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. Osorio**

Your appointment is scheduled for our office located at:

___ 3305 SW 34th Circle, Suite 200-1, Ocala, FL 34474

___ 929 N HWY 441, Suite 502, Lady Lake, FL 32159

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
Oscar Osorio, MD
P: 352-391-6464 • **F**: 352-750-3154
3305 SW 34th Circle, Suite 200-1, Ocala, FL 34474
SIMEDHealth.com

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 ____________
- ☐ Breast Cancer ________________
- ☐ Colon Cancer ______________
- ☐ Heart Disease ______________
- ☐ Ovarian Cancer ______________
- ☐ Osteoporosis ______________
- ☐ Diabetes __________________
- ☐ Uterine Cancer ______________
- ☐ Psychiatric Disorders _________
- ☐ Stroke ____________________
- ☐ Other ____

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