

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	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> other
Home/Cell 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	

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)

Would you like your PRA Clinician to communicate with your Primary Care Provider (PCP) Yes No

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

<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke? If yes, how many cigarettes per day? Would you like information on smoking cessation? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you ever smoke? If yes, when did you stop?
<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 caffeinated beverages? If yes, what beverages and how often?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you vape? <input type="checkbox"/> Yes <input type="checkbox"/> 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

I. Constitutional:

- | | | | |
|-----------------------------------------|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------|
| 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 | Changes in Appetite | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Shortness of breath | <input type="checkbox"/> Current <input type="checkbox"/> Past | Persistent weight loss without dieting | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Chest pain | <input type="checkbox"/> Current <input type="checkbox"/> Past | Weight problem/eating disorder | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Recurrent night sweats, chills, fevers | <input type="checkbox"/> Current <input type="checkbox"/> Past | Hepatitis | <input type="checkbox"/> Current <input type="checkbox"/> Past |
| Swollen glands (neck, armpits or groin) | <input type="checkbox"/> Current <input type="checkbox"/> Past | Other: _____ | <input type="checkbox"/> Current <input type="checkbox"/> 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

Anemia/Blood Disorder Current Past

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:

2.10.2020