

**PRA Medical/Social History Form**

**Directions: Please answer the following questions to the best of your knowledge.**

Your records are considered confidential. Your records will not be released to any party without your written consent.

PATIENT INFORMATION				
Last Name	First Name	Middle	Birthdate	Social Security No.
Home Phone	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone	OK to Call? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, How can you be reached?
Emergency Contact Person		Phone Number	Relationship	

**SPIRITUAL/CULTURAL ISSUES**

Religion: \_\_\_\_\_ Does your religion play a significant supportive role in your life? Circle: YES NO Would like it to

PRIMARY PHYSICIAN(S)		
Name	Address	Phone:

Last time you visited your primary 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  Mental Illness  Epilepsy/Seizure

If you answered Yes to any of the above, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS (INCLUDE OVER THE COUNTER MEDICATIONS)**

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**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If yes, how many cigarettes per day?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use alcohol? If yes, how often, how much?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had or would you like help now with an alcohol or drug problem?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use Herbal Supplements? If yes, what kinds, for what purpose, how much and how often?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink caffineated beverages? If yes, what beverages and how often?

Please explain any yes responses: \_\_\_\_\_  
 \_\_\_\_\_

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

**I. General**

- |   |  |   |  |
|---|--|---|--|
| Lasting cough                           | <input type="checkbox"/> Current <input type="checkbox"/> Past | Unusual discharge (vaginal or from penis) | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Chronic Fatigue                         | <input type="checkbox"/> Current <input type="checkbox"/> Past | Bloody or painful urination               | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Shortness of breath                     | <input type="checkbox"/> Current <input type="checkbox"/> Past | Dark, bloody or painful bowel movements   | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Chest pain                              | <input type="checkbox"/> Current <input type="checkbox"/> Past | Hepatitis                                 | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Recurrent night sweats, chills, fevers  | <input type="checkbox"/> Current <input type="checkbox"/> Past | Weight Gain                               | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Swollen glands (neck, armpits or groin) | <input type="checkbox"/> Current <input type="checkbox"/> Past | Persistent weight loss without dieting    | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Cancer                                  | <input type="checkbox"/> Current <input type="checkbox"/> Past | Weight problem/eating disorder            | <input type="checkbox"/> Current <input type="checkbox"/> Past |

**PRA Medical/Social History Form**

**Directions: Please answer the following questions to the best of your knowledge.**

Your records are considered confidential. Your records will not be released to any party without your written consent.

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: Please  if you currently have or have ever had the following:**

**2. Skin Conditions**

Allergies/Rash/Itching  Current  Past

**3. Eyes**

Vision problems  Current  Past

**4. Ears, Nose, Throat, Lungs**

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

**5. 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

**6. Neurologic**

Stroke  Current  Past  
Dizziness/confusion/wandering  Current  Past  
Forgetfulness/memory lapse/memory loss  Current  Past

**7. Gastrointestinal**

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

**8. Pulmonary**

Difficulty breathing – cough  Current  Past  
Asthma - bronchitis  Current  Past

**9. Genitourinary**

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

**Miscellaneous:**

Anemia / blood disorder  Current  Past  
Arthritis  Current  Past  
Sleep disturbance  Current  Past

**Other conditions / problems not listed:**

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLINICIANS NOTES – MD TO COMPLETE BELOW**

All areas reviewed and no significant medical issues are affecting this patient’s psychiatric care.

Reviewed by (Clinician):

Date: