



Patient Name: _____ Date: _____

Chief Complaint

1. Why are you here to see the Doctor? Please list in order of importance:

- a. _____
- b. _____
- c. _____
- d. _____

2. Is this visit work related? YES NO

Review of Systems: Review the list below and “X” the box that describes a current problem and line through “/” those you have frequently had in the past.

For Internal use & Billing (= Problem Focused – 0; EPF problem pertinent system: Detailed – 2-9 systems; Comprehensive 10+ systems)*

*General:	<input type="checkbox"/> Chills	<input type="checkbox"/> Fever	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Weight Loss
	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Decrease in Appetite		
*HEENT:	<input type="checkbox"/> Itchy Throat	<input type="checkbox"/> Throat Closing	<input type="checkbox"/> Excessive Sputum or phlegm	<input type="checkbox"/> Change in Voice
<input type="checkbox"/> Headache	<input type="checkbox"/> Itchy Eyes	<input type="checkbox"/> Difficulty with Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Dark Circles Under Eyes
<input type="checkbox"/> Ear Pressure	<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Difficulty Hearing	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Ears Popping
<input type="checkbox"/> Deafness	<input type="checkbox"/> Trouble Smelling	<input type="checkbox"/> Nasal Congestion	<input type="checkbox"/> Nasal Drainage	<input type="checkbox"/> Post Nasal Drip
<input type="checkbox"/> Deviated Septum	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Excessive Sneezing	<input type="checkbox"/> Sinus Pressure	<input type="checkbox"/> Trouble Breathing Through Nose
<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Trouble Tasting	<input type="checkbox"/> Tongue Swelling	<input type="checkbox"/> Mouth Sores	<input type="checkbox"/> Frequent Throat Clearing
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Mouth Breathing		
*Pulmonary:	<input type="checkbox"/> Coughing Spells	<input type="checkbox"/> Tightness in Chest	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Shortness / Nighttime Shortness of Breath
	<input type="checkbox"/> Difficulty Breathing		<input type="checkbox"/> Coughing Up Blood	
*Cardiac:	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Heart Attacks	<input type="checkbox"/> High Cholesterol
	<input type="checkbox"/> Swelling in Feet or Ankles	<input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Murmur
	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mitral Valve Prolapse		<input type="checkbox"/> Heart Failure
*Gastrointestinal:	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Gas
<input type="checkbox"/> Belching	<input type="checkbox"/> Cramping	<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Chronic Nausea	<input type="checkbox"/> Trouble Swallowing
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Lip/mouth tingling after eating certain foods	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Chronic Constipation	<input type="checkbox"/> Vomiting Blood
<input type="checkbox"/> Blood in Bowel Movements	<input type="checkbox"/> Black or Loose Bowel Movements	<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Hemorrhoids
*Nephrological:	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Urination in Evening	<input type="checkbox"/> Painful Urination	<input type="checkbox"/> Discolored Urine
	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Reduction in Force of Urine	<input type="checkbox"/> Difficulty Starting Urination	<input type="checkbox"/> Leakage in Urine
	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Enlarged Prostate		
*Musculoskeletal:	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Muscle Cramping	<input type="checkbox"/> Arm or Leg Pain	<input type="checkbox"/> Pain in Legs While Walking
	<input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Pain with Cold Weather	
*Neurological:	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness in Hands, Feet or Legs	<input type="checkbox"/> Difficulty Maintaining Balance
	<input type="checkbox"/> Fainting/Blackout Spells	<input type="checkbox"/> Strokes	<input type="checkbox"/> Change in Facial Appearance	
*Endocrinological:	<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Prefer Hot Weather	<input type="checkbox"/> Prefer Cold Weather	<input type="checkbox"/> Breast Discharge
<input type="checkbox"/> Lumps in Breast	<input type="checkbox"/> Painful Breast	<input type="checkbox"/> Irregular Menses	<input type="checkbox"/> Vaginal Itching	<input type="checkbox"/> Frequent Yeast Infections
*Dermatological:	<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Hives	<input type="checkbox"/> Itching of Skin	<input type="checkbox"/> Dry Skin
	<input type="checkbox"/> Increase of Oiliness of Skin	<input type="checkbox"/> Skin Paleness	<input type="checkbox"/> Eczema	<input type="checkbox"/> Blisters
	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Reaction to Lotions	<input type="checkbox"/> Reactions to Cosmetics	<input type="checkbox"/> Reactions to Chemicals
*Hematological:	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Excessive Bleeding		
*Psychological:	<input type="checkbox"/> Crying Spells	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Depression or Anxiety	<input type="checkbox"/> Difficulty Sleeping
*Sleep Apnea Screening:	<input type="checkbox"/> Snoring	<input type="checkbox"/> Wake Up Fatigued	<input type="checkbox"/> Fatigued Throughout the Day	

SIMEDHEALTH ALLERGY & ASTHMA

Mercedes Pernice, MD • Belen Tan, MD • Wendell Colberg, MD
 4343 Newberry Road, Suite 1, Gainesville, FL 32607, P: 352-331-3502 • F: 352-331-3488
 1315 NW 21st Avenue, Suite 4, Chiefland, FL 32626 P: 352-493-2305 • F: 352-493-2307
 3305 SW 34th Circle, Suite 200-1, Ocala, FL 34474, P: 352-547-1016 • F: 352-547-1018
 426 Commerce Drive, Suite 105, Lake City, FL 32025 P: 386-755-1651 • F: 386-754-6910



Past Medical History

Hospitalizations: _____

Surgical History: _____

ER Visits: _____

Medical Illnesses / Disease: _____

Miscellaneous: have you ever had collagen / silicone implants? YES NO

Have you had metal joints / parts surgically placed in your body? YES NO

Where? _____ When? _____

Drug Allergies: N/A Penicillin Aspirin Sulfa Dye Others

Adverse Food Reactions: _____

Latex Sensitivity: _____

Recent Dental Work: None Type _____ Any Adverse Reactions? Yes No

Contact Sensitivity: None Elastics Bandages Nickel Others _____

Insect Stings: N/A Large Swelling Itching all over body Rash all over body Wheezing
 Shortness of Breath

Vaccination Status: Childhood Current Other: _____

Last Flu Shot: _____ (Year) Last Pneumonia Shot: _____ (Year)

Past Allergy Therapy / Testing

Have you had / or are you currently on allergy shots? YES NO

Did you have any reactions to the shots? YES NO Did the shots help? YES NO

Allergist Name & Address: _____

Immunotherapy: Q _____ Dilution: _____

No Reactions Reactions: _____

Medications

List all the medications you are now taking (Prescriptions, over the counter, eye-drops, nasal sprays, vitamins, "natural products," supplements, herbs, etc...)

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Past Family History

Who in Your Family Had	Self	Father	Mother	Sister(s)	Brother(s)
Migraines					
Hives					
Hay Fever					
Sinus Problems					
Glaucoma					
Emphysema					
Asthma					
Cystic Fibrosis					
Tuberculosis					
Thyroid Disease					
Heart Attack					
Stroke					
High Blood Pressure					
Cancer					
Others					

Past Social History (give parent's status if patient is a child)

Marital Status: _____ Current occupation: _____
 Education: Grade School (Highest Grade____) High School 1 2 3 4 College 1 2 3 4 Other: ____
 Hobbies: _____
 Smoker: N/A Cigarette Cigar Pipe Number Per Day _____ How Long _____ Stopped Smoking ____
 Are you exposed to smoke? At Home At Work Socially
 Drug Use: N/A Marijuana Heroin Cocaine Body Building Steroids Recreational Drugs
 How Often? _____
 Alcohol Intake: N/A Average Per Day _____ Type: Liquor Beer Wine

Environmental History

Home/ Dwelling: Age: _____ Style: Condo/Apt Cement Block Wood House Mobile Boat
 Length of Occupancy: _____ How long have you lived in this part of Florida? _____
 Type of Heating: Central Radiator Type of Air Conditioning: Central Window
 Humidifier: Central Separate Units Water: City Well
 Bed: Foam Waterbed Air Mattress Innerspring (age____)
 Pillow: Feather Foam Dacron Polyester (Age____)
 Comforter: Feather Non-Feather
 Flooring: Living Area: Carpet Tile Wood Bedroom: Carpet Tile Wood
 Type of Pets: _____ Inside Outside Roaches: YES NO
 Indoor Plants: YES NO Do you have any concerns with environment at home or work? YES NO
 Disease Impact on Function: _____

I have reviewed the above patient information sheet with the patient/family member.

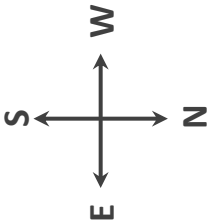
 Clinician

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Dark Green – Ground Floor



Suite 1 – SIMEDHealth Allergy & Asthma

4343 W Newberry Road, Gainesville, FL 32607

(352) 331-3502 | SIMEDHealth.com



COVERED DRIVE-THRU

PHARMACY

MAIN LOBBY

Suite 1
Allergy & Asthma

COURTYARD

NORTH ENTRANCE

COURTYARD

43RD STREET

NEWBERRY ROAD

PARKING LOT

From East parking lot,
enter Suite 1
If you are facing the
east side of the
building, this will be
the entrance on the far
left.
Your Destination

