SIMMONS CARE CLINICS

NAME ____________________ SS# ____________ DATE ________

ADDRESS ____________ CITY/STATE ____________ ZIP ________ OCCUPATION ________

PHONE (HOME) ____________ WORK ____________ DATE OF BIRTH ____________ AGE ______

DRUG ALLERGIES ____

CURRENT MEDS ____

HOSPITALIZATION OR SURGERY ____

WOMEN ONLY: PREGNANT? ☐ YES ☐ NO PLANNING PREGNANCY? ☐ YES ☐ NO

FAMILY HISTORY

	Fathers Parents	Mothers Parents	Father	Mother	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐

	Fathers Parents	Mothers Parents	Father	Mother	Siblings	Children
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis/Arthritis	☐	☐	☐	☐	☐	☐
Genetic Disease	☐	☐	☐	☐	☐	☐
Sudden Death	☐	☐	☐	☐	☐	☐
Death at a Young Age	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐

MEDICAL HISTORY

- ☐ Headache
- ☐ Shortness of breath
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Dizziness / Fainting
- ☐ Allergies / Hay Fever
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Ulcer
- ☐ Stomach/Intestine Problem
- ☐ Diabetes
- ☐ Lactose Intolerance
- ☐ Gallbladder Disease
- ☐ Prostate Disease
- ☐ Problems with Stool
- ☐ Problems with Urine
- ☐ Sexual/Menstrual Dysfunction
- ☐ Sexually Transmitted Disease
- ☐ Frequent Infections
- ☐ Hepatitis
- ☐ Anemia
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Nervousness
- ☐ High Blood Pressure
- ☐ Depression
- ☐ Gout
- ☐ Scarlet Fever
- ☐ Chronic Rashes
- ☐ Rheumatic Fever
- ☐ Mumps
- ☐ Measles
- ☐ Rubella
- ☐ Polio
- ☐ Diphtheria
- ☐ Tetanus
- ☐ Other ____________

HABITS

☐ Smoke: Packs Daily ____________
How long ____________
Interested in stopping? ____________

☐ Smokeless Tobaccos ____________
How long ____________
How much per day ____________

☐ Alcohol Type: ____________
Amount ____________

☐ Sleep Difficulty falling asleep ____________ Difficulty staying asleep ____________ Snoring ____________
Early morning awakening ____________ Other ____________