

# Liberty Doctors, LLC

## Medical History

Please fill out the form completely. The following information will help us to provide you with the best medical care and treatment possible. If you have any questions, please ask the front desk person or one our nurses. Thank you and we look forward to helping you.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ Who is your primary care doctor? \_\_\_\_\_

Highest Level of Education \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed

List ALL medications you are taking (including over the counter medications & vitamin supplements).

\_\_\_\_\_

List any known allergies. Medication Allergy: Reaction:

\_\_\_\_\_

\_\_\_\_\_

### Medical History:

#### Date:

Latex Allergy Y N  
Y \_\_\_\_\_ N

Heart disease Y N  
Y \_\_\_\_\_ N

High Blood Pressure Y N  
Y \_\_\_\_\_ N

High Cholesterol Y N  
Y \_\_\_\_\_ N

Diabetes Y N

Seizures Y N

Mental Health Issues Y N

### Surgeries:

Adhesive Allergy Y N

Asthma Y N

Depression Y N

Stroke Y N

Hypothyroidism Y N

Cancer Y N

Type of Cancer \_\_\_\_\_

Appendix

Tonsils/Adenoids

Gallbladder

Heart

List:

**Women**

Pregnant Y N  
Hysterectomy Y N  
Last Menstrual Cycle \_\_\_\_\_  
Y N  
# of Pregnancies \_\_\_\_\_

Abnormal PAP Y N  
Last PAP Smear: \_\_\_\_\_ C-Section  
# of Live Births \_\_\_\_\_

**Social History**

Do you smoke? Y N  
\_\_\_\_\_  
Marijuana Usage Y N  
\_\_\_\_\_  
Any other forms of Tobacco? Y N  
List? \_\_\_\_\_

How many cigarettes a day?  
How many cigarettes a day?  
How Often? \_\_\_\_\_ Servings per  
Day? \_\_\_\_\_  
Cocaine \_\_\_\_\_ Heroin \_\_\_\_\_

Do you drink Alcohol? Y N  
Day? \_\_\_\_\_  
Other Illicit drug use? Y N  
Methamphetamine \_\_\_\_\_

**Family Medical History:**

Heart disease Y N  
Issues Y N  
High Blood Pressure Y N  
Y N  
High Cholesterol Y N  
Diabetes Y N  
Seizures Y N

Asthma Y N Mental Health  
Stroke Y N Depression  
Hypothyroidism Y N  
Cancer Y N  
Type of Cancer \_\_\_\_\_

Chart # \_\_\_\_\_

