

# COLUMBUS OTOLARYNGOLOGY CLINIC

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Ear, Nose and Throat  
Head and Neck Surgery  
Facial Plastic Surgery

## **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? \_\_\_\_\_