MOBILE PHYSICIAN Associates

When was the Last Time Your Doctor Made a House Call?

NEW PATIENT INTAKE
Part 2 of 2
(Completion of Part 2 is optional)

We appreciate you providing us with the most complete, up-to-date information available before the initial appointment with the Medical Provider. Although the "New Patient Intakes, Part 2 of 2" are not mandatory, we do *highly recommend* that the highlighted sections are completed and in doing so, we are able to provide the patient the most comprehensive and highest-quality care.

Sincerely,

Mobile Physician Associates

9400 Brighton Way, Suite 410 Beverly Hills, CA 90210
Phone: (310) 256-2426 / Fax: (310) 954-9373
www.MyMobilePhysician.com

MOBILE PHYSICIAN Associates

When was the Last Time Your Doctor Made a House Call?

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

Home Health Agency (If Applicable):

Address: _____

Phone: _____

Fax: _____

Hospice Agency (If Applicable):

Address: _____

Phone: _____

Fax: _____

Advanced Directives (If Checked Please Attach Document):

- ☐ POA/Conservatorship
- ☐ Living Will
- ☐ Advanced Directives

Recent Hospital Visit:

Location: _____

Date: _____

Reason: _____

Recent Hospital Visit:

Location: _____

Date: _____

Reason _____

Mobility:

- ☐ Ambulatory
- ☐ Requires Assistance
- ☐ Bedridden

Additional Comments/Requests:

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PAST MEDICAL HISTORY

Please check all appropriate boxes below if you have ever been diagnosed or experienced any of the following:

☐ Pneumonia	☐ Diabetes	☐ Tuberculosis
☐ Bronchitis	☐ Heart Attack	☐ Hepatitis
☐ Cancer: Type _____	☐ Angina	☐ Thyroid Problems
☐ Stomach/Intestinal Ulcers	☐ Gall Stones	☐ Gout
☐ Kidney Stones	☐ Seizures	☐ Strokes
☐ Alzheimer's	☐ Dementia	☐ Mental Illness _____
☐ Migraine Headaches	☐ Cataracts	☐ Glaucoma
☐ Blood clots/phlebitis	☐ High Cholesterol	☐ Pancreatitis
☐ Hernias: Type _____	☐ Diverticulosis	☐ Sexually Trans. Disease
☐ Asthma/emphysema	☐ Irregular Heart Rhythm	☐ High Blood Pressure
☐ Kidney Failure	☐ Arthritis	☐ Parkinson's Disease
☐ Congestive Heart Failure	☐ Pacemaker/Implant	☐ Chronic UTIs

OTHER DIAGNOSES

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MEDICATIONS

Please list the names of all medications you are currently taking along with their dosage and frequency:

Name	Dosage	Frequency

ALLERGIES

Please list all known allergies with a description of specific symptoms:

Allergy	**Reactions**

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UNDIAGNOSED SYMPTOMS

Please describe any additional undiagnosed symptoms you have:

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