PCA Primary Care Associates

Patient Medical History

Name: _____ **DOB:** _____ **Date:** _____

Primary Practitioner: _____

Drug Allergies: _____

Other: _____

Current Medications: (Names and Doses) _____

_____

_____

Past Medical Problems: _____

_____

_____

Operations: (Surgery and Approximate Date) _____

_____

_____

Hospitalizations: _____

Family History:

	Age	Medical Problem	Deceased (Yes/No)	Cause of Death/Age
Father				
Mother				
Siblings				
Spouse				
Children				

Occupation: _____

Social History:

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Domestic Partnership** ☐ **Boyfriend** ☐ **Girlfriend**

Do you smoke/use tobacco? ☐ **Yes** ☐ **No** **If yes, how much per day?** _____

Do you drink alcohol? ☐ **Yes** ☐ **No** **If yes, how much per day?** _____

Do you use recreational drugs? ☐ **Yes** ☐ **No** **If yes, what drug do you use?** _____

Female: Are you pregnant? ☐ **Yes** ☐ **No** **Date of Last Period:** _____

Patient Signature: _____ **Date:** _____