Dear _____,

Enclosed you will find your new patient forms. Please complete these forms and bring them with you to your appointment on:

**M – Tu – W – Th – F** ,_____/_____/_____ @___:____ am/pm with

___**Dr. Grover** ___**Dr. Nair**

Your appointment is scheduled for our office located at:

___ 4343 Newberry Road, Suite 16, Gainesville, FL 32607

___ 426 SW Commerce Drive, Suite 105, Lake City, FL 32025

___ 1315 NW 21st Avenue, Suite 4, Chiefland, FL 32626

If you have had any previous testing done that may be helpful to your doctor, please bring it with you to your scheduled appointment along with a list of current medications. ***All insurance information***, photo I.D., and any referral information will be required at your initial visit. Failure to provide this information may result in you having to reschedule your appointment.

Please make note that all co-pays are due at the time of service. In the event that you are unable to keep your appointment, we do ask for the courtesy of 24 hour notification.

Thank you for choosing SIMEDHealth Women's Health, we look forward to assisting you with your healthcare needs.

**SIMEDHEALTH WOMEN'S HEALTH**
Linda Grover, MD • Meera Nair, MD
**P**: 352-331-1000 • **F**: 352-333-0337
4343 Newberry Road, Suite 16, Gainesville, FL 32607
SIMEDHealth.com

SIMEDHealth

Welcome to our office! Please carefully fill out the following questionnaire and let the nurse know if you are unsure about how to answer a question. You will have the opportunity to discuss in detail any part of this history and medical problems that you may have. You will also be able to ask any questions which may concern you.

**THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL**

Patient Name: _____DOB_____

Spouse / Partner / Parent's Name: _____

Spouse / Partner / Parent's Occupation: _____

Reason for Seeking Medical Attention: _____

_____

_____

**Living Will** --- The State if Florida allows a competent adult the opportunity to provide direction and instructions to health care providers for his/her medical care. This direction should be provided in writing as a "Living Will". The individual can also designate another person as a "Health Care Surrogate" to make those decisions. Please check and sign the following as appropriate:

_____ I have a "Living Will" or have officially designated a health care surrogate, and will provide the office with a copy for inclusion in my medical records.

_____ I do not have a "Living Will", but understand the information outlined above.

_____ I would like additional information, and will request it from the nurse or doctor.

Religious Preference: _____

## MEDICAL HISTORY

| | | | |
|---|---|---|---|
| □ High Blood Pressure | □ Gallbladder Problems | □ Anemia | □ Had Chicken Pox |
| □ Heart Problems | □ Hemorrhoids | □ Bleeding Disorders | □ Bladder Infections |
| □ Diabetes | □ Ulcers | □ Blood Clots / Phlebitis | □ Genital Herpes |
| □ Asthma | □ Jaundice / Hepatitis | □ Migraine Headaches | □ Gonorrhea |
| □ Osteoporosis | □ Colitis / Irritable Bowel | □ Epilepsy / Seizures | □ Chlamydia |
| □ Arthritis | □ Thyroid Problems | □ Emotional Problems | □ Syphilis |
| □ HIV | □ Tuberculosis | □ Kidney Stones | □ Tubal Infection |

□ Other Medical Problems: _____

_____

_____

**SURGERIES** (Please list any surgery you have ever had – *attach extra page if needed*)

Year_____ Procedure_____

Year_____ Procedure_____

Year_____ Procedure_____

**MEDICATIONS** (List all medications with dosages that you take regularly – *attach extra page if needed*)

_____ _____

_____ _____

_____ _____

**MEDICATION ALLERGIES** (Please list reactions) _____

_____

## SOCIAL HISTORY

Do you have any problems at home? □ YES □ NO _____

Have you ever felt threatened or been abused by anyone? □ YES □ NO _____

Do you smoke cigarettes? □ YES □ NO How Much?_____ For how long?_____

Do you use street drugs? □ YES □ NO If yes, describe:_____

Do you drink beer, wine or alcohol? □ YES □ NO How Much?_____ How Often?_____

Do you exercise regularly? □ YES □ NO Describe:_____

**Patient Name:** _____ **DOB:** _____

**FAMILY HISTORY** (Please list which family member had these problems)

- □ High Blood Pressure _____
- □ Heart Disease _____
- □ Diabetes _____
- □ Stroke _____
- □ Breast Cancer _____
- □ Ovarian Cancer _____
- □ Uterine Cancer _____
- □ Other _____
- □ Colon Cancer _____
- □ Osteoporosis _____
- □ Psychiatric Disorders _____

**GYNECOLOGIC HISTORY**

Date of last normal menstrual cycle (LMP): _____ How long does your period last? _____

What form of birth control are you currently using? _____

At what age did you first start having periods? _____ years

If you have experienced menopause, at what age did you stop having periods?____ Any bleeding or spotting since? _____

When not on birth control pills, how often do you have a period? _____

The amount of bleeding you have with your periods is typically: □ Scant □ Moderate □ Heavy □ Excessive with clots

The pain you experience with periods is: □ None □ Mild □ Moderate □ Severe □ Incapacitating

Have you missed periods without being pregnant? □ Yes □ No _____

Are you sexually active? □ Yes □ No _____

If sexually active, do you have bleeding after intercourse? □ Yes □ No _____

Do you have concerns about sexual issues? □ Yes □ No _____

Do you frequently leak urine when sneezing or coughing? □ Yes □ No _____

When was your last Mammogram? _____ Have you ever had an abnormal Mammogram? *Yes □ No □

When was your last pap smear? _____ Have you ever had an abnormal pap smear? *Yes □ No □

*List any details of abnormal Mammogram or Pap smear: _____

**PREGNANCY HISTORY**

**DELIVERIES**

| Month/Year | Type of Delivery | Sex | Baby's Weight | Complications During Pregnancy or Delivery |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**MISCARRIAGES / TERMINATIONS / TUBAL (ECTOPIC) PREGNANCIES**

| Month/Year | Weeks | Complications |
|---|---|---|
| | | |
| | | |

**SYSTEM REVIEW**

- □ Chronic / Frequent Cough
- □ Shortness of Breath
- □ Chest Pains
- □ Rapid/Irregular Heartbeat
- □ Swelling of Hands, Feet or Ankles
- □ Nausea or Vomiting
- □ Heartburn or Indigestion
- □ Abdominal Cramps or Pain
- □ Changes in Bowel Habits
- □ Significant Weight Change
- □ Severe Headaches
- □ Depression
- □ Hot Flashes
- □ Excessive Tiredness / Weakness
- □ Back Pain
- □ Joint Pain or Stiffness
- □ Fractures
- □ Numbness