COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS

Professional Health Monitoring Programs
P.O. Box 10569
Harrisburg, PA 17105-0569

Telephone: 717-783-4857
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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 _____

State: _____ License # _____ Status _____

State: _____ License # _____ Status _____

State: _____ License # _____ Status _____

State: _____ License # _____ Status _____

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

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:_____

Health Care and Past Medical History:

15. Primary care practitioner: _____
Name

Address: _____
Street or P.O Box

_____ _____ _____
City State Zip Code

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
Medication	Prescriber	Illness/Condition

Substance Use and/or Mental Health History

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

_____Yes (C*omplete #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):

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

Date treatment began: _____ ended: _____

Reason for treatment: _____

B. Provider: _____ _____ _____
Name City State

Date treatment began: _____ ended: _____

Reason for treatment: _____

C. Provider: _____ _____ _____
Name City State

Date treatment began: _____ ended: _____

Reason for treatment: _____

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

Date treatment began: _____ ended: _____

Reason for treatment: _____

B. Provider: _____ _____ _____
Name City State

Date treatment began: _____ ended: _____

Reason for treatment: _____

C. Provider: _____ _____ _____
Name City State

Date treatment began: _____ ended: _____

Reason for treatment: _____

24. Mental health medications currently prescribed:

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)

Date treatment began: _____ ended: _____

Reason for treatment: _____

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

Date treatment began: _____ ended: _____

Reason for treatment: _____

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

Date treatment began: _____ ended: _____

Reason for treatment: _____

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	SSN Last 4 Digits	Date