First Choice
Home Health • Hospice • House Calls

First Choice House Calls
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Medical History Form

Name :_____________________________________ Birth date:___/___/____ Date:___/___/____

Person completing medical history form ________________________ Relationship ___________

1. **Current/Past Medical Problems:** Example—Strokes, Heart Trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye Problems, etc.

Current or Past Medical Problems	Approximate date of onset of diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

2. **Past Surgeries:** Example---Gall Bladder removal, 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.	
5.	

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

List all Allergies, Including Medications	Reaction
1.	
2.	
3.	
4.	
5.	

4. **Medications: Please list both prescription and over the counter medications** (such as pain relievers, constipation medicine, heartburn 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 once every other day, once a week, once or twice a month, etc. Add another sheet with additional medications if necessary.

Medications 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 #: ________________**

6. **Family History:** Please list medical problems of close family members (example—dementia, cancer (and what type), heart disease, stroke, hypertension, depression, etc.), if anyone has died, the age of death and the cause of death.

Family Member	Age Died	Cause of Death/Medical Problems
Father		
Mother		
Brother(s)		
Sister(s)		
Children		
Children		

7. **Social History:**
   - **Tobacco Use:** Never Quit Current Smoker
     Packs per day on average: _______ Years smoked: _________ Quit Date: _____
     Type: Cigarette Cigar Pipe Chewing
   - **Alcohol Use:** None Number of drinks per week _______
     Was drinking too much alcohol ever a problem for you Yes No
   - **Illegal Drug Use:** No Yes Type: ___________________________________
   - **Sexual Activity:** Not Currently No Yes

- Describe anyone who cares for you: ______________________________________
- Tell us something you are proud of in your lifetime: __________________________
  ____
  ____
  ____
- **Past Occupation**: ________________________ **Years of Education**: __________
- **Advance Directives:** Durable Power of Attorney for Healthcare (DPOA)

  Name and Relationship of DPOA: ____

  Living Will Do Not Resuscitate Form

  Would you like information on Advance Directives? Yes No

  If you have any of the above documents, please have a copy of them made for us to place in your chart.
- **Religion/Faith**: _______________________ Is your faith important to you and does it affect your health care decisions: ____

8. **Activities of Daily Living:** Please mark or fill in the appropriate box below.

Activities of Daily Living	**No Assistance**	**Total Assistance**	**Needs Some Partial Assistance: Please Describe**
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			

9. **Immunizations:** Please mark the appropriate box below and list dates if known. **If not known, please contact your primary care doctor before our visit and ask if you are up-to-date on your immunizations.**

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

10. **Durable Medical Equipment:** Please list any medical equipment you have in the home such as a bedside commode, wheelchair, walker, hospital bed, tube feeding pump, suction machine, etc. Please list the name of the medical supplier and their phone number.

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

11. **Recent Hospitalization:** Please list the reason for any recent hospitalizations in the past 2 years and the hospital you were in.

Reason for hospitalization	Name of Hospital	Dates of Hospitalization
1.		
2.		
3.		
4.		
5.		

12. Recent doctors: Please list any recent doctors, their specialty (e.g. family practice, internal medicine, cardiology, neurology, etc.) and their phone number and fax number.

Doctor Name	Specialty	Phone #	Fax #
1.			
2.			
3.			
4.			
5.			