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

TPHC
Texas Physician House Calls

(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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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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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**
☐	☐	☐	☐

Submit Print

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Patient Name:_____ DOB :_____ Date:_____

VITAL SIGNS

Height	Weight	BP	HR	RR	Temp

PHYSICIAN / PROVIDER NOTES