1-888-558-4747 | chooseirishealth.com | info@irishealthgroup.com

PRE-VISIT CONSULTATION

- **Please take a few moments to fill out the information below before your scheduled visit.** This will provide us with helpful information about your health.
- The completed pre-visit interview can be faxed to our office (916-404-5556) or handed to the provider on your first home visit.

______________________________________ ____________________

Patient Name – Please print **Date of Birth**

____

Street Address **City** **State** **Zip Code**

____

Preferred Pharmacy – Please print

____

Street Address **City** **State** **Zip Code**

PLEASE ANSWER THE FOLLOWING QUESTIONS

When was the last time you saw your doctor? ____________________

Was it a routine visit or for a specific reason? ____________________

When were you last admitted to the hospital? ____________________

Which hospital? ____________________

What was the problem? ____________________

Who does your grocery shopping? ____________________

Who prepares your meals? ____________________

Who gives you your medications? ____________________

If your medications are pre-poured, who does that? ____________________

Who pays your bills? ____________________

Who drives you to appointments? ____________________

Who does your laundry? ______________________________

Who does your housework? ______________________________

PLEASE CIRCLE ALL THAT APPLY:

Are you bedbound?	Y	N	
Are you able to walk?	Y	N	
Do you require the use of a Walker/Cane/Crutch? (Circle which one)	Y	N	
Do you have a wheelchair?	Y	N	
Do you need someone to assist you in the use of the wheelchair?	Y	N	
Do you use the wheelchair Inside / Outside? (Circle which one)	Y	N	
Do you have control of your bowel?	Y	N	How often?
Do you have control of your bladder?	Y	N	How often?
Do you use the Toilet /Urinal/Bedpan /Commode?	Y	N	Circle each that apply
Do you have a foley catheter?	Y	N	
Do you have a colostomy?	Y	N	
Do you have a Urostomy?	Y	N	
Are you able to feed yourself?	Y	N	Need Assistance
Do you have a feeding tube?	Y	N	If YES: Type
Are you able to give yourself a bath / shower?	Y	N	Need Assistance
Are you able to dress yourself?	Y	N	Need Assistance
Are you able to groom yourself?	Y	N	Need Assistance
Are you able to communicate well on your own?	Y	N	Need Assistance
Do you have an Emergency Lifeline?	Y	N	
Do you have any allergies or sensitivities to any medication?	Y	N	

IF YES, which medications, and how do you react?			

Please tell us about your past medical history. If you are not sure whether you have a certain condition, circle no. We are looking for conditions that you are well aware of.

Diabetes	Y	N	
High Blood Pressure	Y	N	
Coronary Artery Disease/Angina/Chest Pain	Y	N	
History of heart attack	Y	N	Date:
High Cholesterol	Y	N	
Congestive heart failure	Y	N	
Swelling of legs / ankles	Y	N	
Heart valve disease (heart murmur)	Y	N	
Cardiac arrhythmia (irregular heartbeat / pacemaker)	Y	N	Circle all that apply
Ulcers – (Stomach/Duodenal)	Y	N	Circle all that apply
Pancreatitis	Y	N	
Bleeding from stomach or rectum	Y	N	Circle all that apply
Diverticulosis / Diverticulitis – of colon	Y	N	
Acid Reflux Disease – GERD	Y	N	
Hard of hearing / Hearing aid	Y	N	
Vision problems – cannot read even if using glasses	Y	N	
Glaucoma (increased pressure in eye)	Y	N	
Stroke	Y	N	Date:
Parkinson's disease	Y	N	
Treated for Depression	Y	N	
Dementia (Forgetfulness)	Y	N	
Thyroid (hyper/hypo)	Y	N	
Lung disorders/Breathing problems	Y	N	
Bronchitis, pneumonia (in the last few years)	Y	N	Year:

Liver disorders / jaundice			
Kidney disorders:			
Kidney stone / recurring bladder infections			
Arthritis (osteoarthritis / rheumatoid)			
Cancer			
Anemia			
Blood clots (legs / lungs)			
Peripheral Vascular Disease			
Leg pain: Walking or at rest			
Surgeries:			
Cholecystectomy (Gall bladder)			
Appendectomy			
Cataracts (Eye Operation)			
Hysterectomy			
Please list any additional surgeries performed:			

Any additional past medical history that you feel would be helpful for your provider to know? ____

____

____

____

Date of last **COLONOSCOPY** ____________________ Never

Date of last **MAMMOGRAM** ____________________ Never or N/A

Date of last **FLU SHOT** ____________________ Never

Date of last **PNEUMOVAX** shot (Bacterial Pneumonia vaccine) _____________ Never

Date of last **SHINGLES VACCINE** ____________________ Never

FAMILY HISTORY

Please answer the following questions about your family history. This includes your parents, brothers and sisters, aunts and uncles, grandparents, etc…
Please list which member on each line that applies.

Diabetes ____

High Blood Pressure ______________________________________

Heart Attack at age 40's or 50's _________________________________

Cancer (type) ____

Rheumatoid Arthritis _____________________________________

Mother Living/Dead Age at Death ________ Cause of death _________________

Father Living/Dead Age at Death ________ Cause of death __________________

SOCIAL HISTORY

Current marital status: ____________ Do you have any children? Y N #______

Current religious status: ___________________ Is religion important to you now? Y N

Do you have a Do Not Resuscitate order (DNR) in place? Y N

If No – are you interested in talking with the doctor about this?

What work are you retired from? _________________________ Age at retirement: _____

Are you presently smoking cigarettes? Y N Other tobacco products: __________

If YES – How many packs per day? _____ How many years? _______________________

If NO – Have you smoked in the past? Y N

If in the past Yes – how many packs per day? _____ And for how many years ? _______

When did you quit? ________________

Do you drink more than one alcoholic beverage a week? Y N

If YES – how often ___________________ What do you drink? ______________________

If NO – Have you had a period where you drank daily or drank more that 5 drinks on the weekend? Y N

Do you use oxygen at home? Y N

Does anyone else in the home use oxygen? Y N

List below *all* your Medications, including:

- **Injections –** Insulin, Vitamin B12, etc.
- **MDIs –** Meter Dose Inhalers & Nebulized medications
- **Eye Drops**
- **Pain & Sleep medications –** Tylenol, Anacin, and other OTCs
- **Bowel medications, Vitamins, Calcium, Herbal Products, Supplements**
- **Skin creams** and other over the counter medicines you are using

Please list all medications and let us know which you currently use. You can use the back of this page if you have additional medications

	Medicine	Dosage	Currently Use (Y/N)	How many times a day and When taken during the day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				