EQUALITY CARE CENTER™

4220 North 20th Avenue Phoenix, AZ 85015
3306 W. Roosevelt St. Phoenix, AZ 85009

Chart #: ______________________

NEW PATIENT HISTORY

Patient Name: ______________________ **Date of Birth:** ______________

Sex: ☐ Male ☐ Female **Age:** __________

Emergency Contact Name: ______________ **Relationship:** __________ **Phone:** __________

Please list your preferred pharmacy name and location: ______________________

Reason for today's visit: ______________________

Medical History: *Do you have or have you had any of the following?* ***Check ALL that apply***

☐ Anxiety Disorder
☐ ADHD
☐ Asthma
☐ Autoimmune disease
☐ Aneurysm
☐ Arthritis
☐ Autism
☐ Bipolar Disorder
☐ Bleeding Disorder
☐ Cataracts
☐ Cancer
☐ Chronic Pain
☐ Chemotherapy
☐ Clotting Disorder
☐ COPD
☐ Coumadin use
☐ Depression
☐ Diabetes Type I
☐ (insulin dependent)
☐ Diabetes Type II
☐ (non-insulin dependent)
☐ Diabetes Insipidous
☐ Diabetes (unknown)
☐ Dialysis
☐ Heartburn/Reflux
☐ Hepatitis
☐ Heart Attack
☐ Heart Valve Defects
☐ HIV or AIDS
☐ High Blood Pressure
☐ Hyperthyroidism
☐ Glaucoma
☐ Osteoporosis
☐ Pancreatitis
☐ Panic Disorder
☐ Polycystic Ovarian Syndrome
☐ Restless Leg Syndrome
☐ Schizophrenia
☐ Seizure Disorder
☐ Sickle Cell Anemia
☐ Skin disorders (Acne, Psoriasis, Eczema)
☐ Stroke
☐ Thalassemia
☐ Transfusions
☐ Tuberculosis
☐ Visual Difficulties

Other: ______________________

Surgeries or Hospital Admissions: please list any you have had

Date	Surgery or Reason for hopital stay

Current Medications: (Use other side if needed)

Medications	Dose	Frequency	Reason	Prescribed by

Drug Allergies:

Medications	Reactions

Provider Initial: __________

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Family History: Please check any of the conditions that are in your family and list the family member or relative

☐ Heart Disease	
☐ High Blood Pressure	
☐ Stroke	
☐ Diabetes	
☐ Cancer	Type:
☐ Kidney Disease	
☐ Bleeding Disorders/Blood	
☐ Clots	
☐ Thyroid Disease	
☐ Mental Illness	
☐ Osteoporosis	
☐ Epilepsy/Seizures	
☐ Glaucoma	
☐ Other	

Females:

Date of Last Menstrual Period?
Total # of Pregnancies?
Total # of Live Births?
# of miscarriages, abortions?
At what age did you start menstruating?
At what age did you go through menopause?
At what age did you first have sex?
Have you had any of the following? *check all that apply*
☐ Ectopic Pregnancy
☐ Hysterectomy full or partial
☐ Ablation
☐ Tubal ligation

Males:

Do you have any difficulty with Urination?
Do you frequently have to strain to urinate?
Do you have a weaker urine stream than usual?
Do you feel like you empty your bladder fully when your urinate?
Do you have to get up frequently during the night to urinate?
Do you have difficulty achieving or maintaining an erection?
Do you have difficulty ejaculating?

Have you ever had any of the following exams?

Test	Year/ Reason/Results
☐ PAP Smear	
☐ Prostate Biopsy	
☐ Mammogram	
☐ Colonoscopy	
☐ Endoscopy	
☐ EKG	
☐ Cardiac Stress Test	
☐ ECHO	
☐ Chest X Ray	
☐ CT Scan	
☐ EEG	
☐ Bone Density Test	
☐ Other	

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Social History: *Check the box that applies to you*

Are you a: ☐ Current smoker ☐ Former smoker ☐ Never smoked

If you are a current smoker:

Do you smoke: ☐ cigarettes ☐ cigars ☐ tobacco pipes

How often do you smoke cigarettes? ☐ Everyday ☐ Somedays, but not everyday

How many cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

How soon after you wake up do you smoke your first cigarette? ☐ Within 5 Min ☐ 6-30 Min ☐ 31-60 Min ☐ after 60 Min

Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

Do you drink alcohol? If yes, how many drinks per week? ____________________

Do you exercise? If yes, how often and what type? ____________________

Do you work? ____________________ What do you do? ____________________

What is your marriage status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed Other: ____________________

What are your living arrangements? ____________________

Do you feel safe at home? ☐ Yes ☐ No

Have you ever been a victim of abuse? ☐ Yes ☐ No

Have you ever been incarcerated? ☐ Yes ☐ No

Review Systems: *In the* ***last 6 months****, have you experienced any of the following symptoms? Check the box that applies to you*

Constitutional:
- ☐ Fever/chills
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Decreased appetite

Allergy:
- ☐ Watery Eyes/Runny Nose
- ☐ Seasonal Allergies

ENT/Mouth:
- ☐ Ear Pain
- ☐ Frequent sinus infections
- ☐ Hearing changes or loss
- ☐ Nosebleeds

Ophthalmology:
- ☐ Changes in vision
- ☐ Eye irritation
- ☐ Eye Pain

Respiratory:
- ☐ Cough
- ☐ Blood in sputum
- ☐ Shortness of breath
- ☐ Sputum production
- ☐ Wheezing

Cardiovascular:
- ☐ Chest pain
- ☐ Shortness of breath while lying flat
- ☐ Swelling of Ankles
- ☐ Fainting or near fainting

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Diarrhea / Constipation
- ☐ Blood in stool
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Difficulty swallowing

Musculoskeletal:
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Muscle Aches
- ☐

Dermatology:
- ☐ Itching
- ☐ Rash
- ☐ Swelling

Urology/Genitourinary:
- ☐ Pain with Urination
- ☐ Urinary Frequency
- ☐ Blood in Urine
- ☐ Irregular vaginal bleeding (female)
- ☐ Discharge from vagina or Penis

Neurologic:
- ☐ Seizures
- ☐ Gait abnormality
- ☐ Headache
- ☐ Numbness or tingling

Psychological:
- ☐ Trouble sleeping
- ☐ Anxiety
- ☐ Sadness/depression
- ☐ Hear voices/See objects
- ☐ Stressors
- ☐ Thoughts of hurting self or others

Endocrinologic:
- ☐ Hair Loss
- ☐ Frequent Urination
- ☐ Increased thirst
- ☐ Heat or cold
- ☐ intolerance

Hematologic:
- ☐ Bleeding from gums
- ☐ Unexplained bruising
- ☐ Night Sweats
- ☐ Swollen/Painful lymph nodes

Provider Initial: ____________________

Triage: Sex: ______ Weight: ______ Height: ______ BP: ______ HR: ______ Temp: ______ RR: ______ LMP: ______ Room# ______