HomeCare Physicians
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History Form for Exceptional Home-Based Care

Patient 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 provide any information not included here that you think is important.

Main reason for visit: _____

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 diagnosis or onset
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	

2. Past Surgeries: Example Gall Bladder removed, Appendectomy, Hysterectomy with or without ovaries removed, Cataract surgery (note which eyes), Prostate surgery, Heart surgery, Angioplasty, Colonoscopy, hip surgery (note which side), etc.

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

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

Medicine/Substance Allergic To	Reaction
1.	
2.	
3.	

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 daily, 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 or As Needed
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

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 deceased, please include age died. **Underneath "Mother" list other close family members and their medical problems.**

Family Member	Age Died if Deceased	Medical Problems or Cause of Death
Father		
Mother		
Brother		
Sister		

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7. Social History:

- **Tobacco Use:** Never □; Quit □ ; Current Smoker □. Average packs per day: _____; Years smoked: _____; Quit Date: _____; Type; Cigarette □; Cigar □; Pipe □.
- **Smokeless Tobacco:** Current User □; Former User □; Never Used □; Unknown □.
- **Alcohol Use:** None □**;** Number of drinks per week_____?
  Was drinking too much alcohol ever a problem for you? Yes □; No □
- **Recreational Drug Use:** No □**;** Yes □**;** Type **_____**
- **Sexual Activity:** Not currently □; No □; Yes □
- Who helps care for the patient: _____
- Tell us something the patient is proud of in their lifetime: _____
  _____
- **Communication Preference:** Native Language: English □; Other: _____;
  Able to understand English: Yes □**;** No □; Able to read English: Yes □**;** No □
- **Past Occupation:** _____; Years of Education: _____
- **Advance Directives:** Durable Power of Attorney for Healthcare: Yes □**;** No □;
  Name and relationship: _____;
  Living Will □; Do Not Resuscitate Form □; Would you like information on Advanced Directives: Yes □; No □
  If you have any of the above documents please provide a copy.
- **Religion/Faith:** _____; Is your faith important to you and does it affect your health care decisions: _____
- **Finances:** Are you have any trouble paying your bills: Yes □; No □; Are you going without anything you need like food, medications or other household or personal items: Yes □; No □; Durable Power of Attorney for Finance Yes □**;** No □;
  Name and relationship: _____;

8. Ability to do Activities: Please mark or fill in the appropriate box below.

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

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9. Review of Systems: Check or describe below any symptoms you are having:

- **General:** Fever □; Chills □; Weight loss □; Fatigue □; Sweating □; Weakness □
- Height: _____Feet; _____inches; Any loss of height: _____inches
- Weight: _____ pounds (Can estimate); Any weight loss: _____ pounds over ____ months.
- **Skin:** Rash □ ; Location: _____; Itching □; Bed sore □; Location of bedsore and type of dressing: _____
- **Head:** Headaches□; Hearing loss□; Hearing aid□; Ringing in ears□; Ear pain□; Ear discharge□; Nose bleeds□; Nose congestion□; Sore throat□; Last Dental exam: _____
- **Eyes:** Blurred Vision □; Double Vision □; Light Sensitivity □; Eye pain □; Eye discharge □; Eye Redness □; Last eye exam: _____
- **Heart:** Chest pain □; Palpitations □; Trouble breathing lying flat □; Leg cramps □; Leg swelling □
- **Lungs:** Cough □; Sputum production □; Shortness of breath □; Wheezing □; On Oxygen □; Oxygen flow rate: _____
- **Gastrointestinal:** Heart burn □; Nausea □; Vomiting □; Abdominal pain □; Diarrhea □; Constipation □; Blood in stool □
- **Genitourinary:** Urinary burning □; Urgency □; Frequency □; Blood in urine □; Incontinence □;
- **Musculoskeletal:** Muscle aches □; Neck pain □; Mid-back pain □; Low-back pain □; Joint pain □ (Location: _____); Pain intensity on scale of 1 (mild) to 10 (Severe): _____; Fall in past year □;
- **Endocrine:** Easy bruising □; Environmental allergies □; Extreme thirst □; If diabetic Morning sugar range _____, Evening sugar range_____
- **Neurological:** Dizziness □; Tingling □; Tremor □; Sensory change □; Speech change □; Weakness on one side of body from stroke: Right □ / Left □; Trouble swallowing □; Seizures □; Loss of consciousness □;
- **Psychiatric:** Depression □; Suicidal thoughts □; Substance abuse □; Hallucinations □; Nervous/Anxious □; Insomnia □; Memory loss □;

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

10. Caregiver questions: Caregiving can be both rewarding and challenging. Please let us know:

- Do you feel you are able to provide the care your relative needs? Yes □; No □; Comment: _____
- Do you feel you have time to take care of yourself? Yes □; No □; Comment: _____

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11. Immunizations: **Please contact your primary care doctor if you are not sure about what shots you have received before our visit.**

Immunization	Yes	Date	No	Unknown	Refuses
Influenza (Flu)					
Pneumovax (Pneumonia)					
Prevnar (Pneumonia)					
Tdap (Tetanus)					
Zostavax (Shingles)					

12. 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 provide the name of the medical supplier and phone number.

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

13. Home Health/Hospice Agency: Yes □**;** No □**; Name: _____;**
Phone #: _____; Nurse: Yes □**;** No □**; Physical therapy:** Yes □**;** No □**;**
Occupational Therapy: Yes □**;** No □**; Speech Therapy:** Yes □**;** No □**; Aide:** Yes □**;** No □

14. Recent Hospitalizations: Please list hospitalizations in the past 2 years.

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

15. 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 HomeCare Physicians' office at 630-682-3727 or mail it (address on first page) prior to the first visit.

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