DOC AT YOUR DOOR
Physician House Calls and More

CLINICAL INFORMATION

Patient Name: _____

MEDICAL HISTORY

__ Hypertension
__ Diabetes
__ Cholesterol
__ Triglycerides
__ Overweight
__ Low Thyroid
__ Stomach Ulcers
__ Reflux
__ Irritable Bowel
__ Asthma
__ COPD
__ Sleep Apnea
__ Allergies
__ Depression
__ Anxiety
__ Insomnia
__ Chronic Pain
__ Arthritis
__ Coronary Artery Disease
__ Carotid Artery Disease
__ Atrial Fibrillation
__ Pacemaker
__ Cancer: _____
__ Other Medical Hx: _____
_____
_____
_____
__ Stroke/TIA
__ Seizures
__ Migraines
__ Dementia

SURGICAL HISTORY

__ Tonsils
__ Appendix
__ Gallbladder
__ Hysterectomy
__ Hip
__ Knee
__ Neck
__ Back
__ Hernia
__ Cataracts
__ Skin Cancer
__ Prostate
__ Other Surgeries: _____
_____
_____
_____

FAMILY HEALTH HISTORY

Father: __ Alive __ Deceased Health Conditions: _____
Mother: __ Alive __ Deceased Health Conditions: _____
Brothers: How many Alive_____ How many Deceased_____
Health Conditions: _____
Sisters: How many Alive_____ How many Deceased_____
Health Conditions: _____
Children: How many Alive_____ How many Deceased_____
Health Conditions: _____

SOCIAL / LIFESTYLE HISTORY

__ Single __ Married __ Divorced __ Widowed __ Separated __ Remarried
Alcohol: __ None __ Rare __ Some Days __ Most Days __ Excessive
Tobacco: __ Never __ Past __ Current (Details: _____)
Who lives at home with you? _____ Pets: _____
Employment: __ Employed __ Retired What type of work: _____
Nutrition: __ Poor __ Fair __ Good __ Excellent __ Special Diet: _____
Exercise: __ None __ Occas __ Often __ Regular (Details: _____)
Transportation: __ Drive myself __ Others drive __ Don't leave the house
Ambulation Aides: __ None __ Cane __ Walker __ Wheelchair __ Electric Lift Chair
__ Ramp __ Stair Lift Chair __ Hoyer Lift __ Other: _____
Equipment/Devices: __ Hearing Aids __ Dentures __ CPAP __ Oxygen __ Suction
__ Foley __ G-Tube / PEG Tube __ Bedside Commode __ Shower Chair __ Hospital Bed
__ Other: _____

ACTIVITES OF DAILY LIVING

- I need assistance with: __ Nothing
  __ Toileting __ Bathing __ Dressing __ Eating __ Transferring __ Walking

MEDICATION ALLERGIES

__ Penicillin (Reaction: __ Rash __ Hives __ Other:_____)
__ Sulfa (Reaction: __ Rash __ Hives __ Other:_____)
__ Others: _____ (Reaction: _____)
_____ (Reaction: _____)
_____ (Reaction: _____)
_____ (Reaction: _____)
_____ (Reaction: _____)

MEDICATIONS:

Name	**Strength**	**Frequency**	**Reason you take each**

(If additional medications, please continue list on a separate blank page)

VACCINATIONS (Check all vaccines that you have had)

__ Pneumonia: __ Prevnar 13 __ Prevnar 20 __ Pneumovax 23
__ Shingles: __ Zostavax __ Shingrix
__ Tetanus: __ Tdap __ dT What year: _____
__ COVID: __ Approximate year of last booster: _____
__ Respiratory Syncytial Virus (RSV)
__ Do you get a flu shot each Fall? ___Yes ___No ___Sometimes

HEALTH DIRECTIVES (Check any that you have in place)

__ DNR (Do Not Resuscitate) __ Living Will __ Advanced Directive
__ Medical Power of Attorney / Health Agent __ Not Sure

Thank you for providing this information to help us better serve you!