Coastal Healthcare

Patient History Form — Completed by Patient

Name:_____ Date of Birth: _____

Reason for Visit: _____

ALLERGIES

1. _____
2. _____
3. _____
4. _____
5. _____

Do you smoke? _____ Packs per day: _____

Do you drink? _____ How often: _____

PAST MEDICAL HISTORY

Please list your significant illnesses and when they were diagnosed.

1. _____
2. _____
3. _____
4. _____
5. _____

PREVIOUS SURGERY

Please provide approximate date.

1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HISTORY

Please list any significant illnesses of your grandparents, parents, siblings, and children.

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Signature: _____ **Date:** _____