐ Heart Rate Fast
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Lower extremity Edema

Respiratory

- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of Breath on Exertion
- ☐ Spitting up Blood

Genitourinary

- ☐ Dysuria
- ☐ Incontinence
- ☐ Testicular Pain
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Abnormal Vaginal Bleeding
- ☐ Genital Lesion

Heme/Lymph

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Glands

Musculoskeletal

- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness

Integumentary

- ☐ Skin Rash
- ☐ Skin Wound
- ☐ Itching
- ☐ Jaundice

Neurological

- ☐ Confusion
- ☐ Numbness
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache

Psychiatric

- ☐ Suicidal
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disturbances

Endocrine

- ☐ Heat Intolerance
- ☐ Excessive Thirst
- ☐ Cold Tolerance
- ☐ Excessive Urination

Gastrointestinal

- ☐ Poor Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Black Tarry Stools
- ☐ Belching
- ☐ Regurgitation
- ☐ Constipation
- ☐ Recent change in Bowel Habits

MARKOU MEDICAL

MEDICATION LIST / ALLERGIES / PHARMACY

Please help us provide better care by providing us with your current prescription and over-the-counter medications taken regularly.

PRESCRIPTIONS:

Medication Name	Dosage	Times Daily	When Started?

OVER-THE-COUNTER MEDICATIONS / HERBAL REMEDIES / VITAMINS:

_____ _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **Yes** ☐ **No**

If yes, please list medication and the reaction.

MEDICATION ALLERGIES & REACTIONS:

Medication Name	Reaction

PHARMACY INFORMATION (Required):

Pharmacy Name: _____

Pharmacy Address or Cross Streets: _____

Pharmacy Phone: _____

MARKOU MEDICAL

ANNUAL PATIENT ASSESSMENT

Patient label:

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? **(circle the number 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 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 ☐ + ☐ + ☐

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	☐ Very difficult
	☐ Somewhat difficult	☐ Extremely difficult

Bladder and Additional Screening

- Are you having any bladder control problems? ☐ Yes ☐ No
  - *If "yes", please answer the remaining questions. This information will help your practitioner better understand your bladder control problem.
  - I started having bladder trouble: ☐ A Month(s) ago ☐ 1 to 2 years ago ☐ ___ years ago
- Do you require assistance to walk? ☐ Yes ☐ No
- Do you have any problems with your hearing, vision or speech?
  - Hearing: ☐ Yes ☐ No Vision: ☐ Yes ☐ No Speech: ☐ Yes ☐ No

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Patient label:

Date of service: _____/____/_____(mm/dd/yyyy)

This document is intended to capture requested clinical quality information only. Other write-in information will not be considered.

1159F AND 1160F

Prescription (Rx)	Dosage	Disease being treated/reason for medication	Side effects discussed
Please see attached medication list. All medications verified with patient (including name, dose, quantity, route and frequency).			☐
Patient educated on what their medication is intended to do and the reason that they are taking it. Potential side effects discussed.			☐
			☐
			☐
			☐

1170F

Functional assessment: Does patient have difficulties performing the following activities? Date assessed: ____

Bathing	☐	Yes	☐	No	☐	N/A	Transferring	☐	Yes	☐	No	☐	N/A
Dressing	☐	Yes	☐	No	☐	N/A	Using the toilet	☐	Yes	☐	No	☐	N/A
Eating	☐	Yes	☐	No	☐	N/A	Walking	☐	Yes	☐	No	☐	N/A

Treatment plan discussed with patient

☐ Occupational therapy referral ☐ Review of Rx ☐ Physical therapy referral ☐ Assistive device evaluation

Physical activity assessment Date assessed: ____

Patient is physically active	☐Yes	☐No	Patient is active 30 minutes a day most days of the week	☐Yes	☐No
Patient plans to become active in the next few months	☐Yes	☐No	Patient expresses fear to become active or participate in physical activity	☐Yes	☐No
Patient participates in activity regularly	☐Yes	☐No	If so, what type? _____		

1158F

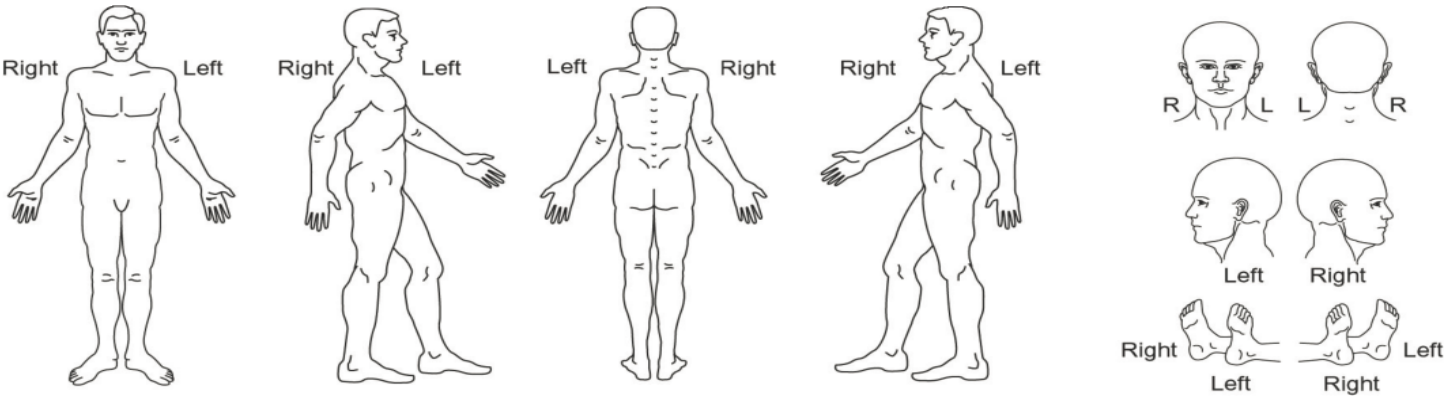
Patient advised: ☐ Daily walks ☐ Stretching ☐ Start taking the stairs ☐ Increase walking as tolerated

1157F OR

Advance care planning: ☐ Advance directive in medical record Discussion on ____/____/____

1125F Pain OR 1126F No Pain

Pain assessment Date assessed: ____



Pain intensity (0 lowest to 10 highest)_____ Present pain_____ Worst pain_____ Best pain _____

Quality of pain: _____ Onset, duration, variation and rhythms? _____

What causes the pain? _____ What relieves the pain?_____

Physician name and credentials:

MARKOU MEDICAL

ANNUAL PATIENT ASSESSMENT - Continued

Patient Label:

Mini Nutritional Assessment (MNA)

Sex: ☐ M ☐ F Age: _____ Weight: _____ Height: _____

A. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	0 = severe decrease in food intake 1 = moderate decrease in food intake 2 = no decrease in food intake	_____
B. Weight loss during the last 3 months?	0 = weight loss greater than 6.6 lbs. (3kg) 1 = do not know 2 = weight loss between 2.2 = 6.6 lbs. (1 - 3kg) 3 = no weight loss	_____
C. Mobility	0 = bed or chair bound 1 = able to get out of bed/chair but do not go out 2 = go out	_____
D. Suffered psychological stress within the past 3 months?	0 = yes 2 = no	_____
E. Neuropsychological problems	0 = severe dementia or depression 1 = mild dementia 2 = no psychological problems	_____
********************STAFF ONLY BELOW THIS FOR MINI NUTRITIONAL ASSESSMENT****************		
F1. Body Mass Index (BMI) (weight in kg / height in M^2) 0 = BMI less than 19 1 = BMI 19 - less than 21 2 = BMI 21 - less than 23 3 = BMI 23 or greater	***If BMI is not available, replace question F1 with F2. Do not answer question F2 if question F1 is already completed.**	_____
F2. Calf Circumference (CC) in cm	0 = CC less than 31 1 = CC 31 or greater	_____
12 - 4 = Normal Nutritional Status	Screening Score: (Max 14 points) 8 - 11 = At risk of Malnutrition 0 - 7 = Malnourished	_____ _____

Annual Patient Conduct Agreement

If at any time a patient is physically threating, verbally abusive, or demeaning to staff (or other patients) whether it is in person or other means of communication, we at Markou Medical have the right to refuse treatment to the patient and dismiss them from the practice.

_____ _____

Patient Signature Date

FOR PHYSICIAN USE

_____ _____

Physician Signature **Date Reviewed**