# Morris Medical Center, P.A.

**Dareld R. Morris II, D.O**.

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Full legal name as it appears on your driver's license: NEW MMJ _____________

Male: ______ Female: _______

Last name: ______________________________ First name: ____________________________ Middle initial: ______

Address: ___________________________________________________________________________________

City: ______________________________ State: _____ Zip code: ________________________

County: ______________ SSN: ________________________________ (required by the state of FL) Medical Cannabis Patients

D.O.B. __________ Weight: _____________ (required by State of FL for Medical Cannabis patients)

Cell#: _______________________ Home#: ______________________

Email address: ____________________________________@__________________.com

**Referred by**:

Radio ______ Web search _________ Website _________Friend/family ___________

**ARE YOU A FULL-TIME FLORIDA RESEIDENT? YES NO**

**(Women only**)

Are you currently pregnant? Yes No

Is there any chance you are pregnant? Yes No

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# CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name:_______________________________________________________Date of Birth: _
__________________________________________________________________

Please Check One of the Following:

______ I REQUEST THAT ALL OF MY PROTECTED HEALTH INFORMATION BE DISCLOSED ONLY TO ME AND NO OTHER FRIENDS OR FAMILY.

**OR**

______ I GIVE MY PERMISSION TO THE EMPLOYEES OF Morris Medical Center, P.A. TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING FAMILY MEMBERS OR FRIENDS.

NAME: ___________________________________________ RELATION __________________________________

NAME: ___________________________________________ RELATION __________________________________

NAME: ___________________________________________ RELATION __________________________________

NAME: ___________________________________________ RELATION __________________________________

## WHAT TYPE OF MESSAGE MAY WE LEAVE FOR YOU?

In an effort to better serve you, Morris Medical Center, P.A would like to know what type of message we may leave on your answering machine/voicemail when contacting you. It is our policy to call you at any phone number you provide to us. Please let us know what type of message we may leave on your answering machine/voicemail by answering the following questions by circling **YES** or **NO**.

**When we contact you by calling you at any telephone number you have provided us:**

May we leave a detailed message on your answering machine/voicemail? **YES** or **NO**

If no, we will leave a message with just enough information for you to call us back.

*****Please Note: We will ALWAYS leave a detailed message on your answering machine/voicemail or with anyone who answers your telephone when we are contacting you to remind you of an appointment at our office.*****

I understand I may revoke or change this consent at any time by filling out another consent form to replace this one.

____________________________________________________ ________________________________

Patient/Guardian/or Legal Representative Signature Date

____________________________________________________ ________________________________

Printed Name if not signed by Patient Relationship

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Internal Use Only: Please post the above information in the patient's off-bill comments.

Date Received:______________________________Posted By ___________________________________

**DATE REVOKED/CHANGED**_________________________

SIGNATURE__________________________________________________ PATIENT'S SIGNATURE (OR PARENT IF MINOR)

DATE__________________________

# Morris Medical Center, P.A.

## Notice of Privacy Practices

Effective April 14, 2003, all medical practices must follow certain guidelines as it pertains to the “Protected Health Information” (PHI) of their patients. PHI is defined as information about the patient, including demo- graphic information, that may identify the patient, and relates to the patient’s past, present, or future physical or mental condition and related health care services.

This short form has been created to provide you an overview explaining how we will handle your PHI and actions you can take if you feel we have not handled your PHI properly. A more detailed explanation of this Notice of Privacy Practices is available on our website at www.swfna.com.

**How we handle your Protected Health Information:**

We will ask each patient to sign consent from allowing our office to use your PHI for three purposes only. Those purposes are for medical treatment, information required for payment of services rendered, and for conducting our operational activities. No other use of your PHI will occur without your written consent, unless it is to comply with state and federal laws.

Patient Signature _______________ Date _______________

Staff /witness signature _______________ Date _______________

### *Review of System*

- Gen ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Fatigue ☐ Loss of appetite ☐ Nausea ☐ Vomiting
- Skin ☐ Skin problem ☐ Rash ☐ Psoriasis ☐ Slow healing ☐ Easy bruising ☐ Itching
- Neuro ☐ Light headed/dizziness ☐ Fainting ☐ Weakness ☐ Stroke ☐ Tremor ☐ Seizure ☐ Memory loss
- Eyes ☐ Vision problem ☐ Glaucoma ☐ Blurred vision ☐ Double vision
- ENT ☐ Ear pain ☐ Hearing loss ☐ Ear noises ☐ Nose bleed ☐ Sore throat ☐ Hoarseness ☐ Dental problems
- Cardiovascular ☐ Chest pain ☐ Chest pressure ☐ Shortness of breath ☐ Irregular heart beat ☐ Murmurs
- Respiratory ☐ Coughing ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Coughing up blood
- Gastrointestinal ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Bloody stool ☐ Pain in stomach ☐ Ulcers ☐ Hepatitis
- Genitourinary ☐ Painful urination ☐ Frequent urination ☐ Bloody urine ☐ Kidney stone ☐ Incontinence ☐ Loss of libido ☐ Sexual difficulty ☐ Infection
- Endocrine ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Parathyroid problems
- Hematology ☐ Anemia ☐ Bleeding disorder ☐ Easy bleeding ☐ Lymphoma/Leukemia ☐ Sickle cell disease
- Immunologic ☐ Catch cold easily ☐ HIV/AIDS ☐ Fever ☐ Hay fever ☐ Frequent sinus problems ☐ Allergies
- Musculoskeletal ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Compression fracture ☐ Head injury ☐ Neck injury ☐ Lower back injury ☐ Spinal trauma ☐ Birth trauma ☐ Birth defect ☐ Lupus ☐ Spina bifida ☐ Gout ☐ Osteoporosis ☐ Muscular dystrophy ☐ Muscle pain ☐ Scoliosis

- Women only ☐ Irregular periods ☐Premenstrual depression ☐ Hot flashes ☐ Menstrual cramps ☐ Vaginal discharge
  ▫ Hysterectomy ☐ Breast surgery ☐ Nipple discharge ☐ Breast lumps ☐ Last mammogram _____
- Men only ☐Burning on urination ☐ Dripping after urination ☐ Prostate problems ☐ Difficulty starting urination
- Psychiatric ☐ Depression ☐ Anxiety ☐ Panic attacks ☐ OCD ☐ Manic ☐ Bipolar ☐ Suicidal attempts
  ▫ Suicidal ideation ☐ Homicidal ☐Hallucination ☐ Psychosis ☐ Other ______

## Past Medical History

- Heart ☐ Coronary artery disease ☐ Hypertension ☐ Murmurs ☐Valvular disease ☐ Aneurysm ☐ High cholesterol
  ☐Pacemaker ☐ Deliberator ☐ Heart failure ☐ Angina ☐ Other ________________
- Lungs ☐Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Pneumonia ☐ Lung cancer ☐ Other _
- Gastrointestinal ☐ Ulcer ☐ Reflux☐ Gastritis ☐ Hepatitis ☐ Cancer ☐ Bleeding ☐ Diverticulosis ☐ Other ____
- Kidney ☐ Failure ☐ Stones☐ Dialysis (When)_________☐ Other ________________
- Endocrine ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Other _____
- Neuro ☐ Stroke ☐ Aneurysm ☐ Brain cancer ☐ Nerve injury ☐ Spinal cord injury ☐ Alzheimer's ☐ Dementia
  ▫ Seizures ☐ Parkinson's ☐Other _______
- Psychiatric ☐ Depression ☐Bipolar☐ Anxiety ☐ Panic disorder ☐ Psychosis ☐ Schizophrenia ☐ Other ____
- Bone/Muscular ☐ Arthritis ☐ Rheumatoid arthritis ☐ Osteoarthritis ☐ Gout ☐ Osteoporosis ☐ Scoliosis ☐ Other _
  _______________
- Cancer ☐ ________________________________________________________________________________
- Other ☐ ________________________________________________________________________________

## Past Surgery History

________________________________________________________________________________

________________________________________________________________________________

## Allergies

- Latex ▫ No ▫ Yes Reaction _______________ • Contrast (Dye) ▫ No ▫ Yes Reaction __________

Allergic to any medication(s) ________________________________________________________

## Current Medications

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Significant Family History** (Cancer, hypertension, diabetes, depression, back pain…)

- Father side ____________________________________________________________
- Mother side ____________________________________________________________

- Siblings ________________________________________________________

## Social History

- Tobacco: ☐ Never ☐ Quit in_______ ☐ Currently___pack per day
- Alcohol : ☐ Never ☐ Rarely ☐ Moderate ☐ Daily_______________
- Use of drugs: ☐ Never ☐ Occasionally ☐ Frequently, Type/frequency __________
- Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
- Family status: Living with ____________________________________________________________________________
- Occupation: ____________________________________________________________________________
- Disability: ☐ No ☐ Yes (Type) ______________________
- Litigation (Lawsuit): ☐ No ☐ Yes against_____________________working with ______________

## Radiological studies / Lab studies

- MRI ☐ Neck__________☐ Upper back____________☐ Lower back_____________☐ Other _____________
  Date Date Date Date
- CT ☐ Neck__________☐ Upper back____________☐ Lower back_____________☐ Other _____________
  Date Date Date Date