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**	
Home Phone	**OK to Call?** ☐ Yes ☐ No	**Work Phone**	**OK to Call?** ☐ Yes ☐ 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 orStroke ☐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)

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?
☐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 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

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
Cancer	☐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: _____

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

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

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

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
Asthma – bronchitis ☐Current ☐Past
Sleep disturbance ☐Current ☐Past
☐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

Other Conditions or 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:

01/01/2013