"We Bring the Doctor to You."SM

Welcome to MD@Home! "We Bring the Doctor to You."

PLEASE COMPLETE THE FOLLOWING FORMS AS ACCURATELY AS POSSIBLE.

1. Patient Intake Form
2. Health History Forms
3. Medical Logs with Prescription Information
4. Activities of Daily Living Form

INSURANCE CARDS

COPIES MEDICAL INSURANCE CARDS

- **Insurance card**
- **Prescription insurance card**
- **Secondary insurance card**

POWER OF ATTORNEY

IF YOU HAVE A POWER-OF-ATTORNEY (P.O.A.), list the names, **PLEASE INCLUDE A COPY OF THE DOCUMENT.**

MAIL OR FAX

Please mail or Fax all of your documents to:

York
FAX# 717-840-8686
2550 Kingston Rd
Suite 205
York, PA 17402

QUESTIONS??? Please call 1-877-638-6968

Thank you for allowing MD@HOME to address your medical needs.

"We Bring the Doctor to You."[SM]

PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name______________________________ First Name_______________________ INIT____ M/F___

Address____ Apt/Room____________

City ____ State________ Zip __________________

Home Phone (_____) _____-_________. Other Phone (______) ______-____________.

Date of Birth ____/______/______ Height_____ft_____in Weight____________lbs

Name of P.O.A ______________________________________ Phone # (____) -______-_________

Emergency Contact Person______________________________ Phone # (____) - ______-_________

___SINGLE ____ Married ____ Widowed ____ Separated ____ Divorced

If married, is patient covered on spouse's group insurance? Yes ___ No___.

Who should we thank for this referral?. Name:_________________________ Ph # (____)-______-______

INSURANCE INFORMATION

Primary Insurance__________________________________ ID#______________________________

Effective Date ________________________ S.S. # _______ - _______ - _______

Secondary Insurance ______________________ I.D. # ___________________ GRP. # ___________

Approved Yes_______ No ______ Date Approved-_____/_____/_____ Initials ______

INSURANCE CARDS

MD@HOME must have a photocopy of all of your:

- **MEDICAL INSURANCE CARDS**
- **PRESCRIPTION CARDS**

Misc. Information for doctor: ____

MD@HOME Representative: ____

HEALTH HISTORY (Confidential)

Patient Name:_______________________________________ Today's Date_________________

Symptoms - Check (√) symptoms you currently have or have had in the past year.

GENERAL
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of weight
- Nervousness
- Sweats

MUSCLE/JOINT/ BONE:
Pain, weak-ness, numbness in:

Arms	Hips
Back	Legs
Feet	Neck
Shoulders	Hands

GENITO-URINARY
- Blood in urine
- Frequent urination
- Painful urination
- Lack of bladder control

GASTROINTESTIONAL
- Appetite Poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR
- Chest pain
- High blood pressure
- Irregular heartbeat
- Low blood pressure
- Poor circulation
- Rapid heartbeat
- Swelling of ankles
- Varicose veins

EYE,EAR,NOSE,THROAT
- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-Flashes
- Vision-Halos

SKIN
- Bruise easily
- Hives
- Itching
- Charges in moles
- Rash
- Scars
- Sore that won't heal

MEN ONLY
- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN ONLY
- Abdominal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period_ ____________

Date of last Pap smear ______________________

Have you had a mammogram___________

Are you pregnant?_____

Number of children_____

Conditions - Check (√) conditions you have or have had in the past year.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast lumps
- Bronchitis
- Bulimia
- Cancer
- cataracts
- Chemical dependency
- Chicken pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart disease
- Hepatitis
- Hernia
- Herpes
- High cholesterol
- HIV positive
- Kidney disease
- Liver disease
- Measles
- Migraine headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate problem
- Psychiatric care
- Rheumatic fever
- Scarlet fever
- Stroke
- Suicide attempt
- Thyroid problem
- Tonsillitis
- Tuberculosis
- Typhoid fever
- Ulcers
- Vaginal infections
- Venereal disease

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HEALTH HISTORY (continued…)

FAMILY HISTORY

Fill in health information about your family

Check (√) if, your blood relatives had any of the following:

Relation	Age	State of Health	Age at Death	Causes of Death	Diseases	Relationship to You
Mother					Arthritis, Gout	
Father					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dep.	
					Diabetes	
					Heart Diseases	
					Stroke	
Sisters					High Blood Prs	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS

PREGNANCY HISTORY

Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex at Birth	Complications (if any)

Have you ever had a blood transfusion? Yes No

If yes, please give approximate dates_____________

Check (√) which substances you use and describe how much you use.

Check (√) if your work exposes you to the following

Health Habits

Occupational Concerns

	Health Habits		Occupational Concerns	
	Caffeine		**Stress**	
	Tobacco		**Hazardous Substance**	
	Drugs		**Heavy Lifting**	
	Other		**Other**	

Serious Illness/ Injuries	**Date**	**Outcome**

Doctor's Signature_________________________ **Date** ______________

ACTIVITIES OF DAILY LIVING

Patient Name_________________________________ **Date**____________

What level of help does the patient need to perform the following tasks?

LEVEL OF HELP CODES

A	Independent with or without assistive devices
B	Requires verbal reminder
C	Requires physical assistance to completel
D	Requires full physical assistance
E	Does not Apply

Instrumental Activities of Daily Living	Code	Activities of Daily Living	Code
Personal Laundry		Eating	
Shopping		Drinking	
Securing and using transportation		Transferring in/out of bed/chair	
Managing finances		Turning and position in bed/chair	
Using the telephone		Toileting (bowel)	
Making and keeping appointments		Toileting (bladder)	
Caring for personal possessions		Personal hygiene- bathing	
Writing Correspondence		Personal hygiene- grooming	
Engaging in social and leisure activities		Personal hygiene- dressing/undressing	
Using a prosthetic device		Securing healthcare	
Obtaining clean, seasonal clothing		Managing healthcare	

Misc. Information____

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MEDICAL LOG

Patient____ D.O.B.__________ Phone(____)___________

Pharmacy_____________________________ Pharm. Ph# (____)__________ Ht. ______ Wt. ______

Date RX	Medication	Qty.	Dosage	Freq.	D/C Date	Medical/Allergy Alerts	
						Immunization	
						Date	**Type & Where**

MEDICAL LOG

Date	Hospitalizations	Reason	Additional Info

Date	Testing Info	Reason	Additional Info

Other Physician Information	
Physician's Name	Physician's Phone

Notes:____

ADDITIONAL INFORMATION

Please use this page to fill out any additional information related to your health care.

Thank you for your patience.

Sincerely,

The MD@HOME Staff