SIMEDHealth

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Please answer the following questions as completely as possible to help your physician understand your health problems.

State your main complaint: _____

_____

List drug allergies: _____

_____

List all medications, frequency and dose, if known (or attach list): _____

_____

_____

Have you had problems with any of the following? If so, describe how long.

Stroke: _____

Diabetes: _____

Blood Pressure: _____

Any Cancer / Tumors: _____

Heart Disease: _____

Neurological Disease: _____

Pelvic/GYN Problems: _____

Blood in Stool: _____

Problems w/ Bowel Movements: _____

Bleeding Disorder: _____

Weight Loss: _____

Family History (please mark):

□ Cancer _____ □ Diabetes _____

□ Heart Disease _____ □ Hypertension _____

□ Stroke _____

How much alcohol do you drink? _____

Do you smoke? How much? _____

SIMEDHEALTH UROLOGY
Cristoforo Cama, MD • Clark Gaddy, MD • Martin Rifkin, MD
P: 352-333-5400 • **F**: 352-333-5404
1179 NW 64th Terrace, Gainesville, FL 32605
SIMEDHealth.com

SIMEDHealth

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other _____		

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other _____		

Allergic / Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other _____		

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness / Tingling	Y	N
Other _____		

Endocrine

Excessive Thirst	Y	N
Too Hot / Cold	Y	N
Tired / Sluggish	Y	N
Other _____		

Gastrointestinal

Abdominal Pain	Y	N
Nausea / Vomiting	Y	N
Indigestion / Heartburn	Y	N
Other _____		

Cardiovascular

Chest Pain	Y	N
Varicose Veins	Y	N
High Blood Pressure	Y	N
Other _____		

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other _____		

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Other _____		

Ear / Nose / Throat / Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other _____		

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinary Frequency	Y	N
Other _____		

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Other _____		

Hematologic / Lymphatic

Swollen Glands	Y	N
Blood Clotting / Problem	Y	N
Other _____		

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N
Other _____		

Physician Use Only: (Comments / Notes)

# Answers	Level of Service
0-1	1 or 2
2-9	3
10+	4 or 5

Physician: _____ Date: _____

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