Liberty Medical Group
A Division of Middletown Medical, PC

Health History

Patient Name:__________________________________ Date of Birth:_______________________

This history form provides us with information to help us meet your entire healthcare needs, please complete all pages of this form answering each question. This is a confidential part of your medical record and will be kept in this office.

Today's Date ______________

When was your last physical exam?___________

Name of Doctor _______________________________________Phone________________________

If Doctor not from here, why did you leave?____

Habits:

Smoking (type & amount/day)_________
Alcohol (type & amount/day)__________
Caffeine (type & amount/day)__________
Street Drugs (type & amount/day__________

Usual Weight__________________
Date of Last Dental Exam__________________
Please list all allergies (food, drugs, environment)

____
____
____
____
____

Please list all serious illnesses, operations and other hospitalizations you have experienced and indicate year that they occurred:

____
____
____
____

Please list all medicines you are currently taking (Include nonprescription drugs)

____
____
____

Past Medical History

____
____
____
____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones include date occurred: _________________________________
____

Are you able to perform:

Ability to Perform Daily Living Activities

Dressing	Yes	No
Feeding	Yes	No
Toileting	Yes	No
Grooming	Yes	No
Bathing	Yes	No

Instrumental Activities of Daily Living

Shopping	Yes	No
Food Preparation	Yes	No
Telephone Usage	Yes	No
Housekeeping	Yes	No
Laundry	Yes	No
Driving	Yes	No
Responsible for own Medication	Yes	No
Ability to handle Finances	Yes	No

Psychiatric:

Do you have depression?	Yes	No
Do you feel lonely or socially isolated	Yes	No
Do you have stress/anger?	Yes	No
Do have pain/Fatigue	Yes	No

Family History

List the present age of the age of each of the following members of the patient's family; also if living, add if their health is good, fair or poor. If deceased, list the cause of death.

Father ________________________________
Mother________________________________
Brother________________________________
____
____
Sister ________________________________
____
____

Paternal Grandfather________________________
Paternal Grandmother________________________
Maternal Grandfather_________________________
Maternal Grandmother________________________

Hearing or Visual Impairment:

Do you have a hearing impairment? Yes No Left __ Right __ Both_____
Do you have a visual impairment? Yes No List: __________________________________

Have you or any blood relative had any of the following? (Circle "Yes" or "No", leave blank if unknown)

Cancer Yes No ______________________
Tuberculosis Yes No __________________
Diabetes Yes No _____________________
Heart Disease Yes No _________________
High Blood Pressure Yes No _____________________
Stroke Yes No _______________________
Epilepsy Yes No ______________________
Allergies Yes No ______________________
Anemia Yes No _______________________
Bleeding Tendencies Yes No _____________________
Asthma Yes No ________________________
Chronic Lung Disease Yes No _______________________
Depression Yes No _____________________
Other: ___________________________________

Psychoses Yes No _________________________
Suicide Yes No ___________________________
Leukemia Yes No _________________________
Migraine Headaches Yes No ________________________
Obesity Yes No ____________________________
Thyroid Disease Yes No ___________________________
Ulcers Yes No _____________________________
High Cholesterol Yes No _______________________
Kidney Disease Yes No ____________________
Glaucoma Yes No __________________________
Drug/Alcohol Problem Yes No ______________________
Gout Yes No ____________________________

End of Life Planning:

Do you have an Order Not to Resuscitate (DNR) Yes No
Do you have a Health Care Proxy Yes No
Do you have a Living Will? Yes No

List other Providers that you see on a regular basis:

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health/patients health.

Signature _________________________________ Date _______________________________