SIMEDHealth

Patient Name: _____ Date: _____

Please indicate if you are having any current problems, signs or symptoms in any of the following areas:

- □ General Weakness
- □ Eyes
- □ Skin
- □ Ears, Nose, Throat
- □ Stomach / Digestive
- □ Lungs / Breathing
- □ Heart / Circulation
- □ Muscles / Joints / Bones
- □ Chest Pains
- □ Neurological
- □ Allergies
- □ Reproductive / Urinary
- □ Thyroid / Endocrine
- □ Psychiatric
- □ Blood / Lymph
- □ Dizziness
- □ Trouble Sleeping
- □ Memory

Physician Comments – Review of Symptoms Date: _____

Please list all medications you are taking:

_____

_____

_____

Previous Surgeries/Dates:

_____

_____

_____

Who prescribed these medications?

_____

_____

Drug Allergies: _____

Please tell us about your social history: Are you : □ Single □ Married □ Divorced □ Widowed

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily How much do you drink? _____

Use of Tobacco: □ Never □ Socially □ Previously, but I quit _____ Current packs per day _____

Use of drugs: □ Never Type and Frequency: _____

Excessive exposure at home or work to: □ Fumes □ Dust □ Solvents □ Air-Borne Particles □ Noise

Please tell us about your family history…

| | Age | | Disease / Illness | If deceased, cause of death |
|---|---|---|---|---|
| Spouse | | M / F | | |
| Children | | M / F | | |
| | | M / F | | |
| | | M / F | | |
| Father | | | | |
| Mother | | | | |
| Siblings | | M / F | | |
| | | M / F | | |
| | | M / F | | |

**SIMEDHEALTH SPINE & NEUROSURGERY**
Steve Bailey, MD • Steven A. Reid, MD
Hope Bishop, PA-C
**P**: 352-332-7246 • **F**: 352-332-7427
4741 NW 8th Avenue, Suite A, Gainesville, FL 32605
SIMEDHealth.com

SIMEDHealth

Patient Name: _____ Date: _____

Chief complaint on today's exam / reason for visit: _____

_____

History of present illness

♦ Location _____
(Where is the pain / problem?)

♦ Severity _____
(How severe is the pain / problem on a scale of 1-5, 5 being most severe?)

♦ Duration _____
(How long have you had this pain / problem? When did it start?)

♦ Timing _____
(Does this pain / problem occur at a specific time or activity?)

♦ Context _____
(Where were you at the onset of this pain/ problem?)

♦ Associated Signs of Symptoms _____
(What other associated problems have you been having?)

♦ Modifying Factors _____
(What makes the pain / problem worse or better?)

♦ Previous Treatments _____
(Have you at any time in your life been treated for this or a similar condition? If yes, please give specific details.)

Have you ever had an MRI? □ Yes □ No If yes, when, where and what type? _____

Have you ever had a CT scan? □ Yes □ No If yes, when, where and what type? _____

Have you ever had an EMG or Nerve Conduction Study? □ Yes □ No If yes, when &, where?_____

Have you ever had a reaction to contrast material? □ Yes □ No If yes, please explain _____

Do you have a pacemaker? □ Yes □ NoHave you ever had metal in the eyes? □ Yes □ No

Have you ever had a problem with anesthesia? □ Yes □ No If yes, please explain _____

Have you ever had any bleeding disorders? □ Yes □ No If yes, please explain _____

Do you have any other health concerns that you would like to discuss with and/or make the provider aware of?

□ Yes □ No If yes, please explain _____

_____

_____

_____

_____

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Patient Name: _____ Date: _____

You only need to complete this page if you have ever been involved in an auto accident or work related injury.

Is the problem or injury we are seeing you for relate to: □ Auto Injury or □ Work Injury?

If auto, date of accident: _____ If work related, date of injury: _____

**Present Work Injury**

What type of injury did you sustain? _____

Who was your employer at the time of injury? _____

Are you still employed with them? □ Yes □ No What is your current work status? _____

Who is your work comp insurance carrier? _____ Your adjustor? _____

**Past Work Injury**

What type of injury did you sustain? _____

What was the date of the injury? _____ Who treated you for this injury? _____

Are you still receiving treatment for this injury? □ Yes □ No If yes, indicate which injury and the name / phone number of your attorney: _____

**Auto Related Injury**

Were you the driver? □ Yes □ No Were you in the automobile? □ Yes □ No

Do you have automobile coverage? □ Yes □ No

Is the automobile insurance in your name? □ Yes □ No If no, who is the policy holder? _____

Who is the adjuster? _____ Does he/she have an ext or back line? _____

Is there litigation in this accident? □ Yes □ No If yes, please provide the name and phone number of your attorney:

_____

## *** IMPORTANT NOTICE TO AUTO INSURANCE PATIENTS ***

It is an industry practice not to pre-authorize services or guarantee benefits on auto insurance patients. Therefore, as a safeguard to you, the patient, we will ask for any health insurance you may have as a secondary (or fallback) to your auto insurance. This does not mean that we will file a claim with your health insurance. We will always file with your auto insurance as the primary carrier. What it does mean is that we will obtain all necessary pre-certifications required by your health insurance and should you exhaust your auto insurance benefits, we will have a safety net to fall back on. Should you choose to not provide us with your health insurance information, you may be required to pre-pay for all or a portion of services rendered in the case where we cannot confirm existing benefits. In cases where the auto insurance carrier advises that they reimburse charges at a percentage, you, the patient, will be required to pay your percentage at the time of services being rendered.

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