Sumana Ketha M.D.
Board certified in Internal Medicine

DFW Medical Home PLLC
2925 Skyway Cir N Irving, TX 75038
PH#: (972) 675-7313, FAX#: (972) 675-7310
Email: admin@texashousecalls.com

(This section needs to be filled by patient)

PATIENT INFORMATION

*Patient Name: ______________________ *DOB: ______________ Date: ______________

*Address: ______________________________ *City: ______________

*Zip Code: ______________ *State: ______________________

*Marital Status *(check one)*: Single Partner Married Divorced Widowed Other

*Home Phone: ______________ *Mobile Phone: ______________ Allow SMS: Yes ☐ No ☐

Email Address: ______________________________ Allow Email: Yes ☐ No ☐

Allow Patient Portal: Yes ☐ No ☐

* Emergency Contact Person Name: ______________________ *Phone: ______________

Occupation: ______________________________

Employer: ______________________________

Drivers/ID Number: ______________ *Social Security Number: ______________

Language: ______________ Ethnicity: ______________

Preferred Pharmacy Name: ______________________________

Preferred Company Lab Name: ______________________________

Current Home Health Agency: ______________________ Admission Date : ______________

Current inpatient facility : ______________________ Admission Date : ______________

INSURANCE INFORMATION

*Primary Insurance Provider: ______________ Secondary Insurance Provider: ______________

*Plan Name: ______________ Plan Name: ______________

*Policy Number: ______________ Policy Number: ______________

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Patient Name: ______________________ DOB : ______________ Date: ______________

CHIEF COMLAINT / REASON FOR VISIT

____
____
____
____
____
____
____
____
____
____

MEDICATION LIST

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*

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PFSH (Past Medical, Family and Social History)

MEDICAL PROBLEMS	

SURGERIES / HOSPITALIZATION / INJURIES / TRANSFUSION		

ALLERGIES NO ALLERGIES

ALLERGY	ALLERGIC REACTION

DENTAL ISSUES

DME

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Patient Name:________________________ DOB :______________ Date:__________

IMMUNIZATION	

FAMILY HISTORY

Father : ____________________

Mother : ____________________

Siblings : ____________________

Spouse : ____________________

Offspring: ____________________

Other Family Relative: ____________________

SOCIAL HISTORY

Current employment: Employed Unemployed Retired Disabled

Current Occupation: ____________________

Use of Tobacco, Alcohol and Recreational Drugs *(check)*:

Tobacco Current Status: Current Quit (date)__________ Never

Alcohol Current Status: Current Quit (date)__________ Never

Recreational Drugs Current Status: Current Quit (date)__________ Never

Education Level: ____________________

Sexual history: ____________________

Other History : ____________________

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REVIEW OF SYSTEMS

GENERAL

Weight change
Anorexia
Night sweats
Heat or Cold
Weakness
Fever
Insomnia
Fatigue
Irritability

SKIN

Rashes
Lumps
Itching or Dryness
Color changes
Hair and nail changes
Psoriasis

HEAD & NECK

Stiffness
Lumps
Pain
Masses
Head injury

EARS

Hearing changes
Earache
Drainage
Ringing in ears

EYES

Vision changes
Pain/redness
Blurry/double vision
Flashing lights
glaucoma

THROAT

Bleeding
Soreness/pain
Dry mouth
Hoarseness
Thrush
Non-healing sores

BREASTS

Lumps/masses
Pain
Discharge
Breast-feeding

RESPIRATORY

Coughing/sneezing
Sputum Coughing
blood Shortness of
breath Wheezing
Painful breathing
Asthma

CARDIOVASCULAR

Chest pain/discomfort
Tightness
Palpitations
Difficulty Breathing while
laying down (Orthopnea)
Swelling
Syncope (temporary loss
of consciousness)
Shortness of breath with
activity

GASTROINTESTINAL

Swallowing difficulties
Heartburn
Appetite changes
Nausea
Change in bowel nature
Rectal bleeding

MUSCULOSKELETAL

Music or joint pain
Stiffness
Back pain
Swelling of joint
Trauma
Aches/cramping
Gout
Arthritis
Limitations in range of
motion/calf pain

NEUROLOGIC

Dizziness/Fainting
Seizures
Weakness and/or
numbers Tingling
Tremors
Paralysis
Changes in mentation

PSYCHIATRIC

Anxiety
Suicidal thoughts
Substance dependence
Depression
Memory loss

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

_______ **+** _______ **+** _______

=Total Score: _______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

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Patient Name:________________________________ DOB :_______________ Date:_______________

VITAL SIGNS

Height	Weight	BP	HR	RR	Temp

PHYSICIAN / PROVIDER NOTES