Westside Primary Care Associates

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Patients name:
DOB:_____

Patient's Medical History

MEDICATIONS

Medication Name:	Strength:	Dose:	Frequency:

ALLERGIES

☐ Patient has no known allergy ☐ Patient has no known drug allergy ☐ Latex ☐ Keflex
☐ Penicillin ☐ Sulfa ☐ Eggs ☐ Ciprofloxin ☐ Iodine
☐ Other:_____

PAST / PRESENT MEDICAL CONDITIONS

Cardiac: ☐ Heart Attack ☐ Atrial Fibrillation ☐ Congestive Heart Failure ☐ Hypertension ☐ Irregular Heart Beat
Neurology: ☐ Stroke ☐ Seizures/Epilepsy ☐ Dementia ☐ Parkinson's
Endocrine: ☐ Diabetes ☐ Thyroid Disorder ☐ Osteoporosis ☐ Elevated Cholesterol
Lungs: ☐ Asthma ☐ COPD ☐ Valley Fever ☐ Sleep Apnea ☐ Lung Cancer
Gastrointestinal: ☐ GERD ☐ Colon Cancer ☐ IBS ☐ Cirrhosis/Liver Disease
Urinary: ☐ Enlarged Prostate ☐ Kidney Stones ☐ Prostate Cancer ☐ Kidney Failure
Rheumatology: ☐ Arthritis ☐ Fibromyalgia ☐ Lupus
Blood: ☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Bleeding Disorder
Psychiatric: ☐ Anxiety Disorder ☐ Depression ☐ Bipolar Disorder ☐ Schizophrenia
Circulation: ☐ DVT ☐ Pulmonary Embolus ☐ Peripheral Vascular Disease ☐ Carotid Artery Disease
Cancer: ☐ Cancer (type)
Other Condition(s) not listed:_____ ☐ NONE

HOSPITAL & SURGERY HISTORY

Date:	Surgery/Reason for Hospital Stay:

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE / DECEASED	MEDICAL CONDITIONS
Father			
Mother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister			
Brother			
Children			

SOCIAL HISTORY

Caffeine: ☐ Yes ☐ No If yes, how much?_____

Alcohol: ☐ Yes ☐ No If yes, how much?_____

Smoking/former smoker: ☐ Yes ☐ No If yes, how much?_____

Marijuana: ☐ Yes ☐ No If yes, how much?_____

Exercise: ☐ Yes ☐ No If yes, how much?_____

Living Will: ☐ Yes ☐ No

Retired: ☐ Yes ☐ No

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:_____

IMMUNIZATIONS

Hep A: ☐ Yes ☐ No Date Received:_____

Hep B: ☐ Yes ☐ No Date Received:_____

Influenza: ☐ Yes ☐ No Date Received:_____

Pneumonia: ☐ Yes ☐ No Date Received:_____

Prevar 13: ☐ Yes ☐ No Date Received:_____

Tetanus: ☐ Yes ☐ No Date Received:_____

Shingles: ☐ Yes ☐ No Date Received:_____

TB: ☐ Yes ☐ No Date Received:_____

MMR: ☐ Yes ☐ No Date Received:_____

Covid Vaccine ☐ Yes ☐ No Date Received:_____

Covid Booster ☐ Yes ☐ No Date Received:_____

Pharmacy

Pharmacy name:_____ Address:_____Phone #_____