Pennsylvania
Department of State

Professional Health Monitoring Programs (PHMP)
Demographics & Medical History Questionnaire

Personal Information:

1. Name:_____ Title:_____

2. Address:_____
Street or P.O. Box

_____
City State Zip Code

Do you plan to relocate? _____Yes _____No If yes, when/where:_____

_____

3. Telephone #:_____ _____
Home or Cell Work

4. Email Address:_____

5. Date of Birth:_____ 6. Last Four Digits of Social Security #:_____

7. Marital Status:_____ 8. # of children & ages: _____

Licensure/Certification and Employment:

9. List all states you hold or held a license to practice.

State: Pennsylvania License #:_____ Status:_____

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10. List any other professional certifications you hold or held (e.g. CRNA, CAC)?

State: _____ Type: _____ Certification #: _____

State: _____ Type: _____ Certification #: _____

State: _____ Type: _____ Certification #: _____

11. Professional specialty: _____ Degree: _____

12. Has any action been taken against you by any licensing and/or certification board, or is any such action pending?
_____Yes (provide details) _____No

13. Are you currently employed as a licensed professional? ____Yes (provide details) _____No

Employer: _____ _____
Employer's Name Date Hired

Address: _____
Street or P.O Box

_____
City State Zip Code

Supervisor's Name: _____ Phone: _____

Is your employer/supervisor aware are in contact with PHMP? _____ Yes _____ No

14. List all places you have been employed in the past three years.

A. Employer Name: _____ City: _____ State: _____

Employment Dates: _____ Reason(s) for Leaving: _____

B. Employer Name: _____ City: _____ State: _____

Employment Dates: _____ Reason(s) for Leaving: _____

C. Employer Name: _____ City: _____ State: _____

Employment Dates: _____ Reason(s) for Leaving: _____

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Health Care and Past Medical History:

15. Primary care practitioner:_____

    Address:_____

    _____

16. A. Current medical conditions you suffer from:

_____ _____

_____ _____

_____ _____

_____ _____

B. Medical conditions you were previously treated for:

_____ _____

_____ _____

_____ _____

_____ _____

17. Medications currently prescribed to you:

Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition

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Substance Use and/or Mental Health History

18. Have you ever been diagnosed as suffering from a substance use disorder?

_____Yes (Complete #19 – #20) _____No

19. History of the course and symptoms of your substance use disorder:

A. Drug/alcohol use began (include age(s) and duration):

B. Specific drug(s) used/abused:

C. How drugs were obtained:

D. Amount/time/place/pattern of use (describe progression of use/abuse):

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E. Date of last use of any alcohol/drug(s) of abuse:_____

20. Have you received drug and alcohol treatment in the past?_____Yes (explain below) _____No

A. Provider Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

B. Provider Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

C. Provider Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

D. Provider Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

21. Have you ever been diagnosed as suffering from a mental health disorder?
_____Yes (Complete #22 – #25) _____No

22. Mental health disorder(s) diagnosed:_____

23. Have you ever received mental health treatment in the past? _____Yes (explain below) _____No

A. Provider Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

B. Provider Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

C. Provider Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

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24. Medications currently prescribed to you:

Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition
Medication	Prescriber	Illness/Condition

25. Have you ever been hospitalized for mental health treatment? _____Yes (explain below) _____No

A. Facility Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

B. Facility Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

C. Facility Name:_____ City:_____ State:_____

Treatment Dates:_____ Treatment Reason(s):_____

I,_____verify that the facts and statements set forth in this document are true and correct to the best of my knowledge, information, and belief.

_____ _____

Licensee/Applicant Signature Date

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