SIMEDHealth

Past Medical History: _____

Patient Name Date

General

- ☐ Anxiety Disorders
- ☐ Depression
- ☐ Dizziness (Vertigo)
- ☐ Forgetfulness
- ☐ Insomnia

Cardiovascular

- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Congestive Heart Failure
- ☐ Chest Pain / Angina
- ☐ Bleeding Disorder
- ☐ Circulatory Problems
- ☐ Edema
- ☐ Varicose Veins
- ☐ Atrial Fibrillation

Neurology

- ☐ Polio
- ☐ Shingles
- ☐ Epilepsy
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Stroke / TIA
- ☐ Alzheimer's
- ☐ Dementia

Chronic Disease

- ☐ AIDS / HIV
- ☐ Arthritis, Type: _____
- ☐ Cancer, Site: _____
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Graves Disease
- ☐ Herpes
- ☐ Hypothyroidism

Other

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Chemical Dependency
- ☐ BPH (Enlarged prostate)
- ☐ Venereal Disease
- ☐ Kidney Stones
- ☐ Renal Failure
- ☐ Renal Insufficiency

Childhood Diseases

- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Whooping Cough
- ☐ Chicken Pox
- ☐ Mumps
- ☐ Measles

Gastrointestinal

- ☐ GERD (Heartburn)
- ☐ GI Bleed
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Ulcers
- ☐ Rectal Bleeding
- ☐ Vomiting Blood
- ☐ Constipation
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Skin

- ☐ Bruises Easily
- ☐ Changes in moles
- ☐ Sore that won't heal

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Pneumonia

Other Illness' Not Listed

_____
_____
_____
_____
_____
_____
_____

SIMEDHEALTH HAND CENTER
Gloria Chin, MD
P: 352-751-0981 • **F**: 352-751-0984
3305 SW 34th Circle, Suite 200-1, Ocala, FL 34474

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Medical / Health History: _____

Patient Name Date

Allergic Reaction to Medication	
Drug Name	Reaction

Previous Surgeries	
Date(s)	Procedure

Reason for today's visit: _____

□ Left □ Right

□ Finger □ Hand □ Wrist □ Forearm □ Elbow □ Other: _____

Have you had any prior treatment for this problem? □ Yes □ No

If Yes, Physician's Name _____ Phone Number: _____

Are you on a pain management plan? □ Yes □ No

If Yes, Physician's Name _____ Phone Number: _____

Primary Care Physician Name: _____ Phone Number: _____

Pharmacy Name: _____ Phone: _____ Fax: _____

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Social / Family History: _____

Patient Name Date

Social History

Do you drink alcohol? □ Yes □ No □ Daily □ Weekly □ Monthly

Dominant Hand: □ Left □ Right

Do you exercise regularly? □ Yes □ No

Hobbies, please list: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Life Partner

Work Status: □ Retired □ Full Time □ Student □ Disabled □ Unemployed

Occupation (If retired what type of work did you do?): _____

Employer Name: _____ Employer Phone: _____

Do you use recreational drugs? □ Yes □ No

Do you use tobacco? □ Yes □ No

Have you ever used tobacco? □ Yes □ No Year Quit: _____

Do you travel? □ Yes □ No

Height:_____ Weight: _____

Family History: Please mark or respond to each item in the boxes below.

	Mother	Father	Sister(s)	Brother(s)
Breast Cancer				
Prostate Cancer				
Heart Disease				
Stroke				
Diabetes				
High Blood Pressure				
Age				
Deceased Age				
Cause of Death				

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Medications

Patient Name:		Date of Birth:
Pharmacy:	Pharmacy Phone#:	Pharmacy Fax#:
Allergies to Medications:		

Date Prescribed	Medication	Dose	Quantity	Frequency

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