HOMECARE MEDICINE *of* ATLANTA

PRE-VISIT INTERVIEW

- **Please take a few moments to fill out the following medical history below before your scheduled visit**. This will provide us with helpful information about your health.
- The completed form can be **faxed to our office at (770) 800-3100.**

_____

Patient Name (**Please print)** Date of Birth

_____

Street Address City State Zip Code

Patient's Room/Apt. Number (if applicable): _____

Patient's Phone number: _____

Veteran's Status

Are you a veteran? _____Yes _____No
Did you serve war time? _____Yes _____No
If yes, when? _____
In which war did you serve? _____

Medical History

When was the last time you saw your doctor? _____
Was it a routine visit or for a specific problem? _____
When last were you last admitted to the hospital? _____
Which hospital? _____What was the problem? _____

PLEASE CIRCLE ALL THAT APPLY:

Are you **bed bound**?	Y	N
Are you able to **walk**?	Y	N
Do you require the use of a **Walker** / **Cane**/ or **Crutch**? (Circle which one)	Y	N
Do you have a **wheelchair**?	Y	N

3330 Cumberland Blvd.
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Do you need someone to **assist** you in the use of the **wheelchair**?			Y	N
Do you use the wheelchair **Inside/Outside?** (Circle which one)			Y	N
Do you have control of your **bowels**?	Y	N	How often?	
Do you have control of your **bladder**?	Y	N	How often?	
Do you use the **Toilet** / **Urinal** / **Bedpan** / or **Commode**?	Y	N	Circle **each** that applies.	
Do you have a **Foley** catheter?		Y	N	
Do you have a **Colostomy**?		Y	N	
Do you have a **Urostomy**?		Y	N	

Are you able to **feed** yourself?	Y	N	Need Assistance
Do you have a **feeding tube**?	Y	N	If YES: Type?
Are you able to give yourself a **bath** / **shower**?	Y	N	Need Assistance
Are you able to **dress** yourself?	Y	N	Need Assistance
Are you able to **groom** yourself?	Y	N	Need Assistance
Are you able to **communicate** well on your own?	Y	N	Need Assistance
Do you have an **Emergency Lifeline**?	Y	N	

Do you have any **allergies** or **sensitivities** to any medications? Y N

IF YES —**what** medications, and how do you **react**?

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Who does your **grocery** shopping? _____

Who prepares your **meals**? _____

Who gives you your **medications**? _____

If your medications are pre-poured, who does that? _____

Who pays your **bills**? _____

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Who **drives** you to appointments? _____

Who does your **laundry**? _____

Who does your **housework**? _____

Please tell us about your past medical history. If you are not sure whether you have a certain condition, circle no. We are looking for conditions that you are aware of.

Diabetes	Y	N	
High blood pressure	Y	N	
Coronary artery disease/Angina/Chest Pain	Y	N	
History of heart attack	Y	N	Date:
High cholesterol	Y	N	
Congestive heart failure	Y	N	
Swelling of legs / ankles	Y	N	
Heart Valve disease (heart murmur)	Y	N	
Cardiac arrhythmia (irregular heartbeat)/Pacemaker	Y	N	Circle all that apply
Ulcers – (Stomach/Duodenal)	Y	N	Circle all that apply
Pancreatitis	Y	N	
Bleeding from stomach or rectum	Y	N	Circle all that apply
Diverticulosis/Diverticulitis — of Colon	Y	N	
Acid Reflux Disease - **GERD**	Y	N	
Hard of hearing/Hearing Aid:	Y	N	
Vision problems—**can't** read even if using glasses	Y	N	
Glaucoma (increased pressure in eye)	Y	N	
Stroke	Y	N	Date:
Parkinson's disease	Y	N	
Treated for Depression	Y	N	
Dementia (Forgetfulness)	Y	N	

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Thyroid (hyper/hypo)	Y	N	
Lung disorders/Breathing problems	Y	N	
Bronchitis, pneumonia (in the last few years)	Y	N	Year:
Liver disorders/jaundice	Y	N	circle all that apply
Kidney Disorders:	Y	N	circle all that apply
Kidney Stone/Recur Bladder Infect	Y	N	
Arthritis (osteoarthritis/rheumatoid arthritis)	Y	N	circle all that apply
Cancer	Y	N	type:
Anemia	Y	N	
Blood clots (Legs or Lungs)	Y	N	
Peripheral Vascular Disease --	Y	N	
Leg pain: Walking/ at Rest	Y	N	circle all that apply
Surgeries:			
Cholecystectomy (Gall Bladder)	Y	Year: _____	N
Appendectomy	Y	Year: _____	N
Cataracts (Eye operation)	Y	Year: _____	N
Hysterectomy	Y	Year: _____	N
Please list any additional surgeries performed:			

Any **additional past medical history** that you feel would be helpful for your physician to know.

_____

_____

_____

Date of last **Colonoscopy** _____ Never

Date of last **Mammogram** _____ Never not applicable.

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Date of last **Flu shot** _____ Never

Date of last **Pneumovax** shot (Bacterial pneumonia): _____ Never

Date of last **Shingles Vaccine** _____ Never

FAMILY HISTORY

Please answer the following questions about your family history. Please **list which family member** applies on each line.This **includes** your parents, brothers, sisters, aunts, uncles, grandparents, etc.

Diabetes _____

High Blood Pressure _____

Heart Attacks at age 40's or 50's _____

Cancer (type) _____

Rheumatoid Arthritis _____

Mother Living/Dead Age at death _____ Cause of death _____

Father Living/Dead Age at death _____ Cause of death _____

SOCIAL HISTORY

Current **marital** status: _____ Do you have any children? **Y N** #____

Current **religious** status: _____ Is religion important to you now? **Y N**

Do you have a **Do Not Resuscitate** (**DNR**) Order in place? _____

If No—are you interested in talking with the doctor about this? _____

Do you have a **Health Care Proxy**? _____

If No—are you interested in talking with the doctor about this? _____

What **work** are you retired from: _____ Age at retirement: ____

Are you presently smoking **cigarettes**? **Y N** Other tobacco products: _____

If Yes, how many **packs per day**? _____ For how many **years:** _____

If No, have you smoked in the past? **Y N**

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If Yes in the past, how many **packs per day?** ____ For how many **years**? _____

When did you quit? _____

Do you drink more than **one alcoholic beverage** a week? **Y** **N**

If Yes, how often _____ what do you drink? _____

If No— Have you had a period where you drank daily or drank more than 5 drinks on the weekend? **Y** **N**

Do you use oxygen at home? **Y** **N**

Does anyone else in the home use oxygen? **Y** **N**

Please list *all* your Medicines on the next page, including:

- **Injections** — Insulin, Vitamin $B_{12,}$ etc.
- **MDIs** — Meter Dose Inhalers & Nebulized medications.
- **Eye Drops**
- **Pain and Sleep** medications — Tylenol, Anacin and other OTC's.
- **Bowel** medications, **Vitamins**, **Calcium**, **Herbal** Products, **Supplements**.
- **Skin creams** and any other over the counter medicines you are using.

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	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.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Preferred Pharmacy

Name: _____

Number: _____

Address: _____

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