PCA Primary Care Associates
A Concentra Affiliate

Name: ______________________ **DOB:** __________ **Date:** __________

Primary Practitioner: ______________________

Drug Allergies: ______________________

Other: ______________________

Current Medications: (Names and Doses) ______________________

____

____

Past Medical Problems: ______________________

____

____

Operations: (Surgery and Approximate Date) ______________________

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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:** __________

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