Medicine at Home
COMPASSIONATE CARE MATTERS

Tel: 443-858-9401 MedicineAtHome.NET Fax: 240-766-8060

New Patient Intake Form

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

PATIENT INFORMATION

Date: _____

First Name _____ Middle Initial _____ Last Name _____

Date of Birth _____ / _____/ _____ Sex _____ Social Security Number _____

Street Address _____ City _____ State _____ Zip Code _____

Is this an Assisted Living facility? YES NO Name of the facility _____

Best times for telehealth visits: ☐ Morning ☐ Afternoon ☐ Evening Email _____

Phone: Home ( ) _____ - _____ Mobile ( ) _____ - _____ Work ( ) _____ - _____

Is your mobile phone a smartphone? YES NO If YES, is it ☐ iPhone or ☐ Android

Preferred method of communication: ☐ Email ☐ Mobile Phone ☐ Text on Mobile ☐ Home Phone ☐ Work Phone

EMERGENCY CONTACTS (Next of Kin / Durable Power of Attorney (POA)

1) Name _____ Relationship _____ POA?

Phone: Home ( ) _____ - _____ Mobile ( ) _____ - _____ Work ( ) _____ - _____

Street Address _____ City _____ State _____ Zip Code _____

2) Name _____ Relationship _____ POA?

Phone: Home ( ) _____ - _____ Mobile ( ) _____ - _____ Work ( ) _____ - _____

Street Address _____ City _____ State _____ Zip Code _____

INSURANCE

Medicare Beneficiary Identifier (MBI) _____

Co-Insurance Carrier _____ Plan _____

Contact Number _____ Policy Number _____

Group Number _____ Policy Holder ☐ Self or Name _____

PREFERRED PHARMACY

Pharmacy Name _____ Phone _____

Street Address _____ City _____ State _____ Zip Code _____

ADVANCED DIRECTIVE

Is there a Completed Legal Advanced Directive? YES NO

Is there a “Do Not Resuscitate” order? YES NO

REFERRALS and ADJUNCTIVE CARE

Are you currently under a specialist’s care? YES NO For?_____

Physician _____ Phone _____

MEDICINE at HOME: PATIENT INFORMATION *(continued)* Date: _____

First Name _____ Middle Initial _____ Last Name _____

MEDICAL HISTORY

Have you ever had or currently have any of the following health concerns? *(attach addendum if needed)*

- ☐ Alcohol
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Colitis
- ☐ Convulsions/Seizures
- ☐ Cough (Chronic)
- ☐ Depression
- ☐ Diabetes
- ☐ Disability/Handicapped
- ☐ Drug Abuse
- ☐ Ear Trouble /Hearing Loss
- ☐ Eating Disorder
- ☐ Eye Disease/Problems
- ☐ Gallbladder Trouble
- ☐ Hay Fever (Recurrent)
- ☐ Head Injury
- ☐ Headache (Recurrent)
- ☐ Heart Disease/Problem
- ☐ Hepatitis/Jaundice
- ☐ Hernia /Rupture
- ☐ Intestinal/stomach Trouble
- ☐ Joint Disease/Injury
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Mononucleosis, Infectious
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychological Counseling
- ☐ Rheumatic Fever
- ☐ Rubella (3 Day Measles)
- ☐ Sexually Transmitted Disease (STD
- ☐ Sickle Cell Trait/Anemia
- ☐ Sinus Trouble
- ☐ Skin Problems (Chronic)
- ☐ Sleep Problems
- ☐ Smoking (How long?)
- ☐ Suicide Attempt
- ☐ Surgery
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Tract Infection
- ☐ Other _____

Surgical History with year of each *(attach addendum if needed)*

_____ *Year* _____ _____ *Year* _____

_____ *Year* _____ _____ *Year* _____

_____ *Year* _____ _____ *Year* _____

Allergies to medications: _____

Current Medications and Dosage *(attach addendum if needed)*

_____ *Dose* _____ _____ *Dose* _____

_____ *Dose* _____ _____ *Dose* _____

_____ *Dose* _____ _____ *Dose* _____

Special Medical Equipment or Treatments *(attach addendum if needed)*

_____ _____

_____ _____

CURRENT SYMPTOMS

- ☐ Abdominal Pain
- ☐ Behavior Change
- ☐ Bowel: Constipation - Diarrhea Incontinence
- ☐ Breast Tenderness
- ☐ Breathing: Wheezing - Cough
- ☐ Changes in Appetite
- ☐ Chest Pain
- ☐ Dental Problem
- ☐ Depression
- ☐ Exercise Intolerance
- ☐ Fall
- ☐ Headache
- ☐ Hearing Problem
- ☐ Joint Pain
- ☐ Joint Swelling: Location _____
- ☐ Memory Change
- ☐ Muscle: Pain - Weak - Numb - Tingling
- ☐ Neck: Pain - Stiffness
- ☐ Palpitations
- ☐ Passing Out
- ☐ Seizure
- ☐ Sinus: Congestion - Runny - Sneezing - Post Nasal Drip
- ☐ Skin Rash
- ☐ Skin Ulcer
- ☐ Sleep Changes
- ☐ Swallowing Difficulty
- ☐ Tremor
- ☐ Urinary: Urgent/Frequent - Incontinence
- ☐ Vaginal Discharge
- ☐ Vision Problem
- ☐ Vulval Itching
- ☐ Weight Change: Gain - Loss
- ☐ Other _____

What are the GOALS for care?

_____

_____

_____