Mary Snellings M.D.

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PATIENT INFORMATION

Please fill in all sections/blanks

Legal Name: ____ Date of Birth: ____

Phone: Home: ____ Cell phone: ____

Address: (where you will be seen) ____

Medicare Number: ____ **Social Security Number**: ____

Primary Insurance: ____ Member ID#: ____

Secondary Insurance: ____ Member ID#: ____

Guarantor/Responsible Party Name: ____

Guarantor Address: ____

Emergency contact ____ Phone: ____

Power of Attorney (if appl) ____ Phone: ____

Email Address: ____

Pharmacy name & phone #: ____

Pharmacy (secondary, name/phone #): ____

Home health agency name/number (if app): ____

Hospice Agency name/number (if app): ____

Have you been in a hospital or a facility in the past year? Yes ☐ No ☐

If yes, name and location of hospital/SNF/Rehab: ____

Do you currently have any of the following? (Check all that apply) **DME**

	Infectious Disease – including COVID 19		Bedbound
	Wound(s) (location)		Walker
	Catheter		Cane
	Pacemaker		Rollator
	IV Line (type)		Crutches
	Recent fall(s)		Wheelchair
	Colostomy/Ostomy		Oxygen
	Staples/Sutures (location)		Special Transportation Required

MEDICATIONS:

Please list or attach ALL of the medications you are currently taking, including prescriptions, Insulin, vitamins, inhalers, eye drops, over-the-counter medications.

MEDICATION	DOSE	FREQUENCY	REASON

Allergies:

Please list **all** allergies, including medications/supplements, latex, foods etc.

VACCINATION DATES:

Flu (most recent) ______ **Pneumonia** ______ **Shingles** ______

PERSONAL MEDICAL HISTORY

Are you currently or have you ever been treated for: **check all that apply**

	Height Weight		
	Anemia		Iron deficiency aplastic
	Arthritis		Knees elbows pelvis multiple joints
	Back problems		Low back pain Scoliosis Previous back surgery
	Blood Pressure		Low High
	Cancer		Breast Colon Skin Prostate Lung Other:
	Cholesterol / triglycerides		High Cholesterol
	Cognition/Memory		Short term long term Dementia Alzheimer's Age-Related Mild Confusion
	Diabetes		Insulin dependent oral meds diet controlled
	Edema / swelling		Feet Ankles Legs Arms
	Eye disease		Glaucoma Macular degeneration Cataracts Poor vision
	Fainting / passing out / dizzy		Upon standing All the time History of Falls
	Frequent infections		Bladder Sinus Lung Skin Intestinal
	Gastrointestinal problems		Heartburn Reflux Ulcers Nausea Abdominal pain Diarrhea Constipation
	Heart disease		Blocked arteries Stents Bypass Heart attack Congestive heart failure Atrial Fibrillation
	Incontinence		Urine Bowel
	Kidney problems		Frequent Urination Kidney failure Dialysis Kidney Stones
	Muscle problems		Muscle spasm Muscle pain Weakness
	Osteoporosis		
	Neuropathy		Burning pain numbness in hands feet/legs
	Psychological		Depression Anxiety Bipolar Schizophrenia Hallucinations
	Respiratory disease		Short of breath Cough COPD Asthma Smoker Seasonal allergies
	Seizures		
	Skin problems		Rash Wounds Itching Dryness
	Sleep disorders		Insomnia Sleeping too much Sleep apnea
	Stroke / TIA		
	Thyroid disease		Hyperthyroidism Hypothyroidism
	Serious Injury / broken bones		Location
	Weight changes / Appetite changes		Weight loss Weight gain Poor appetite

Other Physicians or Specialists:

Specialty:	Name:	Phone number:

FAMILY MEDICAL HISTORY:

Please list all medical problems of your immediate family (Mother, Father, Siblings):

SOCIAL HISTORY:

Smoking
Alcohol
Street Drugs
Marital status
# of Children
Branch of Military

SURGICAL HISTORY: (list all previous surgeries)

Please indicate if you attend any of the following:

Dialysis (days/times and location)

Wound care clinic (days/times and location)

Adult Day Care (days/times and location)

Other routine outings

Please indicate if you are experiencing any of the following symptoms:

Memory:

Repeating questions or stories
Forgetting appointments, phone numbers, names, addresses
Difficulty with multi-step tasks (cooking, grooming, dressing)
Difficulty managing medications
Permanently forgetting where things are placed
Difficulty remembering current place of residence, month/year

Language:

Increased difficulty finding words
Inappropriate word substitutions
Increased generic wording ("thing", "stuff", "you know what I mean")
Word errors with no attempt to correct
Totally inappropriate response
Decreased spontaneous speech

Judgment:

Difficulty managing bills, checkbook, money; spending money frivolously
Difficulty planning activities that require decisions (meals, errands, traveling)
Decline in person appearance (not wanting to bathe or groom, dressing inappropriately)
Decline in social functioning
Decline in recognizing safety issues (left food burning on the stove, hoarding, wandering)

Visual-spatial:

Lost in own home/assisted living facility
Lost while walking in own neighborhood
Misidentify or fail to recognize familiar family or friends
Difficulty finding things that are immediately in front of them

Personality/mood:

Increased irritability
Verbal or physical threats
Screaming repeatedly
Paranoia
Delusions of theft
Hallucinations
Disinhibition (inappropriate jokes, inappropriate dressing or undressing, cursing)
Cry for no reason
Suicidal ideation
Decreased concentration
Loss of motivation
Decreased enjoyment of activities
Feelings of guilt or worthlessness

FAX COMPLETED FORM TO 682-321-7036, EMAIL TO INFO@DOCSATHOME.COM OR

MAIL TO: Doctors At Home

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