SIMEDHealth

Patient Name: _____

Appointment Date and Time: _____

Dear Patient:

We would like to take a moment to welcome you to our practice!

We want you to know that we appreciate the opportunity to take care of you. Thank you for selecting us and we look forward to serving you. Our goal is to provide you with the highest quality care. To reach this goal our skilled professionals take a personalized approach with your healthcare needs and treatment.

In order to expedite the new patient registration process we ask that you **complete the enclosed forms prior to your appointment and bring them with you to your scheduled appointment**.

You will also need to bring your insurance card and driver's license (or other form of photo I.D.). Please be advised that your deductible and/or co-payment will be due at the time of service.

If you have had any recent blood work, MRI scans CT scans, x-rays, etc., in regards to the condition for which we are scheduled to see you, please contact your referring physician and request that these reports be mailed or faxed to our office prior to your appointment. We also ask that if you have had MRI or CT scans performed, please **pick up a copy of these films to bring with you to your appointment.**

If you are unable to keep your appointment please contact our office 48 hours in advance to cancel.

Again, thank you for choosing us. We look forward to seeing you at the clinic and will do our best to make your visit as pleasant, efficient and complete as possible.

Sincerely,

SIMEDHealth Neurology

SIMEDHEALTH NEUROLOGY
Anthony Ackerman, MD • Galina Bogorodskaya, MD • Kraiyuth Vongxaiburana, MD
P: 352-374-2222 • **F**: 352-374-8050
4343 Newberry Road, Suite 3, Gainesville, FL 32607
SIMEDHealth.com

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Patient Name: _____ **Age:**_____

Main Problem

Please describe the main problem you are here to see a neurologist about today:

_____

Medical History

Please check any disease or condition you have had in the past or have now:

□ High blood pressure	□ Diabetes	□ Heart disease	□ Arthritis
□ Asthma	□ Glaucoma	□ Heart attack	□ Anemia
□ Lung Disease	□ Liver disease	□ Thyroid disease	□ Gout
□ Kidney failure	□ Acid reflux/ulcers	□ Fibromyalgia	□ Migraines
□ Kidney stones	□ Seizures/Epilepsy	□ Depression	□ Anxiety
□ High cholesterol	□ Muscle disease	□ Psychiatric disease	□ Neuropathy

□ Cancer (where? _____ when? _____ therapy _____)

Please list any other health problems not described above or describe above condition further:

_____

Surgical History

Please list any surgeries you have had and the approximate dates: _____

_____

Current Medications: Please provide a list of your medications or write them here

Name	Strength (mg)	# of Tablets	# of times per day

What over the counter medications or remedies do you take?

_____

List/describe any "alternative" or "complimentary" therapies you are receiving:

_____

Medication allergies: _____

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Family History

Relative:	Father	Mother	Brother(s)	Sister(s)	Child(ren)
Age (if living)					
Cause / Age at time of death					
Cancer					
Seizures					
Stroke					
Heart Attack					
Migraines					
Dementia					
Neuropathy					
Muscle Problems					
Diabetes					
Movement Disorders					
Psychiatric Illness					
Glaucoma					
High Blood Pressure					

Social History

Do you smoke? □ No Did you ever smoke? _____ If so, how much? _____ How long? _____

When did you quit? _____□ Yes How much per day? _____ for how many years? _____

How much caffeine do you drink/day? _____

How much alcohol do you drink? _____

Family: □ Single □ Married □ Divorced □ Widowed □ Significant other

Children: How many? _____ What are their ages? _____

Occupation: _____

Education level (how far did you go in school?): _____

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Review of Systems: Please check symptoms you have had in the past 3 months.

Constitutional

- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Recurrent Fevers
- ☐ Night Sweats

HEENT

- ☐ Severe Headaches
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Loss of Hearing
- ☐ Ringing in the Ears
- ☐ Difficulty Swallowing
- ☐ Difficulty Chewing
- ☐ Pain in jaw with chewing
- ☐ Change in voice / speech
- ☐ Head injury with loss of consciousness
- ☐ Flashing Light in the eyes
- ☐ Brief loss of vision in one eye
- ☐ Snoring
- ☐ Wake up un-refreshed
- ☐ Wake up with dry mouth/headache

Cardio-respiratory

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Unusual Cough
- ☐ Palpitations
- ☐ Coughing up blood
- ☐ Wake from sleep gasping

GI

- ☐ Abdominal Pain
- ☐ Chronic Diarrhea
- ☐ Chronic constipation
- ☐ Loss of bowel control
- ☐ Nausea/Vomiting
- ☐ Blood in stool

GU

- ☐ Loss of bladder control
- ☐ Sexual difficulties
- ☐ Menstrual problems
- ☐ Frequent urination at night

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle cramping / stiffness
- ☐ Joint pain

Endocrine

- ☐ Tendency to fatigue easily
- ☐ Unusual thirst
- ☐ Urinating often
- ☐ Intolerant of cold
- ☐ Intolerant of heat
- ☐ Hair loss

Hematologic

- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Frequent infections

Neuropsychiatric

- ☐ Numbness of arms
- ☐ Numbness of legs
- ☐ Weakness of legs
- ☐ Weakness of arms
- ☐ Vertigo / spinning feeling
- ☐ Tremors/Shaking
- ☐ Difficulty walking
- ☐ Poor balance
- ☐ Thinking impairment
- ☐ Language problems
- ☐ Memory loss
- ☐ Passing out
- ☐ Poor coordination
- ☐ Slowness of movements
- ☐ Frequently depressed mood
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Trouble relaxing
- ☐ Personality changes
- ☐ Nervousness / anxiety
- ☐ Frequent worried thoughts
- ☐ Loss of interest in work or home activities
- ☐ Hallucinations

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Dark Green – Ground Floor

Suite 3 – SIMEDHealth Neurology

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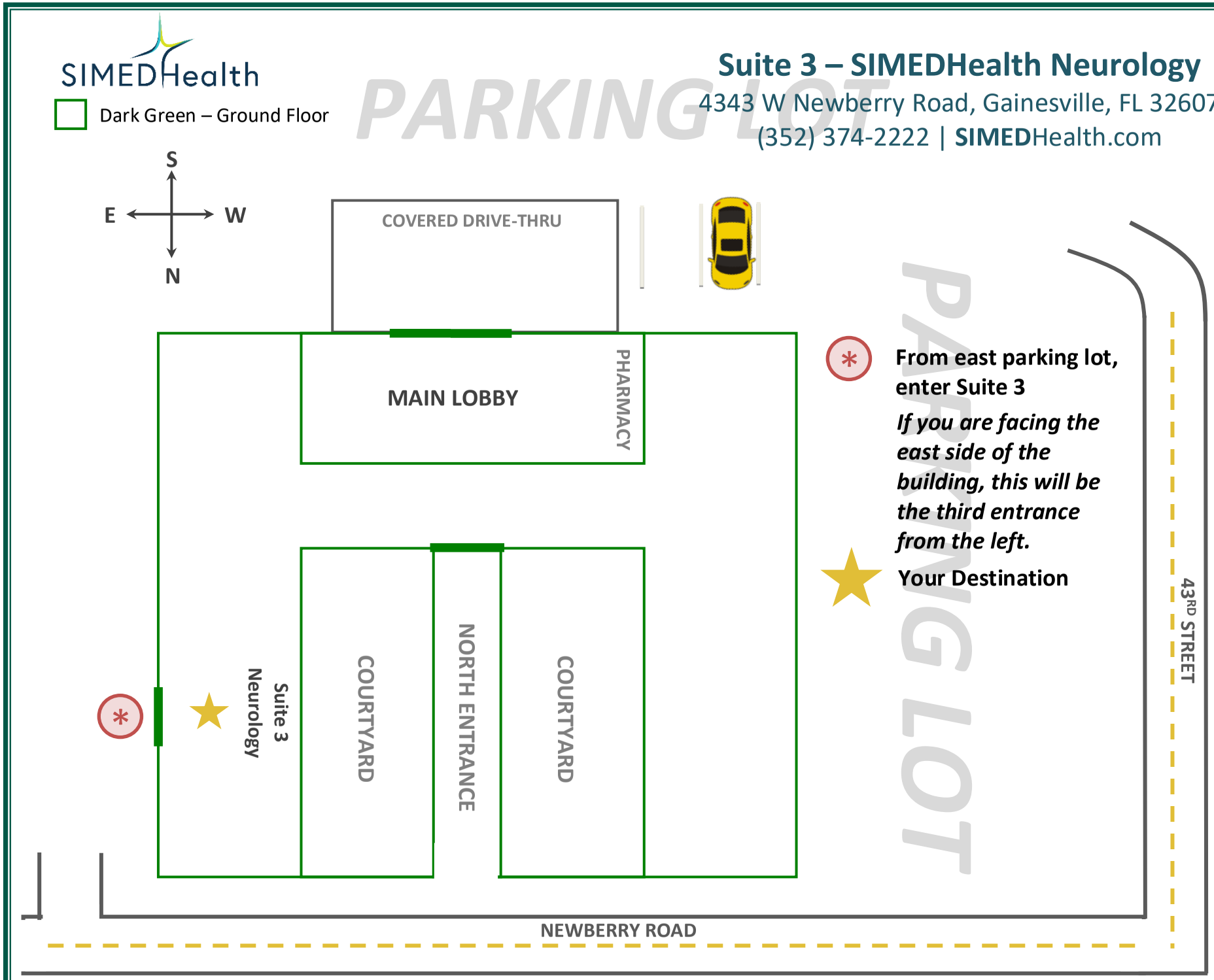
(352) 374-2222 | **SIMED**Health.com



* From east parking lot, enter Suite 3

If you are facing the east side of the building, this will be the third entrance from the left.

★ Your Destination