PRA Medical/Social History Form **Directions: Please answer the following questions to the best of your knowledge.**

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PATIENT INFORMATION				
Last Name	**First Name**	**Middle**	**Birthdate**	**Marital Status** ☐ M ☐ S ☐ D ☐ W ☐ other
Home/Cell Phone	**OK to Call?** ☐ Yes ☐ No	**Work Phone**	**OK to Call?** ☐ Yes ☐ No	

SPIRITUAL/CULTURAL ISSUES

Religion: _________________________ Does your religion play a significant supportive role in your life? Circle: YES NO

PRIMARY CARE PHYSICIAN		
Name	Address	Phone:

Last time you visited your Primary Care Physician: ________________________Reason for visit:____

Medication Allergies? ❐ Yes ❐ No **Substance or Food Allergies**? ❐ Yes ❐ No

If yes, what medication(s) _________________________ If yes, what substance(s) __________________________________

Current Height: _________ Current Weight: ___________ (Please give best estimate)

FAMILY HISTORY: **Please ☒ if your family has a history of:**

❐ Diabetes ❐ High Blood Pressure ❐ Heart Attack, Heart Disease ❐ Blood Clots or Stroke ❐ Tuberculosis
❐ Cancer ❐ Alzheimer's ❐ Family History Unknown ❐ Epilepsy/Seizure ❐ Thyroid/Other Endocrine Conditions
❐ Mental Illness…be specific below…If you answered Yes to any of the above, please explain: ____

MEDICATIONS (INCLUDE OVER THE COUNTER MEDICATIONS) **Continue on back of page if more space is needed**

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past Medications / For what condition? (list over the counter medications, sedatives, pain medications, sleeping pills, antidepressants, etc)

Social Risk History	
❐ Yes ❐ No	Do you smoke? If yes, how many cigarettes per day? Would you like information on smoking cessation? ❐ Yes ❐ No
❐ Yes ❐ No	Did you ever smoke? If yes, when did you stop?
❐ Yes ❐ No	Do you use alcohol? If yes, how often, how much?
❐ Yes ❐ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
❐ Yes ❐ No	Have you ever had or would you like help now with an alcohol or drug problem?
❐ Yes ❐ No	Do you use Herbal Supplements? If yes, what kinds, for what purpose, how much and how often?
❐ Yes ❐ No	Do you drink caffeinated beverages? If yes, what beverages and how often?
❐ Yes ❐ No	Do you vape? ❐ Yes ❐ No If yes, how long have you been vaping? _____________ How often do you vape? ____________

Please explain any yes responses: ____

REVIEW OF SYSTEMS: **Please ☑ if you currently have or have ever had the following**

1. Constitutional:

Lasting cough	❐ Current ❐ Past	Unusual discharge (vaginal or from penis)	❐ Current ❐ Past
Chronic Fatigue	❐ Current ❐ Past	Changes in Appetite	❐ Current ❐ Past
Shortness of breath	❐ Current ❐ Past	Persistent weight loss without dieting	❐ Current ❐ Past
Chest pain	❐ Current ❐ Past	Weight problem/eating disorder	❐ Current ❐ Past
Recurrent night sweats, chills, fevers	❐ Current ❐ Past	Hepatitis	❐ Current ❐ Past
Swollen glands (neck, armpits or groin)	❐ Current ❐ Past	Other: ______________________	❐ Current ❐ Past

Tuberculosis: Ever Tested? ❐ Yes ❐ No Date and result of last test: ___________________ If Positive, did you have a chest x-ray? _________

Ever Treated? ❐ Yes ❐ No Date(s) and type(s) of treatment: ____

REVIEW OF SYSTEMS CONTINUED…. Please ☑ if you currently have or have ever had the following

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2. Skin Conditions

Allergies/Rash/Itching	❒ Current ❒ Past
Severe Dry Skin	❒ Current ❒ Past

3. Eyes

Vision problems	❒ Current ❒ Past
Glaucoma	❒ Current ❒ Past

4. Endocrine

Fatigue	❒ Current ❒ Past
Weight gain/loss	❒ Current ❒ Past
Headaches	❒ Current ❒ Past
Excessive Thirst	❒ Current ❒ Past
Grave's Disease/Thyroid Conditions	❒ Current ❒ Past
Diabetes's	❒ Current ❒ Past

5. Ears, Nose, Throat

Hearing problems	❒ Current ❒ Past
Teeth/gum problems or disease	❒ Current ❒ Past
Frequent nosebleeds	❒ Current ❒ Past
Recurrent sinusitis	❒ Current ❒ Past
Frequent sore throats	❒ Current ❒ Past

6. Cardiac

Palpitations/arrhythmia	❒ Current ❒ Past
Heart disease/murmur	❒ Current ❒ Past
High blood pressure / Low blood pressure	❒ Current ❒ Past
High cholesterol	❒ Current ❒ Past
Thrombophlebitis/blood clots	❒ Current ❒ Past

7. Neurologic

Stroke	❒ Current ❒ Past
Dizziness/confusion/wandering	❒ Current ❒ Past
Forgetfulness/memory lapse/memory loss	❒ Current ❒ Past
Migraines	❒ Current ❒ Past
Multiple Sclerosis	❒ Current ❒ Past

8. Psychiatric

Problems with Concentration	❒ Current ❒ Past
Persistent Worries	❒ Current ❒ Past
Prolonged Periods of Sadness	❒ Current ❒ Past
Paranoid Thoughts	❒ Current ❒ Past
Hallucinations	❒ Current ❒ Past
Insomnia	❒ Current ❒ Past
Mood Instability	❒ Current ❒ Past
Panic Attacks	❒ Current ❒ Past

9. Gastrointestinal

Recurrent nausea/vomiting/diarrhea	❒ Current ❒ Past
Constipation	❒ Current ❒ Past
Stomach/bowel problems	❒ Current ❒ Past

10. Respiratory

Difficulty breathing – cough	❒ Current ❒ Past
Asthma – bronchitis	❒ Current ❒ Past
Sleep disturbance	❒ Current ❒ Past

11. Hemalogic/Lymphatic	❒ Current ❒ Past
Anemia/Blood Disorder	

12. Genitourinary

Bladder/kidney problems or infection	❒ Current ❒ Past
Incontinence (unable to control bladder)	❒ Current ❒ Past
Enuresis (bedwetting)	❒ Current ❒ Past
Sexually transmitted diseases:	❒ Current ❒ Past
Bloody or painful urination	❒ Current ❒ Past

Females:

Menstrual Difficulties	❒ Current ❒ Past
Cycle: Regular ___ Irregular ___ Pre-Menopause ___ Menopause ___	
Problems/infection of tubes/ovaries/uterus	❒ Current ❒ Past
Breast disease / tumor / surgery	❒ Current ❒ Past

13. Allergic/Immunologic

Allergies	❒ Current ❒ Past
Autoimmune Disorder	❒ Current ❒ Past

14. Musculoskeletal

Orthopedic Injuries	❒ Current ❒ Past
Muscle Aches	❒ Current ❒ Past
Arthritis	❒ Current ❒ Past

15. **Chronic Issues**

Cancer	❒ Current ❒ Past

Other Conditions or Problems Not Listed:	❒ Current ❒ Past

I certify that I have answered these questions to the best of my knowledge

Patient Signature (if 12 and older) ________________________ **Parent/Guardian Signature:** _______________________ **Date:** ___________

CLINICIANS NOTES – MD TO COMPLETE BELOW

Reviewed by (Clinician):	Date: