UB|MD INTERNAL MEDICINE PRIMARY & SPECIALTY CARE

HEALTH HISTORY ANNUAL UPDATE

Please **take time** to provide the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs. **Please address every section**.

PATIENT NAME	BIRTH DATE / /	TODAY'S DATE / /

MEDICAL HISTORY UPDATES
Since your last visit

Please list any Surgeries-Procedures-Hospitalizations, ER visits or Urgent Care Visits

☐ **NONE**

Any New Allergies: Reaction:

☐ **NONE**

Have you seen any specialist since your last visit? ☐ No ☐ Yes, if yes please list below.

Location seen at:

Location seen at:

Location seen at:

IMMUNIZATIONS & PREVENTIVE SERVICES Please list any vaccinations or testing that you have had since your last visit and PROVIDE DATE and SERVICE LOCATION (Pharmacy/Hospital/physician order)

☐ **NONE** ☐ Flu vaccine ☐ Tetanus ☐ Pneumococcal ☐ PAP smear ☐ Mammogram ☐ Colonoscopy

FAMILY HISTORY

Has anything changed with the health of your biological relatives <u>since your last visit</u>?
Please note which relatives are affected, if extended family, such as aunt/cousin/grandparent, please note whether on maternal (mother's) or paternal (father's) side.
Include behavioral health. Examples are: stress, schizophrenia, alcohol, prescription drug abuse, illegal drug use, maternal depression. etc.

☐ **NONE**

MEDICAL SUPPLY TEAM
Please list any companies involved in your care including oxygen, wheelchair services, durable medical equipment and suppliers.

☐ **NONE**

SOCIAL / PERSONAL HISTORY UPDATE
Please complete the following information about yourself.

Current Occupation: _____

Current employment status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Student ☐ Stay-at-home ☐ Retired ☐ Disabled

Have you had a change in marital status: Y / N If yes please update: _____

Personal habits: *(check all that apply)* ☐ Never used nicotine

☐ Currently nicotine use: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco ☐ e-Cigarettes

Amount / day: _____ Years: _____

PATIENT NAME	BIRTH DATE

☐ Former nicotine use: Type/ amount / day: _____ Years: _____ Quit Date: _____

☐ Exposed to second-hand smoke/nicotine Amount / day: _____ Years: _____

Last dental appointment _____ Any oral health issues? Y / N If yes _____

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				

Do you drink alcohol or use substances? Y / N If Y, please fill in below

- Have you ever felt you needed to Cut down on your drinking or substances use? Y / N
- Have people Annoyed you by criticizing your drinking or substances use? Y / N
- Have you ever felt Guilty about drinking or substances use? Y / N
- Have you ever felt you needed a drink or used substances first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover? Y / N
- Recent Use: please check any substances used and note number of days/month used and usual amount:

☐ NONE ☐ Alcohol ☐ Amphetamines ☐ Benzodiazepines ☐ Cocaine/Crack ☐ Marijuana ☐ Methadone ☐ Heroin

☐ Opiates (Lortab, OxyContin) ☐ Other substances: ☐ _____

Do you exercise regularly? Y / N If Yes, type and frequency: _____

Do you eat 5 or more servings of fruit and vegetables most days? Y / N

Do you have any unsecured guns in the home? Y / N

Would you like to be screened for HIV or sexually transmitted diseases? Y / N

If born between 1945-1965, would you like to be screened for Hepatitis C? Y / N

Please describe your comfort level in understanding concepts and care requirements related to managing your health: ☐ no concerns ☐ occasional difficulty, with guidance/direction feel comfortable ☐ frequent difficulty, require extra assistance

Living Situation/Circumstances:

Do you live alone? Y / N If No, with whom do you live? _____

Do you have a caregiver? Y / N If Yes, whom: _____

Are you a caregiver for an adult? Y / N If Yes, for whom: _____

Do you have any pets? Y / N If Yes, type/how many: _____

Do you have a good support network of family/friends? Y / N If No, please explain:

_____

Do you have concerns about meeting basic needs for shelter, food, and clothing? Y / N If Yes, would you like information on resources that may be of assistance to you? Y / N

Do you have trouble affording the care or prescriptions prescribed? Y / N

Do you have any communication needs due to hearing, seeing, memory and mental conditions or difficulty reading?

Y / N If Yes, please explain: _____

Do you have any beliefs or practices, which affect decision-making, coping, commitment to treatment, use of complementary health practices and general wellbeing? Y / N If Yes, please explain:

_____

Do you have a health care proxy? Y / N / Not Sure If Yes, please share a copy for your records.

Do you have advanced care directives? Y / N / Not Sure If Yes, please ensure this practice has a copy for your records.

Would you like to discuss Advance Directives or a Healthcare Proxy at your visit? Y / N

PATIENT NAME	BIRTH DATE

GOAL SETTING

Please complete the following information about yourself.

What are your healthcare goals for this year? (Examples include: exercise 3 days per week; be able to kneel down and play with my grandchildren.) _____

_____

How do you plan to accomplish these goals? _____

What are the barriers, if any? (Examples include lack of healthy food, knowledge, lack of outside exercise or play time, no safe outside environment, family distractors, genetics)

_____

_____

MEDICATIONS

Include all current medications including prescription and over-the-counter herbal/vitamins/supplements IF NOT ON ANY MEDICATIONS PLEASE CHECK "NONE"

NAME OF MEDICATION	DOSAGE	HOW OFTEN IS IT TAKEN?	REASON FOR MEDICATION	PROVIDER PRESCRIBING THIS MEDICATION
EX: Aspirin	**81 MG**	**Daily, Twice, Bedtime etc.**	**Stroke Prevention**	**Dr. John Doe**
☐ **NONE**				

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient: Your Name: Relationship:

UB|MD INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

Medicare Annual Wellness Visit Health Risk Assessment

Patient Name: _____ DOB: _____

Date of Visit: _____

In general, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

Please list the date of your last:

Dental visit: _____

Eye exam: _____

- **In the past 7 days**, how many servings of fruits and vegetables did you typically eat **each day**? (please circle)
  0 1 2 3 4 5 or more servings per day
  (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables or 1 medium piece of fruit. 1 cup is approximately the size of a baseball.)

- **In the past 7 days**, how many servings of high-fiber or whole-grain foods did you typically eat **each day**? (please circle)
  0 1 2 3 4 5 or more servings per day
  (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, ½ cup of cooked brown rice or whole wheat pasta.)

- **In the past 7 days,** how many sugar-sweetened beverages did you typically consume each day? (please circle)
  0 1 2 3 4 Other:_____ beverages per day
  (Sugar-sweetened beverages include drinks such as regular soda/pop, sweet tea, lemonade, Kool-aid, sports drinks, energy drinks. Do NOT include 100% fruit juices or diet drinks.)

- **In the past 7 days**, how many days did you exercise? _____
  - On days when you exercised, for how many minutes did you exercise? _____
  - Please describe what you typically do for exercise: _____

- **In the past 7 days**, how much pain have you felt?
  - ☐ None
  - ☐ Some
  - ☐ A lot

- **In the past 7 days**, on how many days did you drink alcohol? _____
  - If you do drink alcohol, in the past year did you ever have 3 or more drinks on one occasion?
    ☐ Yes ☐ No
  - If yes, how many times in the past year? _____

- Have you had any unintended weight loss **over the past year**? ☐ Yes ☐ No
- How fast do you feel you can walk? ☐ Slow ☐ Medium ☐ Fast
- How much energy do you feel you have? ☐ Low ☐ Medium ☐ High
- How many hours of sleep do you usually get each night? _____

Patient Name: _____ DOB: _____

Do you:

Live alone?	☐ Yes	☐ No
Feel safe in your home?	☐ Yes	☐ No
Use sunscreen?	☐ Yes	☐ No
Drive?	☐ Yes	☐ No
Wear seatbelts?	☐ Yes	☐ No
Feel afraid of falling?	☐ Yes	☐ No
Have you fallen within the past year?	☐ Yes	☐ No

Do you have the following in your home?

Stairs?	☐ Yes	☐ No
Area rugs?	☐ Yes	☐ No
Smoke detectors?	☐ Yes	☐ No
Carbon monoxide detectors?	☐ Yes	☐ No
Pets?	☐ Yes	☐ No
Unsecured firearms?	☐ Yes	☐ No

Do you:

Use tobacco products? ☐ Yes ☐ No

If yes, are you interested in quitting? ☐ Yes ☐ No

If you used tobacco products in the past, what year did you quit? _____

Use recreational (street) drugs? ☐ Yes ☐ No

On more than half the days over the past 2 weeks, have you felt:

Nervous or anxious?	☐ Yes	☐ No
Stress has interfered with your obligations?	☐ Yes	☐ No
Anger has interfered with your relationships with others?	☐ Yes	☐ No

Activities of Daily Living	Do you need help with any of the following?		If yes, do you have the help you need?		
Preparing your own meals	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Shopping	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Paying bills or managing checkbook	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Housework/laundry	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Using phone	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Transportation in community	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Travelling by train/bus/plane	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Taking medications	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Moving from bed to chair	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Feeding yourself	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Dressing	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Bathing	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Grooming	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A
Using the toilet	☐ Yes	☐ No	☐ Yes	☐ No	☐ N/A

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. **Little interest or pleasure in doing things:**
   ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (4)
2. **Feeling down, depressed, or hopeless:**
   ☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (4)

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your name_____ Relationship: _____

UB|MD INTERNAL MEDICINE
PRIMARY & SPECIALTY CARE

REVIEW OF SYSTEMS

PATIENT NAME	BIRTH DATE / /	TODAY'S DATE / /

GENERAL HEALTH					
Is your general health good? ☐ Yes ☐ No					
Do you have or have you <u>recently</u> had:					
Gain or loss of weight without trying?	☐ Yes	☐ No	Drenching sweats at night?	☐ Yes	☐ No
Fever or chills?	☐ Yes	☐ No	Low energy	☐ Yes	☐ No
Changes in vision?	☐ Yes	☐ No	Contact or glasses	☐ Yes	☐ No
Itchy or dry eyes?	☐ Yes	☐ No			
Difficulty hearing?	☐ Yes	☐ No	Ringing in your ears?	☐ Yes	☐ No
Runny nose?	☐ Yes	☐ No	Congestion in your nose or sinus pain/pressure?	☐ Yes	☐ No
Change in your voice or hoarseness?	☐ Yes	☐ No	Dentures?	☐ Yes	☐ No
Chest pain?	☐ Yes	☐ No	Fainted or felt as though you were about to faint?	☐ Yes	☐ No
Feeling your heart skipping beats or racing?	☐ Yes	☐ No	Difficulty exercising due to shortness of breath/fatigue?	☐ Yes	☐ No
Pain in your buttocks (rear-end) or legs when walking?	☐ Yes	☐ No	Shortness of breath that awakens you at night?	☐ Yes	☐ No
Swollen legs or ankles?	☐ Yes	☐ No	Shortness of breath lying flat in bed?	☐ Yes	☐ No
Wheezing (high pitched breathing noises)?	☐ Yes	☐ No	Trouble staying awake in the daytime?	☐ Yes	☐ No
Cough?	☐ Yes	☐ No	Shortness of breath?	☐ Yes	☐ No
Decreased appetite?	☐ Yes	☐ No	Frequent diarrhea?	☐ Yes	☐ No
Difficulty swallowing?	☐ Yes	☐ No	Frequent constipation (hard, painful bowel movement/poop)?	☐ Yes	☐ No
Pain in your abdomen (belly)?	☐ Yes	☐ No	Black, tarry, or bloody stools (poops)?	☐ Yes	☐ No
Frequent indigestion/heartburn?	☐ Yes	☐ No	Change in color or size of stool?	☐ Yes	☐ No
Frequent nausea or vomiting?	☐ Yes	☐ No	Leaking of stool?	☐ Yes	☐ No
Burning when you urinate (pee)?	☐ Yes	☐ No	Weakness of urinary stream?	☐ Yes	☐ No
Leaking of urine?	☐ Yes	☐ No	Waking up more than twice per night to urinate?	☐ Yes	☐ No
Frequent urination?	☐ Yes	☐ No	Urgent need to urinate immediately?	☐ Yes	☐ No
Blood in your urine?	☐ Yes	☐ No			
WOMEN ONLY					
Irregular, heavy, or overly painful menstrual periods?	☐ Yes	☐ No	If you are postmenopausal (completed "change in life"), any vaginal bleeding since menopause?	☐ Yes	☐ No
Pain with sex?	☐ Yes	☐ No			
MEN ONLY					
Do you have difficulty achieving or maintaining an erection?	☐ Yes	☐ No			

PATIENT NAME	BIRTH DATE / /

Do you have or have you <u>recently</u> had:					
Unexplained muscle aches?	☐ Yes	☐ No	Joint stiffness upon awakening or sitting for prolonged period of time?	☐ Yes	☐ No
Joint aches?	☐ Yes	☐ No	Frequent back pain?	☐ Yes	☐ No
Swelling of your joints?	☐ Yes	☐ No	Fall(s)?	☐ Yes	☐ No
Skin rash?	☐ Yes	☐ No	Wound or sore on skin?	☐ Yes	☐ No
Dry skin?	☐ Yes	☐ No	Pain or lumps in your breasts?	☐ Yes	☐ No
New or changing mole(s)?	☐ Yes	☐ No	Nipple discharge?	☐ Yes	☐ No
Itching?	☐ Yes	☐ No			
Swollen glands?	☐ Yes	☐ No	Bruising without any explanation?	☐ Yes	☐ No
Bleeding from your gums or frequent nose bleeds?	☐ Yes	☐ No			
Frequent headaches?	☐ Yes	☐ No	Feeling that you are spinning or the room is spinning?	☐ Yes	☐ No
Loss of memory or feel confused frequently?	☐ Yes	☐ No	Loss of balance?	☐ Yes	☐ No
Numbness or tingling?	☐ Yes	☐ No	Tremor (shaking in your head/hand/foot)?	☐ Yes	☐ No
Feelings of being down, depressed, or hopeless?	☐ Yes	☐ No	Feelings of being overwhelmed by stress in your life?	☐ Yes	☐ No
Trouble falling or staying asleep, or sleeping too much?	☐ Yes	☐ No	Feelings of nervousness, anxiety, being on edge, or worried a lot about different things?	☐ Yes	☐ No
Thoughts that you would be better off dead or of hurting yourself in some way?	☐ Yes	☐ No			
Sensitivity to heat or cold, more than most people?	☐ Yes	☐ No	**WOMEN ONLY:**		
Excessive thirst?	☐ Yes	☐ No	Do you have excessive hair on the face, chest, or abdomen?	☐ Yes	☐ No
Decreased interest in sex?	☐ Yes	☐ No			

SIGNATURE

_____ _____

Signature **Date**

If completed by someone other than the patient:

Your Name:_____ **Relationship:**_____

HEALTHeLINK

Patient Consent to Participate in HEALTHeLINK Health Information Exchange
Level 1 Multi-Provider/Multi-Payer Consent

Please carefully read the information that follows before making your decision.

You may use this Consent Form to decide whether or not to allow Participating HEALTHeLINK Providers and Payers ("Participants") who are involved in your care to see and obtain access to your electronic health records for treatment and/or care management purposes. This form may be filled out now or at a later date. You can give consent or deny consent to some or all of the Participants. A complete list of Participants can be found at www.wnyhealthelink.com/Home/Patients/Participants. If you have any questions on completing this form go to www.wnyhealthelink.com/Home/Patients/PatientConsent. If you do not have internet access and would like a list of Participants or need help completing this form, please call (716)206-0993 ext 311. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

In this Consent Form, you can choose whether to allow the Participants to obtain access to your medical records through a computer network operated by HEALTHeLINK, which is a part of a statewide healthcare computer network. This helps collect the medical records you have in different places where you get health care, and make them available electronically to the Participants rendering services to you.

SELECT ONLY ONE

☐ **YES** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL of** my electronic health information through HEALTHeLINK. By checking this box you agree that, "Yes, the staff involved in my care including emergency care, quality improvement, care management, and pre-authorization activities at all the Participants may see and get access to all of my medical records through HEALTHeLINK."

☐ **YES EXCEPT** — **I GIVE CONSENT for all Participants who are involved in my care to access ALL** of my electronic health information through HEALTHeLINK except the following Participants:

Participant's Name **Participant's address or phone number**

These Participants cannot access my electronic health information via HEALTHeLINK *EXCEPT in a medical emergency*. If you have chosen to exclude any Participants, you **must** contact HEALTHeLINK at (716)206-0993 ext 311 to verify your form. If you wish to deny consent to additional Participants, please identify them on the Participant Exclusion Form and attach it to this form. You can find the form at www.wnyhealthelink.com/Home/Patients/PatientConsent. If you have attached the Participant Exclusion Form please check here ☐

☐ **NO EXCEPT** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, EXCEPT *in a medical emergency*. By checking this box you agree, "No, none of the Participants may be given access to my medical records through HEALTHeLINK unless it is a medical emergency."

☐ **NO NEVER** — **I DENY CONSENT for all Participants who are involved in my care to access** my electronic health information through HEALTHeLINK for any purpose, INCLUDING *in a medical emergency*.

NOTE: Unless you select "NO NEVER" New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HEALTHeLINK.

PATIENT/LEGAL REPRESENTATIVE

Patient Last Name:

Patient First Name:

/ / ☐ **Male** ☐ **Female**

Patient Date of Birth:

Patient Address

City **State** **ZIP**

Signature of Patient or Patient's Legal Representative **Date of Signature**

Print Name of Patient's Legal Representative (if applicable)

Relationship of Legal Representative to Patient (if applicable)

☐ parent ☐ healthcare agent/proxy ☐ guardian ☐ other _____

Entity Consent Received By

WITNESS *

* If you are NOT completing this form in a Participant's office, you must have a witness complete the information below.

Print Name of Witness

Signature of Witness

Relationship of Witness to Patient (ex., spouse, son, neighbor, etc.)

Health Care Proxy Form Instructions

Item (1)

Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)

If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)

Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)

If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and alternate and they know my wishes including those about artificial nutrition and hydration.*

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatments....

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:....

I have discussed with my agent my wishes about_____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- surgical procedures
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Item (5)

You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)

You may state wishes or instructions about organ and /or tissue donation on this form. New York law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your health care agent, your decedent's agent, your spouse , if you are not legally separated, or your domestic partner, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death.

Item (7)

Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____

hereby appoint _____
(name, home address and telephone number)

_____

_____

*as my health care agent to make any and all health care de*cisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent
If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby

appoint _____
(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. *(Optional: If you want this proxy to expire, state the date or conditions here.)* This proxy shall expire *(specify date or conditions)*: _____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*: _____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)*, your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification *(please print)*

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of:
(check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1
(print) _____

Name of Witness 2
(print) _____

Signature _____ Signature _____

Address _____ Address _____

_____ _____

NEW YORK STATE | Department of Health