Appt. Date: _____

Patient History Sheet

Patient's Name: _____ DOB: _____ / ____ / _____

Prior Surgeries	Dates	Medical Illness	Onset
_____	___/___/____	_____	____/____/_____
_____	___/___/____	_____	____/____/_____
_____	___/___/____	_____	____/____/_____
_____	___/___/____	_____	____/____/_____

Prior Hospital Visits	Dates	Allergies	Reaction
_____	____/___/____	_____	_____
_____	____/___/____	_____	_____
_____	____/___/____	_____	_____
_____	____/___/____	_____	_____

Current medication and dosages

_____
_____
_____
_____
_____

Family History

Deceased or Alive
Year died/ Age/Cause of death

Mother _____
Father _____
Brother _____
_____
Sister _____
_____
Children _____
_____
_____

Habits (amount and duration)	Prior
Smoking _____	_____
Alcohol _____	_____
Coffee_____	_____
Other _____	_____

Social History

Education _____
Marital Status _____
Occupation_____
Religious Preference _____
Other_____

Family member with:		Relationship
Cancer	Y or N	_____
Diabetes	Y or N	_____
Heart Disease	Y or N	_____
Hypertension	Y or N	_____
Liver Disease	Y or N	_____
Kidney Disease	Y or N	_____

Immunizations

Last Tetanus Booster ___/___/___
Hepatitis B Vaccine _____
Pneumonia Vaccine _____
Childhood Vaccines _____

Transfusion History

Any history of prior transfusion? _____
If yes, when? _____

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