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Head and Neck Surgery
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PATIENT HISTORY FORM, SIDE #1

Date_______________

Name______________________________

Family Physician_____________________ Address____

City, State, Zip___________________________________

Referring Physician___________________ Address____

City, State, Zip___________________________________

Allergies to medication____

Latex sensitivity? Yes_____ No_____

Illness____

Operations____

Hospitalizations____

Serious Accidents____

Medications____

Do you take aspirin? Yes_____ No_____ How much?_______________

If female, are you pregnant? Yes_____ No_____

Family Medical History____

Do you smoke? Yes_____ No_____ How much?_______________ How long? _________________________

Quit________ When?_______________

Do you drink alcohol? Yes_____ No_____ How much? ____

Substance use/recreational use? Yes_____ No_____ What? _________ How much?______________________

What is your occupation?____