Medical History Form

Name:___________________________; Birth date: ___/___/___; Date: ___/___/___

Person filling out form: ______________________; Relationship: ______________

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible to our patients. Feel free to use additional pages to write any information not included here that you think is important.

1. Current/Past Medical Problems: Example Strokes, Heart trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye problems, etc.

Current or Past Medical Problem	Approximate date of onset or diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	

2. Past Surgeries: Example Gall Bladder removed, Appendectomy, Hysterectomy with or without ovaries removed, Cataract surgery, Prostate surgery, Heart surgery, Angioplasty, Colonoscopy, etc.

Past Surgery	Approximate Date of Surgery
1.	
2.	
3.	
4.	

3. Medical Allergies and reaction: Example rash, swelling, trouble breathing, etc.

Medicine Allergic To	Reaction
1.	
2.	
3.	
4.	

4. Medications: Please list both prescription and over the counter medication (such as pain relievers, constipation medicine, heart burn medicine, vitamins, etc.) and how many times a day medication is taken. For as needed medication please give an estimate of how often you take it such as once every other day, once a week, once or twice a month, etc. Add another sheet with additional medications if necessary.

Medication and Strength (mg or mcg, etc.)	How Often Taken
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

5. Local Pharmacy: ________________________; Phone #: ___________________
Mail Order Pharmacy: ___________________; Phone #: ___________________
Member ID #: ___________________________; Fax #: _____________________

6. Family History: Please list medical problems of close family members (example Dementia, Cancer and what type, Heart disease, Stroke, Diabetes, Hypertension, Depression, etc.), if anyone has died, the age of death and the cause of death. **Underneath "Mother" list any brother(s)/sister(s) and their medical problems.**

Family Member	Age Died	Cause of Death or any Medical Problems
Father		
Mother		

6. Social History:

- Lives with: ___________________________________
- Married: _______; Widow(er): _______; Divorced: _______; Single: _______
- Who is the primary caregiver and are there other caregivers involved: __________ ____
- How do you get transportation and how often and for what purpose do you leave the house? ____
- Smoking: Never □**;** How many years smoked: _______; How many packs per day on average: ___________; What age did you quit smoking: ___________
- Alcohol Use: Never □**;** How often and how many alcohol drinks do you have now and in the past? Was drinking too much alcohol ever a problem for you? ____
- Past Occupation(s): ____
- What was the highest level of education completed: ________________________
- Ever used street drugs or overused prescription drugs: ______________________
- Religion/Faith: _____________________; Is your faith important to you and does it affect your health care decisions: ______________________________________
- Do you have Advance Directives: Yes □**;** No □**;** Unsure □**.** Would you like information on Advance Directives: Yes □**;** No □
  I have a: Living Will □**;** Durable Power of Attorney for Health Care □ (Name and relationship of POA: ________________________)**;** Do Not Resuscitate Form □
  If you have any of the above documents please have a copy of them made for us to place in their chart.

7. Activities of Daily Living: Please mark or fill in the appropriate box below.

Activities of Daily Living	No Assistance	Total Assistance	Needs Some Partial Assistance: Please Describe
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			

8. Medicare Home Health Agency: Yes □**;** No □**; Name:** ________________________**;**
Phone #: _______________**; Nurse:** Yes □**;** No □**; Physical therapy:** Yes □**;** No □**;**
Occupational Therapy: Yes □**;** No □**; Speech Therapy:** Yes □**;** No □

9. Review of Systems: Please check or describe below any of the following symptoms you may be having:

- General: Decreased Appetite ☐; Fevers or Sweats ☐
- Height: ____Feet ____inches; Any loss of height: _____inches
- Weight: _______pounds (Can estimate); Please list weight loss or gain approximately ______ pounds over the past ______ months.
- Eyes: Decreased Vision ☐; Double Vision ☐; Last eye exam: ________________
- Ears, Nose, Throat, Mouth: Hearing Loss ☐; Hearing Aide ☐; Runny Nose ☐; Sinus Problems ☐; Dentures ☐; Swallowing problems ☐; Last dental exam: ____________
- Cardiovascular: Chest pain ☐; Do you have to prop yourself up to breath comfortably at night ☐
- Respiratory: Shortness of breath ☐; Trouble Breathing when you exert yourself ☐; Coughing ☐; Wheezing ☐
- Gastrointestinal: Nausea ☐; Vomiting ☐; Diarrhea ☐; Constipation ☐; Abdominal pain ☐; Heart burn ☐; Blood in stool ☐
- Genitourinary: Urinary frequency ☐; Burning ☐; Intermittently losing urine or wetting pants ☐; Completely incontinent ☐; Nighttime urination episodes: _______
- Musculoskeletal: Joint pain ☐ (Location: ____________________________); Joint swelling ☐; Weakness arms ☐; Weakness legs ☐; One sided weakness from stroke ☐
- Skin: Rash ☐ (Location: _________________); Bed sore ☐; Location of bedsore and type of dressing: ____)
- Neurologic: Seizures ☐; Falling ☐; Memory loss ☐; Confusion ☐; Numbness ☐; Tingling ☐; Dizziness ☐; Trouble sleeping ☐
- Psychiatric: Depression ☐; Anxiety ☐; Lack of motivation ☐; Suicidal thoughts ☐
- Endocrine: Heat intolerance ☐; Cold intolerance ☐; Hot flashes ☐; If diabetic how many times a day glucose checked: _______; Morning glucose range: __________; Evening glucose range: ___________
- Hematology/Lymphatics: Easy bruising ☐; Leg swelling ☐
- Allergy/Immunology: Environmental Allergies ☐; Hay fever ☐; Allergies to foods ☐
- What are your main concerns you would like to have addressed when we come to see you and are there any other problems not discussed above: _________________
  ____
  ____
  ____
  ____
  ____
  ____

9. Immunizations: Please mark the appropriate box below and list dates if known. **If not known please contact your primary care doctor before our visit and ask if you are up-to-date on your immunizations.**

Immunization	Yes	Date	No	Unknown	Refuses
Influenza (Flu)					
Pneumococcal (Pneumonia)					

10. Durable Medical Equipment: Please list any medical equipment you have in the home such as a bedside commode, wheel chair, walker, hospital bed, tube feeding pump, suction machine, etc. Please also list the name of the medical supplier and their phone number.

Name of Equipment	Supplier Name	Supplier Phone #
1.		
2.		
3.		
4.		
5.		

11. Recent Hospitalizations: Please list the reason for any recent hospitalizations in the past 2 years and the hospital you were in.

Reason for Hospitalization	Name of Hospital	Date
1.		
2.		
3.		
4.		

12. Recent Doctors: Please list any recent doctors, their specialty (e.g. Primary doctor, cardiologist, neurologist, etc.) and their phone number and fax number.

Doctor Name	Specialty	Phone	Fax
1.			
2.			
3.			

Please fax this information to NOVA HouseCall Physicians' office at 866-578-5925