Physician House Call Service
(571) 484 4000 | info@dmvmedicalconcierge.com
8280 Willow Oaks Corp Drive Fairfax VA 22031

Medical History Form

Name: _____ Birth date: ___/___/___

Date: ___/___/___ Person filling out form: _____; Relationship: _____

Thank you for taking the time to complete this important form. This enables us to provide our patients with the best possible treatment. Please feel free to use extra pages to write any information that isn't covered here but that you believe is significant.

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 all prescription and over-the-counter medications** (pain relievers, constipation medicine, heartburn medicine, vitamins, and so on) as well as how many times a day they are taken. Please offer an estimation of how much you take as required medicine, such as once every other day, once a week, once or twice a month, etc. If required, add another sheet with additional medications.

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 Members: Please list medical problems of close family members (for example, dementia, cancer and what kind of cancer, heart disease, stroke, diabetes, hypertension, depression, and so on), as well as the age and cause of death if someone has died. List any brother(s)/sister(s) and their medical problems under "Mother."

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

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

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

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 check the appropriate box and include dates if available. If you don't remember, call your primary care doctor ahead of time and see if you're up to date with your immunizations.

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

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

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

11. Recent Hospitalizations: Please mention the reason for any recent hospitalizations you've had in the last two years, as well as the hospital where you were treated.

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

12. Recent Doctors: Please note any recent doctors you've seen, as well as their specialty (e.g., primary care physician, cardiologist, neurologist, etc.) and phone and fax numbers.

Doctor Name	Specialty	Phone	Fax
1.			
2.			
3.			