TRANSFUSION SERVICES PATIENT MEDICAL HISTORY QUESTIONS

**Nursing Personnel:** Please complete this form with information directly from the patient or family member if possible. If the patient is unsure of any answer, please write “unsure”.

1. Please list all medications the patient is currently taking (you may attach a printed copy if desired):

   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________

2. **If patient is female**, please list pregnancy history:
   # Live Births______ # Pregnancies______ Date of last pregnancy _________

3. Has the patient ever received a blood transfusion?   Yes _____       No _____
   If Yes or unsure, was it **within the last 3 months**?   Yes _____       No _____
   If Yes, approximately when & where? _________________________________

4. Is the patient actively bleeding?      Yes _____      No _____

5. Please list patient’s current diagnosis and any known diseases: ________________
   ______________________________________________________________________

6. Is the patient scheduled for a surgical procedure?  Yes _____       No _____
   If Yes, what procedure & date? __________________________________________

7. Please state patient’s race (ethnic background) _____________________________

Please FAX this form immediately to the requesting Transfusion Service Department


***This form is not intended for placement in the patient’s chart and is for Transfusion Services use only***