Westside Primary Care Associates

Main Location: 14420 W. Meeker Blvd, Suite 207, Sun City West, AZ 85375
Buckeye Office: 865 S. Watson Road, Suite 108 Buckeye, AZ 85326
Phone: 623-267-6700 **Fax:** 623-267-6701 **Web:** westsidepca.com

Patient's Medical History

Patient's Name:_____ **Date of Birth:**_____

MEDICATIONS

Medication Name	Strength	Dose	Frequency

ALLERGIES

- Patient has no known allergies (food OR environmental)
- Patient has no known DRUG allergies
- Latex ☐Keflex ☐Penicillin ☐Sulfa ☐Eggs ☐Ciprofloxacin ☐Iodine ☐Shellfish
- Other:_____
  If yes, describe your reaction(s):_____

PHARMACY

Pharmacy Name:_____ Address:_____ Phone#_____

PAST/PRESENT MEDICAL CONDITIONS

Cardiac: □Heart Attack □Atrial Fibrillation □Congestive Heart Failure □Hypertension □Irregular Heartbeat

Neurology: □Stroke □Seizures/Epilepsy □Dementia □Parkinson's

Endocrine: □Diabetes □Thyroid Disorder □Osteoporosis □Elevated Cholesterol

Lungs: □Asthma □COPD □Valley Fever □Sleep Apnea

Gastrointestinal: □GERD □IBS □Cirrhosis/Liver Disease

Urinary: □Enlarged Prostate □Kidney Stones □Kidney Failure

Rheumatology:□Arthritis □Fibromyalgia □Lupus

Blood:□Anemia □Leukemia □Lymphoma □Bleeding Disorder

Psychiatric:□Anxiety □Depression □Bipolar Disorder □Schizophrenia

Circulation: □DVT □Pulmonary Embolism □Peripheral Vascular Disease □Carotid Artery Disease

Cancer:□Cancer(type) _____

Other Condition(s) not listed: □None

HOSPITAL & SURGERY HISTORY

FAMILY HISTORY

Date: **Reason**:

Family Member: **Age**: **Alive/Deceased**: **Medical Conditions**:

Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister			
Brother			
Children			

SOCIAL HISTORY

- **ADOPTED**

Caffeine: ☐YES ☐NO If yes, how much?_____ ☐Previous Use When did you quit?_____

Alcohol: ☐YES ☐NO If yes, how much?_____ ☐Previous Use When did you quit?_____

Tobacco: ☐YES ☐NO If yes, how much/often?_____ ☐Previous Use When did you quit?_____

Marijuana:☐YES ☐NO If yes, how much/often?_____ ☐Previous Use When did you quit?_____

Vaping(e-Cigarette):☐YES ☐NO If yes, how much/often?_____ ☐Previous Use When did you quit?____

PREVENTATIVE CARE

Date of last physical exam:_____
Date of last mammogram:_____
Date of last colonoscopy:_____
Date of last bone density scan (DEXA):_____
Date of last Pap Smear:_____
Date of last PSA:_____
Date of last stool test (colorguard):_____

IMMUNIZATIONS

Hep A: ☐Yes ☐No Date Received:_____ **Hep B**: ☐Yes ☐No Date Received:_____

Influenza: ☐Yes ☐No Date Received:_____ **Pneumonia**: ☐Yes ☐No Date Received:_____

Prevar13: ☐Yes ☐No Date Received:_____ **Tetanus**: ☐Yes ☐No Date Received:_____

Shingles:☐Yes ☐No Date Received:_____ **TB**: ☐Yes ☐No Date Received:_____

MMR:☐Yes ☐No Date Received:_____ **HPV**: ☐Yes ☐No Date Received:_____

COVID Vaccine: ☐Yes ☐No Date Received:____ **COVID Booster**: ☐Yes ☐No Date Received:_____

SPECIALISTS

Do you see any specialists?

Cardiology:

GI:

Neurology:

Pulmonology:

Rheumatology:

Immunology:

Endocrinology:

Hematology:

Dermatology:

Audiology:

Oncology:

Ophthalmology:

ENT:

Other:

Please fill out a medical record release form for each specialist you would like us to have records from.