MedStar House Call Program

Intake Questionnaire

Patient Name: _____ **Date of Birth**: _____
Patient height: _____ Weight: _____
Person completing this form (if not patient): _____
Relationship to patient: _____
Emergency contact name: _____ Phone number: _____
How did you hear about MTEC? _____
Current doctors

	Name	Specialty	Phone number
Primary:	_____	_____	_____
Other:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Recent hospital and emergency room visits

Date	Hospital	Reason(s)	Length of stay

☐ *Check here if continued on reverse*

Rehab or nursing home stays

Date	Hospital	Reason(s)	Length of stay

☐ *Check here if continued on reverse*

Medical history
Have you ever had:

Yes	**No**		**Yes**	**No**	
		Anxiety			Heart attack
		Arthritis			Heart failure
		Blood clots			High blood pressure
		Cancer			Kidney disease
		Dementia/memory problems			Liver disease
		Depression			Lung disease
		Diabetes			Seizure
		Diverticulosis			Stroke
		Falls			Thyroid disease
		Gout			Other:

Patient's last name:

Surgical history

Date	Hospital	Surgery/Procedure	Reason

☐ *Check here if continued on reverse*

ALLERGIES OR MEDICINES YOU CANNOT TAKE

☐ Check here if NO KNOWN ALLERGIES

Medicine	Reaction

☐ *Check here if continued on reverse*

Preferred pharmacy: _____ **Phone number**: _____

Current medications
Please include vitamins, herbal remedies, and over-the-counter medicines

Medication name	Dose	Timing

Family history

Relative	Date of death	Diseases/conditions
Mother		
Father		
Sister(s)		
Brother(s)		
Other		

Social history

What year did you move into your current home? _____
Who owns your current home? _____

Formal educational level
□ Did not complete high school
□ High school graduate
□ Some college
□ Bachelor's degree
□ Graduate degree

Substance use
Did you ever smoke cigarettes? □ Yes □ No
Packs per day: _____ (average)
When did you start?_____ Quit? _____
Did you ever drink alcohol? □ Yes □ No
How much? _____ (average)
When did you start? _____ Quit? _____

Occupation(s): _____
Race: □ African-American □ Asian □ Hispanic □ White □ Other: _____
Marital status: □ Unmarried □Married □ Widowed □ Divorced □ Separated

Do you have children? □ Yes □ No
How many? _____ Are you in regular contact with any of them? □ Yes □ No

Who else lives in the home you are in?

Name	Relationship	Helps during day?
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No

Do you currently receive any of the following services?

□ In-home aide □ Meals-on-Wheels □ Social worker
□ Home health care (nurse, physical therapist)
Agency: _____ Phone number: _____

Do you have an advance directive or living will? □ Yes □ No

If yes, please have a copy available at the home for our first visit.

Other emergency contacts:
Name: _____ Phone number: _____
Name: _____ Phone number: _____
Name: _____ Phone number: _____

Functional status

Can the patient walk inside the home? □ Yes □ No
Can the patient walk to the curb? □ Yes □ No
Does the patient need a wheelchair or stretcher to go farther than the curb? □ Yes □ No

Patient's last name:

How many steps into the home from outside? Front: _____ Back _____

Activity	Can do alone	Needs help	Can't do at all	Who helps?
Bathe/shower				
Dress				
Get to toilet				
Get in/out of bed/chair				
Control bowel/bladder				
Feed self				
Make a phone call				
Take medications correctly				
Grocery shop				
Fix meals				
Do housework				
Do laundry				
Manage money				

What equipment do you have at home?

□ Wheelchair □ Walker □ Cane □ Hospital bed □ Power recliner
□ Stair lift □ Hoyer lift □ Tub bench □ Ramp
□ Other: _____

Health maintenance

Test	Date	Provider	
Colonoscopy			
Flu shot			
Pneumonia shot			
Tetanus shot			
Shingles shot			
Eye exam			
Dental exam			
Foot exam			

Is there anything else you want us to know about the patient, or any concerns you want to make sure we discuss on the first visit?

_____
_____
_____
_____
_____

Thank you for completing this form!