HouseCall
PRIMARY CARE

Pre-Visit Questionnaire: Initial Visit

Today's Date: _____
Purpose of Visit: (circle one)
Geriatric Consultation Establish Primary Care Urgent Visit, Plan to Establish Primary Care

Name:_____
Sex: Male Female
Person Completing this Form: Patient Other
If Other, Name: _____
Relationship: _____
Current Primary Care Physician: _____
Phone #:_____
Do you plan to continue to be followed by this doctor? Yes No

List any other medical supplier(s) you use: (such as diabetic or nebulizer supplies)
_____
_____
Do you have active Home Health Care (Nursing, Therapy, etc): ____No ____Yes
Name of Agency: _____Phone #:_____
Name of Nurse: _____ Phone#: _____

HEALTH MAINTENANCE

Have you ever had an examination of your bowel with a scope?___No ____Yes
If yes: Date: _____Results:_____
In the past year, have you had a test for blood in your stool (three cards at home)? ____No ____ Yes
Have you had a hearing test within the last two years? ____No ____Yes
Have you had an eye exam by an eye doctor within the past year? ____No ____Yes
Have you had a bone density test (DEXA)? ____No ____Yes
Date: _____ Results: _____
Have you seen a dentist in the last year? ____No ____Yes
Last Appointment: _____

QUESTIONS FOR MEN ONLY
Have you ever had a prostate exam (rectal exam)? ___No ____Yes
Date: Year _____ Were you told normal or abnormal (circle one)
Have you ever had a blood test to look for cancer of the prostate (PSA)? ____No _____Yes
Date: Year_____ Were you told normal or abnormal (circle one)

QUESTIONS FOR WOMEN ONLY
Have you ever had a mammogram? ____No _____Yes Date: Month/Year: _____

Were you told normal or abnormal? (circle one)

Vaccine History

Vaccine	Yes	No	Date
Pneumonia			
Shingles			
Tetanus or TdAP			
Flu			

SOCIAL HISTORY

Are you currently (circle one)
Married Single Widowed Divorced Living with Significant Other
How many children do you have? Sons_____ Daughters_____
Are you in regular contact with your children? _____ No ____Yes
How many live in the area? _____

Which of the following best describes your residence? (circle one)
Assisted Living Condo/Apartment Single-family house Mobile Home Nursing Home
With whom do you live? (please list everyone in your home)
_____
_____
_____
_____

What is your highest level of education? (circle one)
Elementary School 8th Grade High School Graduate Some College
Technical or Trade School College Degree Associates Degree JD/MD/Ph.D

Do you currently participate in any regular activity to improve or maintain your physical fitness? ___No ___Yes
How many hours per week? _____
List your activities:_____
_____

Do you EMPLOY someone to provide care or help you in your home? _____No _____Yes
If Yes, how often is your paid helper available to you?
Hours a day:_____ Days a week: _____
Is this sufficient to meet your needs? _____No_____Yes

Do you get help from a family member or friend in your home? _____No _____Yes
If Yes, how often is your family member or friend available for you?
Hours a day: _____ Days a week: _____
Is this sufficient to meet your needs? _____No____Yes

Who would you call if you were sick and needed help? _____
Do you provide care for a family member? _____No ____Yes
Do you have a medical Durable Power of Attorney? _____No _____Yes (If yes, please bring a copy)
Do you have a living will?_____No _____Yes (If yes, please bring a copy)

Have you ever used tobacco products? _____No _____Yes
If Yes, what type of product? _____
Are you now using? _____No _____Yes
If no: How many years ago did you quit? _____
For how many years did you smoke? _____
How much did you smoke? _____ packs per day
If yes: How many years have you used? _____
How much per day? _____
How many years? _____

Do you drink alcohol, including beer and wine, or other alcohol? _____ No _____ Yes
If yes: How often do you drink? Daily Weekly Monthly Yearly
When was your last drink?_____
Amount you consume in one sitting?_____
Have you ever attended alcohol rehabilitation? _____No _____Yes
Has anyone ever been concerned about your drinking? _____No _____Yes
If Formerly, Year Quit _____

Do you currently use illegal drugs or take prescription medications not prescribed to you? ____No____ Yes
If yes please describe: _____
Have you previously used illegal drugs? _____ No _____ Yes
If yes please describe: _____

Do you currently participate in any regular activity to improve or maintain your physical fitness?__ No ___Yes
How many hours per week? _____
List your activities: _____
_____

Do you have any drug allergies? ____No _____Yes - List Below

Name of Drug	Reaction

List all medicines that you use. (Prescriptions, Non-Prescriptions, Natural Products)

Current Medication Used	What Strength?	How do you use it? (How many? How many times a day? Skip doses?)
EXAMPLE: TYLENOL	500MG	1 PILL TWICE DAILY, EVERY DAY

If there are any questions regarding this form please contact us at (865)980-5200. Thank you for your time and we look forward to meeting you.