Jacque' Inc health wellness &beyond

Telehealth/Mobile services available in
North and South Florida
www.jacquemedspa.com
PHONE: [786-496-4091]/FAX: [214-241-4839]

DATE:_____

FULL NAME:_____ DATE OF BIRTH:

GENDER: ≤ FEMALE ≤ MALE DO YOU HAVE AN ADVANCED DIRECTIVE (LIVING WILL)? ≤ YES ≤ NO
HOME ADDRESS:_____

CITY:_____STATE:_____ ZIP CODE:_____

EMAIL:_____

PRIMARY PHONE:_____≤ HOME ≤ MOBILE ≤ WORK ≤ SPOUSE ≤ CAREGIVER ≤ OTHER

SECONDARY PHONE: _____≤ HOME ≤ MOBILE ≤ WORK ≤ SPOUSE ≤ CAREGIVER ≤ OTHER

INSURANCE NAME: _____SUBSCRIBER ID:_____GROUP:_____

SOCIAL SECURITY #:_____ REFERRED BY:_____

NEXT OF KIN (FOR EMERGENCY): _____

RELATION: _____PHONE: _____

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

NAME: _____ SPECIALTY: _____

LIST ANY MEDICATION THAT YOU CURRENTLY TAKE, INCLUDING OVER-THE-COUNTER			
NAME	STRENGTH	DIRECTION	PRESCRIBED BY

1. _____ 3. _____

2. _____ 4. _____

1. _____ YEAR: _____ 4. _____ YEAR: _____

2. _____ YEAR: _____ 5. _____ YEAR: _____

3. _____ YEAR: _____ 6. _____ YEAR: _____

1. _____ 3. _____

2. _____ 4. _____

	LIVING/DECEASED	AGE	MEDICAL PROBLEMS
FATHER:	_____	_____	_____
MOTHER:	_____	_____	_____
BROTHER(S):	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
SISTER(S):	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
MOTHER'S FATHER:	_____	_____	_____
MOTHER'S MOTHER:	_____	_____	_____

FATHER'S FATHER:_____ _____ _____

FATHER'S MOTHER:_____ _____ _____

GLAUCOMA/EYE EXAM: _____ HEPATITIS B SHOT:_____ FLU VACCINE:_____

PNEUMONIA VACCINE:_____ ZOSTAVAX SHOT:_____ BONE DENSITY SCAN:_____

COLONOSCOPY: _____ GLUCOSE: _____ ECHOCARDIOGRAM: _____

HEARING EXAM: _____ HEMOCULT: _____ LIPID PANEL: _____

MAMMOGRAM: _____ PAP SMEAR: _____ PELVIC EXAM: _____

PROSTATE EXAM: _____ PSA TEST: _____ RECTAL EXAM: _____

ABDOMINAL AORTIC ANEURYSM SCREENING:_____ TETANUS DIPHTHERIA VACCINE:_____

DIABETES SELF MANAGEMENT TRAINING: _____ NUTRITIONAL THERAPY: _____

SMOKING CESSATION: _____

DO YOU DRINK ALCOHOL? ≤ YES ≤ NO IF YES, HOW MUCH? _____

ARE OTHERS CONCERNED ABOUT YOUR DRINKING? ≤ YES ≤ NO

DIET: ≤ BALANCED ≤ VEGETARIAN ≤ DIABETIC ≤ LOW SALT ≤ LOW FAT ≤ LOW CARB ≤ OTHER:

EDUCATION: ≤ HIGH SCHOOL ≤ COLLEGE ≤ SOME COLLEGE ≤ TRADE SCHOOL ≤ OTHER:

DO YOU DO ANY FORM OF REGULAR EXERCISE EVERY DAY? ≤ YES ≤ NO IF YES, HOW MUCH?

MARITAL STATUS: ≤ MARRIED ≤ SINGLE ≤ DIVORCED ≤ WIDOWED ≤ OTHER:

OCCUPATION: _____HOW LONG AT CURRENT EMPLOYER:

LIST EVERYONE IN YOUR HOUSEHOLD (INCLUDING PETS):

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU WEAR SEATBELTS? ≤ YES ≤ NO

HAVE YOU EVER SMOKED OR CHEWED TOBACCO? ≤ YES ≤ NO IF YES, HOW MUCH?

FEEDING YOURSELF ≤ YES ≤ NO IF YES, WHO HELPS? _____

GETTING FROM BED TO CHAIR ≤ YES ≤ NO IF YES, WHO HELPS? _____

GETTING TO THE TOILET ≤ YES ≤ NO IF YES, WHO HELPS? _____

GETTING DRESSED ≤ YES ≤ NO IF YES, WHO HELPS? _____

BATHING OR SHOWERING ≤ YES ≤ NO IF YES, WHO HELPS? _____

USING THE TELEPHONE ≤ YES ≤ NO IF YES, WHO HELPS? _____

TAKING YOUR MEDICINES ≤ YES ≤ NO IF YES, WHO HELPS? _____

PREPARING MEALS ≤ YES ≤ NO IF YES, WHO HELPS? _____

SHOPPING FOR GROCERIES ≤ YES ≤ NO IF YES, WHO HELPS? _____

DRIVING ≤ YES ≤ NO IF YES, WHO HELPS? _____

CLIMBING A FLIGHT OF STAIRS ≤ YES ≤ NO IF YES, WHO HELPS? _____

MANAGING MONEY
(KEEPING TRACK OF EXPENSES/PAYING BILLS) ≤ YES ≤ NO IF YES, WHO HELPS? _____

WALKING ACROSS THE ROOM
(INCLUDES USING A CANE OR WALKER) ≤ YES ≤ NO IF YES, WHO HELPS? _____

MODERATELY STRENUOUS HOUSEWORK
SUCH AS DOING THE LAUNDRY ≤ YES ≤ NO IF YES, WHO HELPS? _____

SHOPPING FOR PERSONAL ITEMS LIKE
TOILETRIES OR MEDICINES ≤ YES ≤ NO IF YES, WHO HELPS? _____

DO YOU FIND IT DIFFICULT TO FOLLOW A CONVERSATION IN A CROWDED ROOM? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU SOMETIMES FEEL THAT PEOPLE ARE MUMBLING OR NOT SPEAKING CLEARLY? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU EXPERIENCE DIFFICULTY FOLLOWING DIALOGUE IN THEATER? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU FIND YOURSELF ASKING PEOPLE TO SPEAK UP OR REPEAT THEMSELVES? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU FIND MEN'S VOICES EASIER TO UNDERSTAND THAN WOMEN'S? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU EXPERIENCE DIFFICULTY UNDERSTANDING SOFT/WHISPERED SPEECH? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU FEEL HANDICAPPED BY A HEARING PROBLEM? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU EXPERIENCE RINGING/NOISES IN YOUR EARS? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU HEAR BETTER WITH ONE EAR THAN THE OTHER? ≤ YES ≤ NO ≤ SOMETIMES

HAVE ANY OF YOUR RELATIVES (BY BIRTH) HAD A HEARING LOSS? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU SOMETIMES HAVE DIFFICULTY UNDERSTANDING SPEECH ON THE TELEPHONE? ≤ YES ≤ NO ≤ SOMETIMES

DOES A HEARING PROBLEM CAUSE YOU TO FEEL EMBARRASSED WHEN MEETING
NEW PEOPLE? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU SOMETIMES FIND IT DIFFICULT TO UNDERSTAND A SPEAKER AT A PUBLIC
MEETING OR RELIGIOUS SERVICE? ≤ YES ≤ NO ≤ SOMETIMES

DOES A HEARING PROBLEM CAUSE YOU TO VISIT FRIENDS, RELATIVES, OR NEIGHBORS
LESS OFTEN THAN YOU WOULD LIKE? ≤ YES ≤ NO ≤ SOMETIMES

HAVE YOU HAD ANY SIGNIFICANT NOISE EXPOSURE DURING WORK, RECREATION,
OR MILITARY SERVICE? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU FEEL LITTLE INTEREST/PLEASURE IN DOING THINGS? ≤ YES ≤ NO ≤ SOMETIMES

DO YOU FEEL DOWN, DEPRESSED, OR HOPELESS? ≤ YES ≤ NO ≤ SOMETIMES

ARE YOU AFRAID OF FALLING? ≤ YES ≤ NO ≤ SOMETIMES

HAVE YOU FALLEN IN THE PAST YEAR? ≤ YES ≤ NO

AUTHORIZED SIGNATURE:_____DATE:_____