Mary Snellings M.D.
5802 Berryhill Dr, Arlington, TX. 76017 *Office (682)321-7007 * FAX (682)321-7036

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 & Number: _____

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): _____

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

	Infectious Disease – including COVID 19		Bedbound
	Wound(s) (location)		Walker
	Catheter/Urostomy		Cane
	Pacemaker		Rollator
	IV Line (type)		Crutches
	Fall(s) in Past 6 months		Wheelchair
	Colostomy/Ostomy		Oxygen
	Staples/Sutures (location)		Special Transportation Required
	Shunt Site		

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**

Covid:

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
	Psychological		Depression Anxiety Bipolar Schizophrenia Hallucinations
	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/Urinary problems		Frequent Urination Kidney failure Dialysis Kidney Stones Chronic Kidney Disease BPH
	Muscle problems		Muscle spasm Muscle pain Weakness
	Osteoporosis		Fractures Scoliosis Kyphosis
	Neuropathy		Burning pain numbness in hands feet/legs
	Respiratory disease		Short of breath Cough COPD Asthma Smoker Seasonal allergies Oxygen
	Seizures		
	Skin problems		Rash Wounds Itching Dryness
	Sleep disorders		Insomnia Sleeping too much Sleep apnea
	Stroke / TIA		Paralysis Weakness Behavior Changes Impaired Speech Difficulty Swallowing
	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):

Mother: _____

Father: _____

Sibling: _____

SOCIAL HISTORY:

Smoking ☐ Year Quit ☐ Alcohol ☐

Marital status ☐ # of Children ☐

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

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

Reason for Hospitalization:

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