Age	Patient Name_						Today's Da	te	
Other treating Physicians History of Present Illness (Describe all in detail what is bothering you, when started, treatments, tests performed) Past Medical History (List all hospitalizations and illnesses for which you have been treated, e.g. diabetes, hypertension, heart disease, lung disorders, etc.) Past Surgical History (List all operations and major injuries) Allergies and Adverse Reactions (Include allergies to antibiotics, Latex, X-ray, dye, skin preps, pain medications if applicable) Blood Transfusions: I will accept blood products in an emergency 1. YES 2. NO 4. NO 4. NO 5. Previously in the property of transfusion reactions? 3. YES 4. NO 5. Prequency Drug Dose Frequency Drug Dose Frequency SOCIAL HISTORY (Circle all that apply) Marital Status: 1. Single 2. Married with children 3. Divorced since 4. Widowed since Living Will: YES NO Occupation: Tobacco: 1. None 2. Currently smoke packs/day and have done so for years 3. Previously smoked packs/day for years. Stopped in 4. Smokeless tobacco Alcohol: 1. None 2. Minimal 3. Moderate 4. Heavy 5. Previously Heavy Caffeine: 1. None 2. 1-3 servings daily 3. 4-6 servings daily 4. More than 6 servings daily Drug Use: 1. Marijuana 2. Cocaine 3. Crack 4. Heroin 5. Other (list) Family History (Please include history of diabetes, heart disease, hypertension, or cancer) ALIVE/DECEASED AGE HEALTH PROBLEMS/CAUSE OF DEATH Mother Brothers/Sisters	Age	Date	of Birth		Phone Nur	mber			
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Brothers/Sisters	Mother								
	Brothers/Siste	rs							