PHYSICIAN
HOUSECALLS

# PATIENT EVALUATION QUESTIONNAIRE

REFERAL SOURCE: _____ Date: _____ DOB: _____

Patient Name: _____ SSN: _____

Address: _____ Facility/Apt: _____

Telephone: _____ City/Zip code: _____

Billing Address: _____ City/Zip code: _____

Email: _____

Would you like to use our patient portal? **Y** **N**

Important Directions: _____

Race: _____ Ethnicity: _____ Language: _____

Gender: Male Female

Emergency Contact: _____ Relationship to Pt: _____

Contact Telephone #1: _____ Contact Telephone #2: _____

Current Pharmacy/Mail-In Pharmacy: _____

Home Care/Hospice/Advantage CM Agency: _____

Previous PCP: _____

Is the patient's condition related to: Employment: **Y** **N** Auto Accident: **Y** **N** Other Accident: **Y** **N**

## BILLING AND INSURANCE INFORMATION

Do you have a DPOA or Guardian? **Y** **N**

If yes, who? _____

DPOA or Guardian Address: _____

Are you responsible for your financials? **Y** **N**

If no, who? _____

Responsible Party Address: _____

**Primary Insurance Information**:

Insurance Company: _____ Number: _____

Name of Policy Holder: _____ Policy Holders DOB _____

Policy Holders SSN: _____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____

**Secondary Insurance Information**:

Insurance Company: _____ Number: _____

Name of Policy Holder: _____ Policy Holders DOB _____

Policy Holders SSN: _____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____

| **ALLERGIES** | | | | |
|---|---|---|---|---|
| Food allergies: | | | | |
| Drug allergies: | | | | |
| Environmental allergies: | | | | |
| **ACTIVITIES OF DAILY LIVING HISTORY** | | | | |
| Are you bed bound? | Y N | | | |
| Are you able to walk? | Y N<br>Walker/Cane/Crutch/Wheelchair? | | | |
| Do you have control of your bladder? | Y N | | | |
| Do you have control of your bowel? | Y N | | | |
| Are you able to groom/bath/dress yourself? | Y N | | | |
| Patient's height and weight | _____Lbs. | _____'____" | | |
| **SOCIAL HISTORY** | | | | |
| Marital Status | Married | Single | Widowed | Divorced |
| Number of Children | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Smoking Status | Never | Currently | | Quit | Details |
| Alcohol Usage | Never | Currently | | Quit | Details |
| History of Substance or Narcotics Use | | | Y | N | |
| Oxygen Used in the Home | | | Y | N | If yes: _____Liters |
| Armed Forces Service **(if yes, THANK YOU)** | | | Y | N | |
| Previous Occupation | | | | | |

| **FAMILY MEDICAL HISTORY** | | | |
|---|---|---|---|
| Heart Disease | Mother | Father | Other |
| Cancer | Mother | Father | Other |
| Diabetes | Mother | Father | Other |
| Dementia/Alzheimer's | Mother | Father | Other |
| Mothers cause of death: | | Fathers cause of death: | |
| Age at time of death: | | Age at time of death: | |

| **PAST MEDICAL HISTORY** | | |
|---|---|---|
| __Alcoholism | __Diabetes | __Hiv/Aids |
| __Arthritis | __Eczema/Skin Issues | __Intestinal Issues |
| __Anxiety/Depression | __Empysema/Asthma | __Muscle Problems |
| __Autoimmune Disease | __Epilepsy/Seizures | __Respiratory Issues |
| __Bladder/Kidney | __Eye issues | __Scarlet Fever |
| __Cancer | __Headaches | __Stroke |
| __Chronic Pain | __Heart Disease | __Swallowing Issues |
| __Digestive Issues | __High Blood Pressure | __Other: |
| __Diabetic Eye Exam | __ Diabetic Foot Exam | |

| **PAST SURGICAL / HOSPITALIZATION HISTORY** |
|---|
| |
| |
| |
| |
| |

| IMMUNIZATION HISTORY | | |
|---|---|---|
| **Pneumonia Y N** | **Zoster (Shingles) Y N** | **Influenza Y N** |
| **Date:** | **Date:** | **Date:** |

## CODE STATUS

____Do Not Resuscitate and/or _____MOST form

Does the patient have a Living Will/ Advanced Directive? _____

## MEDICATION INFORMATION

Patient gave verbal consent to the electronic download and review of medication insurance eligibility and medication history. **Y N**

Please list below all medications patient is currently taking:

| **Injections** | **Meter Dose Inhalers** | **Eye Drops** |
|---|---|---|
| **Vitamins and Supplements** | **Over the Counter Medications** | **Skin Creams** |

| | 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. | | | | |