PHYSICIAN
HOUSECALLS

Physician Housecalls is a mobile primary care medical practice composed of highly trained and compassionate medical providers that specialize in home care.

The mission of Physician Housecalls is to increase access to healthcare when it's become difficult to transport to a traditional medical office. At Physician Housecalls we support decisions to stay at home or in a residential community, provide comprehensive healthcare and decrease visits to the emergency department and hospital admissions.

Our philosophy surrounds our belief that patients and families deserve to be treated with dignity and respect, should be allowed control over health care decisions and have access to high quality, complex care.

Our providers offer varied levels of care, from regular exams to complex treatment plans. As Home Care Specialists, we can act as your primary care provider (PCP) or work alongside your current doctor and specialists. If you should need hospitalization, Physician Housecalls coordinates the admission process with your hospital of choice. (Should we include that we do not provide hospital services and care would be provided by a hospitalist?) Upon discharge, our providers will coordinate a visit to ease your transition home.

Available Services:

- Physical exams
- Chronic Disease Management
- Acute Care Visits
- Prescription refills
- Functional Assessments
- Geriatric Health Assessments
- Cognitive Assessments
- Home Health & Hospice Coordination

We currently accept:

- Medicare
- Medicaid
- Private Insurance
- Private Pay

We look forward to serving you!

The Physician Housecalls Team

PHYSICIAN
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PATIENT EVALUATION QUESTIONNAIRE

Tele: _____ Fax: _____ VO Given by Whom: _____

REFERAL SOURCE: _____ Date: _____ DOB: _____

Patient Name: _____ SSN:_____

Address: _____ Facility/Apt: _____

Telephone: _____ City/Zip code: _____

Billing Address: _____ City/Zip code: _____

Important Directions: _____

Emergency Contact: _____ Relationship to Pt: _____

Contact Telephone #1: _____ Contact Telephone #2: _____

Current Pharmacy: _____ Home Care/Hospice/Advantage CM Agency:

Previous PCP:_____ _____

Is the patient's condition related to: Employment: **Y** **N** Auto Accident: **Y** **N** Other Accident: **Y** **N**

ALLERGIES	
Food allergies:	
Drug allergies:	
Environmental allergies:	
ACTIVITIES OF DAILY LIVING HISTORY	
Are you bed bound?	Y N
Are you able to walk?	Y N Walker/Cane/Crutch/Wheelchair?
Do you have control of your bladder?	Y N
Do you have control of your bowel?	Y N
Are you able to groom/bath/dress yourself?	Y N
Patient's height and weight	_____Lbs. _____'____"

SOCIAL HISTORY				
Marital Status	Married	Single	Widowed	Divorced
Number of Children				
Smoking Status	Never	Currently	Quit	Details
Alcohol Usage	Never	Currently	Quit	Details
History of Substance or Narcotics Use		Y N		
Oxygen Used in the Home		Y N	If yes: _____Liters	
Armed Forces Service **(if yes, THANK YOU)**		Y N		
Previous Occupation				
Race:	Ethnicity:		Language:	
Gender: Male	Female			

FAMILY MEDICAL HISTORY			
Heart Disease	Mother	Father	Other
Cancer	Mother	Father	Other
Diabetes	Mother	Father	Other
Dementia/Alzheimer's	Mother	Father	Other
Mothers cause of death:		Fathers cause of death:	
Age at time of death:		Age at time of death:	

PAST MEDICAL HISTORY		
__Alcoholism	__Diabetes	__Hiv/Aids
__Arthritis	__Eczema/Skin Issues	__Intestinal Issues
__Anxiety/Depression	__Empysema/Asthma	__Muscle Problems
__Autoimmune Disease	__Epilepsy/Seizures	__Respiratory Issues
__Bladder/Kidney	__Eye issues	__Scarlet Fever
__Cancer	__Headaches	__Stroke
__Chronic Pain	__Heart Disease	__Swallowing Issues
__Digestive Issues	__High Blood Pressure	__Other:
__Diabetic Eye Exam	__ Diabetic Foot Exam	

PAST SURGICAL / HOSPITALIZATION HISTORY

IMMUNIZATION HISTORY		
Pneumonia Y N	**Zoster (Shingles) Y N**	**Influenza Y N**
Date:	**Date:**	**Date:**

CODE STATUS

____Do Not Resuscitate and/or _____MOST form

Does the patient have a Living Will/ Advanced Directive? _____

BILLING AND INSURANCE INFORMATION

Do you have a DPOA or Guardian? **Y N**

If yes, who? _____

DPOA or Guardian Address: _____

Are you responsible for your financials? **Y N**

If no, who? _____

Responsible Party Address: _____

Primary Insurance Information:

Insurance Company: _____ Number: _____

Name of Policy Holder: _____ Policy Holders DOB _____

Policy Holders SSN: _____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____

Secondary Insurance Information:

Insurance Company: _____ Number: _____

Name of Policy Holder: _____ Policy Holders DOB _____

Policy Holders SSN: _____ Group Number: _____

Insurance Phone #: _____

Submit claims to address: _____

MEDICATION INFORMATION

Patient gave verbal consent to the electronic download and review of medication insurance eligibility and medication history.

Please list below all medications patient is currently taking:

Injections **Meter Dose Inhalers** **Eye Drops**

Vitamins and Supplements **Over the Counter Medications** **Skin Creams**

	Medicine	Dosage	Currently Use (Y/N)?	How many times a day *and* When taken during the day
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				