

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? _____