Please complete and return to our office prior to initial visit

House Calls Medical History Form

Practice:_____ Address:_____ Phone: _____ Email:_____

Thank you for taking the time to provide this valuable information. This knowledge allows us the ability to provide the best care possible. Please use additional pages to provide pertinent information.

Patient Name: _____ O Male O Female Birth Date: _____

Name of person filling out form: _____ Relationship: _____

Main reason for visit: _____ Date: _____

#1: CURRENT/PAST MEDICAL ISSUES

(Examples include strokes, heart trouble, high blood pressure, high cholesterol, thyroid problems, eye issues, etc.)

Current or Past Medical Issue	Date of Diagnosis

#2: PAST SURGERIES

(Examples include gall bladder removal, appendectomy, hysterectomy with or without ovary removal, cataract surgery, prostate surgery, heart surgery, angioplasty, colonoscopy, hip surgery, etc.)

Past Surgery	Date of Surgery

#3: MEDICAL ALLERGIES AND REACTIONS

(Examples include rash, swelling, trouble breathing, etc.)

Medicine/Substance Allergic To	Reaction

#4: MEDICATIONS: list both prescription and over-the-counter medication(s)

(Examples include pain relievers, laxatives, heart burn medication, vitamins, etc. Include how many times per day the medication is taken. For "as needed" medication provide an estimate of how often it is taken whether daily, every other day, once per week, etc.)

Name of Medication and Strength (mg, mcg, etc.)	Frequency or As Needed

#5: PHARMACY INFORMATION

Pharmacy Name: _____ Phone # _____

Mail Order Pharmacy Name: _____ Phone # _____

Member ID # _____ Fax # _____

#6: FAMILY HISTORY: list medical problems of close family members

(Examples include dementia, type of cancer, heart disease, stroke, diabetes, hypertension, depression, etc. If deceased, include the age they past away. Use blank lines to include additional family members.)

Family Member	Alive/Deceased	Age	Medical Problems or Cause of Death
Father			
Mother			
Brother			
Sister			

#7: SOCIAL HISTORY

Tobacco Use:
O Never
O Quit (Date: _____)
O Current Smoker
O Packs per Day _____
O # Years Smoked _____
Type: O Cigarette O Cigar O Pipe

Smokeless Tobacco Use:
O Never
O Quit (Date: _____)
O Current User
Type _____

Alcohol Use:
O None
O # Drinks/week: _____
Was drinking too much ever a problem: O Yes O No

Recreational Drug Use :
O No
O Yes
Type _____

Sexually Active: O Yes O No

Firearms: Do you have firearms in the home? O Yes O No
If yes, are they locked and secured? O Yes O No

Communication Preference: O English O Other _____
Able to understand and read English language: O Yes O No

Religion/Faith: _____
O Yes O No Is your faith important to you?
O Yes O No Does your faith affect health care decisions?

Finances:
O Yes O No Durable Power of Attorney for Finance
Name/Relationship: _____
O Yes O No Are you having trouble paying your bills?
O Yes O No Are you going without food/medication?
O Yes O No Are you going without personal items?

Past Occupation: _____
Years of Education: _____
Who helps care for patient? _____
Something patient is proud of in their lifetime: _____
_____

#8: ADVANCE DIRECTIVES *(attach copy of document)*

O Yes O No Durable Power of Attorney for Healthcare
Name/Relationship: _____
O Yes O No Living Will
O Yes O No Do Not Resuscitate Form
O Yes O No Would like more info on Advance Directives

#9: ABILITY TO DO ACTIVITIES

Activity	No Assist	Total Assist	Partial Assist: Describe
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			
Housework			
Meal Preparation			
Manage Money			
Use Telephone			
Other:			

#10: CAREGIVER QUESTIONS *Caregiving can be both rewarding and challenging. Please let us know the following:*

Do you feel you are able to provide the care your relative needs: O Yes O No

Comment: _____

Do you feel you have time to take care of yourself? O Yes O No

Comment: _____

#11: REVIEW OF SYSTEMS *Check or describe any symptoms you are experiencing*

General	Skin	Head	Eyes
O Fever O Chills O Fatigues O Sweating O Weakness Height: _____ Height loss? _____ in. Weight: _____ Weight loss? _____ lbs in _____ months	O Rash Location _____ O Itching O Bed sore Location _____ Dressing type _____ _____ _____	O Headaches O Hearing loss O Hearing aid O Ringing in ears O Ear pain O Ear discharge O Nose bleeds O Nose congestion O Sore throat O Date of last dental exam _____	O Blurred vision O Double vision O Light sensitivity O Eye pain O Eye discharge O Eye redness O Date of last eye exam _____
Heart	**Lungs**	**Gastrointestinal**	**Genitourinary**
O Chest pain O Palpitations O Leg cramps O Leg swelling O Trouble breathing while laying flat	O Cough O Sputum production O Shortness of breath O Wheezing O On oxygen O Oxygen flow rate _____	O Heartburn O Nausea O Vomiting O Abdominal pain O Diarrhea O Constipation O Blood in stool	O Urinary burning O Urgency O Frequency O Blood in urine O Incontinence
Musculoskeletal	**Endocrine**	**Neurological**	**Psychiatric**
O Muscle aches O Neck pain O Mid-back pain O Low-back pain O Join pain Location _____ O Fall within the past year O Pain intensity (10=severe) 1 2 3 4 5 6 7 8 9 10	O Easy bruising O Environmental allergies O Extreme thirst O Diabetic Morning sugar range: _____ Evening sugar range: _____	O Dizziness O Tingling O Tremor O Sensory change O Speech change O Trouble swallowing O Seizures O Loss of consciousness O Weakness on one side of body from stroke: Right or Left	O Depression O Suicidal thoughts O Substance abuse O Hallucinations O Nervous/Anxious O Insomnia O Memory loss

Over the past two (2) weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things? O Not At All O Several Days O More Than Half of the Days O Nearly Every Day
2. Feeling down, depressed or hopeless? O Not At All O Several Days O More Than Half of the Days O Nearly Every Day

#12: IMMUNIZATIONS

(Please contact your primary care provider if you are uncertain regarding immunizations received prior to our visit)

Immunization	Date Received
Influenza (Flu)	
Pneumovax (Pneumonia)	
Prevnar (Pneumonia)	
Tdap (Tetanus)	
Zostavax (Shingles)	

#13: DURABLE MEDICAL EQUIPMENT

(List any medical equipment utilized such as bedside commode, wheelchair, walker, hospital bed, tube feeding pump, etc.)

Equipment	Supplier Name and Phone

#14: RECENT HOSPITALIZATIONS

(List all hospitalizations within the past two (2) years)

Reason	Hospital	Date

#15: RECENT DOCTOR VISITS

(List any recent doctors seen, their specialties (i.e. primary, cardiologist, neurologist, etc.) and their phone number)

Name	Specialty	Phone

#16: HOME HEALTH/HOSPICE AGENCY INFORMATION

Agency Name: _____ Phone: _____

Nurse O Yes O No Physical Therapy O Yes O No Occupational Therapy O Yes O No

Aide O Yes O No Speech Therapy O Yes O No