



# Patient Questionnaire

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: ( ) - Cell #: ( ) -

SSN: - - Email address: \_\_\_\_\_

Spoken Language: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Race: \_\_\_\_\_

Marital Status:  Married  Separated  Divorced  Single  Widowed

If married, spouse name: \_\_\_\_\_

Children: \_\_\_\_ Sons \_\_\_\_ Daughters

Emergency contact name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: ( ) -

Emergency contact name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone #: ( ) -

Contact Information to schedule appointments if different than patients' information

Name: \_\_\_\_\_ Phone #: ( ) -

## Education

High School or GED Technical/Professional: \_\_\_\_\_

College (years or degree(s)): \_\_\_\_\_

How did you hear about **PHYSICIANS HOME VISITS**? \_\_\_\_\_

**PHYSICIANS HOME VISITS APPRECIATES THE OPPORTUNITY TO SERVE YOU.**

## Insurance Information

**Please provide copies of all insurance cards**

### Primary Insurance Information

Insurance Company \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Policy Holders DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Policy Holders SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_ ( ) - \_\_\_\_\_  
Submit claims to address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Secondary Insurance Information

Insurance Company \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_ Policy Holders DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Policy Holders SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Insurance Phone #: \_\_\_\_\_ ( ) - \_\_\_\_\_  
Submit claims to address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Outside services

- Name of pharmacy: \_\_\_\_\_ Phone #: \_\_\_\_\_ ( ) - \_\_\_\_\_
- Do you currently have a Home Health Agency?     No     Yes  
If yes, please provide the name of the agency: \_\_\_\_\_
- Do you currently have a Patient Care Service Agency?     No     Yes  
If yes, please provide the name of the agency: \_\_\_\_\_
- Medical equipment company: \_\_\_\_\_
- Preferred Hospital: \_\_\_\_\_

**Health Information**

Age \_\_\_\_\_ Ht \_\_\_\_\_ Wt \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Tobacco use**

Does the patient smoke or use tobacco in any form?  No  Yes

Is there a history of tobacco use in the past?  No  Yes

**Alcohol use**

Does the patient drink alcoholic beverages?  No  Yes

Is there a history of alcohol use in the past?  No  Yes

**Recreational Drugs use**

Does the patient use recreational drugs?  No  Yes

Is there a history of recreational drugs use in the past?  No  Yes

**Allergies**  NONE (If yes, please list)

<input type="checkbox"/> Drugs			
<input type="checkbox"/> Latex			
<input type="checkbox"/> Foods			

**Immunizations**

Please check all that apply:

<input type="checkbox"/>	Pneumonia vaccination	Date of vaccination	_____
<input type="checkbox"/>	Zoster (shingles) vaccination	Date of vaccination	_____
<input type="checkbox"/>	Influenza vaccination	Date of vaccination	_____

**Your Medical History (check all that apply)**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Alcoholism         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> HIV/AIDS           |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Eczema/Skin Issues  | <input type="checkbox"/> Intestinal Issues  |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Emphysema/Asthma    | <input type="checkbox"/> Muscle Problems    |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Epilepsy/Seizures   | <input type="checkbox"/> Respiratory Issues |
| <input type="checkbox"/> Bladder/Kidney     | <input type="checkbox"/> Eye Issues          | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Chronic Pain       | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Swallowing Issues  |
| <input type="checkbox"/> Digestive Issues   | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other:             |

## **CURRENT MEDICATIONS**

Please list all medications that you are taking, including vitamins and over the counter:

	<b>Medication</b>	<b>Dose</b>	<b>Frequency</b>
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			
<b>5</b>			
<b>6</b>			
<b>7</b>			
<b>8</b>			
<b>9</b>			
<b>10</b>			
<b>11</b>			
<b>12</b>			
<b>13</b>			
<b>14</b>			
<b>15</b>			

## **SURGERIES OR HOSPITALIZATIONS**

Please list any prior surgeries or hospitalizations:

	<b>Surgery</b>	<b>Date</b>	<b>Location</b>
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			
	<b>Hospitalizations</b>	<b>Date</b>	<b>Location</b>
<b>1</b>			
<b>2</b>			
<b>3</b>			
<b>4</b>			

**Code Status**

What is the patient's wishes regarding response to sudden severe change in health condition (also referred to as Code Status)?

Do Not Resuscitate  Yes  No

Does the patient have a living will/Advanced Directive?  Yes  No

Does the patient have a health care power of attorney and POA?  Yes  No

If yes, Name of health care power of attorney: \_\_\_\_\_

If yes, Name of the Power of attorney: \_\_\_\_\_

**Functional Status**

How does the patient get around?

Walks independently  Walks with a cane  Walks with a walker  
 Wheelchair (self-propelled)  Wheelchair (powered)

Does the patient require assistance with any of the following?

Eating  Dressing  Toileting  Bathing  
 Is the patient continent of bladder?  Yes  No  Sometimes  
 Is the patient continent of bowels?  Yes  No  Sometimes

**Family Medical History:**

What are the major medical problems, if any, of your parents, grandparents, siblings?

<b>(Check all that apply)</b>	M=Mother, F=Father, S=Sister, B=Brother									
<input type="checkbox"/> Heart Disease	M	F	S	B	<input type="checkbox"/> COPD	M	F	S	B	
<input type="checkbox"/> Diabetes	M	F	S	B	<input type="checkbox"/> Cancer	M	F	S	B	
<input type="checkbox"/> High Blood Pressure	M	F	S	B	<input type="checkbox"/> Stroke	M	F	S	B	
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:									

**Mother**

Is your mother still living?  Yes  No

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If not, age at death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

**Father**

Is your father still living?  Yes  No

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If not, age at death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Thank you for your time and attention to this material. The information you gave will help us to provide care for you and your loved one.

Name of person filling out form if other than patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Notice of Privacy Practices Acknowledgement**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used for the following:

To conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Physicians Home Visits has the right to change its Notice of Privacy Practices from time to time and that I may contact Physicians Home Visits at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Other Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

<b>For office use only:</b>	<b>DATE</b>	<b>EMPLOYEE SIGNATURE</b>
Date Questionnaire was received:		
Insurance eligibility verified		
Admittance approval <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for non-approval		
Date Demographics were entered:		
Date Registered:		
Provider's Name: _____		
Date of first appointment:		

**Please indicate diagnosis you have been given by checking next to the appropriate box:**

<p><b>Bleeding Problems:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Bleeding Disorder  <input type="checkbox"/> Deep Vein Thrombosis/Blood Clots    <input type="checkbox"/> Eczema  Other: _____</p>	<p><b>Cancer:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Breast    <input type="checkbox"/> Colon    <input type="checkbox"/> Leukemia    <input type="checkbox"/> Lung    <input type="checkbox"/> Lymphoma  <input type="checkbox"/> Metastatic    <input type="checkbox"/> Nasal Cavity    <input type="checkbox"/> Oral Cavity  <input type="checkbox"/> Prostate    <input type="checkbox"/> Renal/Kidney    <input type="checkbox"/> Skin    <input type="checkbox"/> Throat    <input type="checkbox"/> Thyroid  Other: _____</p>
<p><b>Eyes, Ears, Mouth &amp; Throat</b>    <input type="checkbox"/> None  <b>Eyes:</b>    <input type="checkbox"/> Cataracts    <input type="checkbox"/> Glaucoma  Corrective lenses or Contacts    <input type="checkbox"/> Yes    <input type="checkbox"/> No  <b>Ears:</b>    <input type="checkbox"/> Hearing loss    <input type="checkbox"/> Meniere's  <b>Mouth:</b>    <input type="checkbox"/> Cancer    <input type="checkbox"/> Dental Conditions  Other: _____</p>	<p><b>Endocrine/Metabolism:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Diabetes    <input type="checkbox"/> High Cholesterol    <input type="checkbox"/> Hyperthyroidism  <input type="checkbox"/> Hypothyroidism  Other: _____</p>
<p><b>Gastro-Intestinal:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Cancer    <input type="checkbox"/> Gall Bladder Disease or stones    <input type="checkbox"/> GERD  <input type="checkbox"/> Hepatitis    <input type="checkbox"/> Inflammatory bowel disease  <input type="checkbox"/> Irritable bowel disease    <input type="checkbox"/> Stomach Ulcers  Other: _____</p>	<p><b>Gynecological</b>  <b>Female:</b>  <input type="checkbox"/> Cancer    <input type="checkbox"/> Hysterectomy    <input type="checkbox"/> Infertility    <input type="checkbox"/> Menopausal  Other: _____  <b>Date of last mammogram?</b> _____</p>
<p><b>Heart Disease:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Angina/Chest Pain    <input type="checkbox"/> Arrhythmias    <input type="checkbox"/> Blood clots    <input type="checkbox"/> CHF  <input type="checkbox"/> Heart Attack    <input type="checkbox"/> High blood pressure    <input type="checkbox"/> Stroke  <input type="checkbox"/> Valvular Disease    <input type="checkbox"/> Varicose veins  Other: _____</p>	<p><b>Infectious Disease:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Chlamydia    <input type="checkbox"/> Gonorrhea    <input type="checkbox"/> HIV/AIDS    <input type="checkbox"/> Tuberculosis  Other: _____</p>
<p><b>Neurologic Problems:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Alzheimer's    <input type="checkbox"/> Anxiety Disorder  <input type="checkbox"/> Chronic Regional Pain    <input type="checkbox"/> Dementia    <input type="checkbox"/> Migraine  <input type="checkbox"/> Parkinson's    <input type="checkbox"/> Seizures    <input type="checkbox"/> Sleep Disorder    <input type="checkbox"/> Stroke  Other: _____</p>	<p><b>Psychiatric Problems:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Anxiety    <input type="checkbox"/> Depression  <input type="checkbox"/> Drug or alcohol dependency    <input type="checkbox"/> Psychosis  <input type="checkbox"/> Other: _____</p>
<p><b>Respiratory:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Asthma    <input type="checkbox"/> Bronchitis    <input type="checkbox"/> Cancer    <input type="checkbox"/> Emphysema  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Other: _____</p>	<p><b>Rheumatologic:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Arthritis    <input type="checkbox"/> Connective Tissue Disease  <input type="checkbox"/> Fibromyalgia    <input type="checkbox"/> Psoriasis    <input type="checkbox"/> Sarcoidosis  <input type="checkbox"/> Sjogren's Syndrome  <input type="checkbox"/> Other: _____</p>
<p><b>Skin:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Any Chronic Condition  <input type="checkbox"/> Cancer  <input type="checkbox"/> Other: _____</p>	<p><b>Urinary System:</b>    <input type="checkbox"/> None  <input type="checkbox"/> Bladder Infection    <input type="checkbox"/> Cancer    <input type="checkbox"/> Kidney Failure  <input type="checkbox"/> Kidney Infection    <input type="checkbox"/> Kidney Stones  <input type="checkbox"/> Other: _____</p>
<p><b>Other Medical Problems:</b>    <input type="checkbox"/> None  (If yes, Please List) _____</p>	

