GREENVILLE HEALTH SYSTEM

Today's Date _____ Patient Name_____ DOB _____

Hospitalization & Surgical History – List all hospital admissions and operations you have had.

	Reason for Hospitalization/Surgery	Year
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

❑ Yes ❑ No Did you have any problems with anesthesia? If yes, please describe.

_____

Social History

❑ Yes ❑ No Do you currently smoke or use other tobacco products? If yes, how many per day? _____

❑ Yes ❑ No Have you smoked or used other tobacco products in the past? If yes, how many per day? _____

How many years since you last smoked? _____

❑ Yes ❑ No Do you drink caffeinated beverages? If yes, what type, how often, how much? _____

❑ Yes ❑ No Do you drink alcohol? If yes, what type, how often, how much? _____

❑ Yes ❑ No Do you exercise regularly? If yes, what type? _____

How often and how long? _____

Family Medical History – Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters), state your relationship and their age at onset.

	Relationship	Age at onset
❑ High Blood Pressure		
❑ High Cholesterol		
❑ Heart Disease		
❑ Stroke		
❑ Migraines		
❑ Seizures/Convulsions		
❑ Diabetes		
❑ Bleeding/Blood-clotting Disorder		
❑ Allergies		
❑ Asthma		
❑ Thyroid Problems		
❑ Osteoporosis		
❑ Psychiatric Disorder/Mental Illness		
❑ Alzheimer's/Dementia		
❑ Cancer - type:		
❑ Other:		