Medical History Form

Northview Medical House Calls
1184 Cleaver Rd Suite 300
Caro MI 48723
Ph: 888-759-5709
Fax: 888-491-7220
www.northviewmedicalhousecalls.com

Name:	**Birth Date:**	**Date:**
Person filling out form:		**Relationship:**
Current or Past Medical Problems:	**3.**	**7.**
1.	**4.**	**8.**
2.	**5.**	**9.**
Past Surgeries: (include date)	**2.**	**4.**
1.	**3.**	**5.**
Medicine Allergies:		
Local Pharmacy (Name/Phone):		
Family History: (e.g. medical conditions/age of death)	**Father/Mother:**	**Siblings:**
Social History / Tobacco:	**Alcohol:**	**Past Occupation:**
Religion:	**Advanced Directives:**	**Diet:**
Activities of Daily Living: Needs assistance with the following (Yes or No)	**Feeding:** **Bathing:** **Transferring:**	**Toileting:** **Dressing:** **Walking:**
Home Health Agency:		
Immunizations (Yes or No)	**Influenza(flu):**	**Pneumococcal:**
Durable Medical Equipment (e.g walker, cane, Hospital bed)		**Company name:**
Recent Hospitalizations: Hospital / Reason / Date:		
Recent Doctors (name and phone):		
Other information:		

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Review of Systems : **Please check or describe below any of the following symptoms you may be having:**

General **: Fever:**	**Chills:**	**Weight loss:**
Height:	**Weight:**	**Loss/ Gain weight:**
Skin **: Rash:**	**Itching:**	**Wounds:**
Head: **Headaches:**	**Hearing loss:**	**Hearing aide:**
Ear discharge:	**Nose bleeds:**	**Nose congestion:**
Eyes: **Blurred vision:**	**Double vision:**	**Eye discharge:**
Eye redness:		
Heart**: Chest pain:**	**Palpitations:**	**Trouble breathing lying flat:**
Leg swelling:		
Lungs**: Cough**	**Sputum production:**	**Shortness of breath:**
Oxygen use:		
Gastrointestinal: **Nausea**	**Heart Burn:**	**Constipation:**
Blood in stool		
Genitourinary: **Burning:**	**Urgency:**	**Incontinence:**
Musculoskeletal: **Joint pain:**		**Muscle aches:**
Falls:		
Endocrine: **Bruising:**	**High or low blood sugar:**	
Neurological: **Dizziness:**	**Tingling:**	**Tremor:**
Difficulty swallowing	**Weakness:**	**Seizures:**
Psychiatric: **Depression:**	**Hallucinations:**	**Anxiety:**
Insomnia:		
Other:		