LABORATORY ALLIANCE of Central New York, LLC

Name:_____
MR #:: _____
DOB: _____
Today's Date: _____

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

Crouse: 315-470-7138 St. Joseph's: 315-448-6115 Community General: 315-492-5806

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