CRYSTAL COMMUNITY ENT & FACIAL PLASTIC SURGERY
PATIENT HISTORY

TODAY'S DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____/_____/_____

FAMILY DOCTOR: _____ **DR'S PHONE #** _____

PHARMACY: _____ **PHARMACY PHONE #**_____

ENVIRONMENTAL / FOOD ALLERGIES: _____
_____

FAMILY HISTORY

PROBLEM	RELATIONSHIP*
Diabetes	M F S B
Tuberculosis	M F S B
Hay Fever	M F S B
Asthma	M F S B
Heart Disease	M F S B
High Blood Pressure	M F S B
Hearing Loss	M F S B

*__M__other, __F__ather, __S__ister, __B__rother

ENT SURGERIES

- ☐ Tonsils_____
- ☐ Adenoids _____
- ☐ Ear Surgery/ Mastoid _____
- ☐ Nasal sinus/ Septum/ Polyps _____
- ☐ Skin Cancer of Head & Neck _____
- ☐ Head/ Neck Cancer _____
- ☐ Salivary Gland _____

PLEASE LIST ALL OTHER SURGERIES YOU HAVE HAD SINCE BIRTH:

SURGERY	DATE

PLEASE ANSWER THE FOLLOWING QUESTIONS, IF YES PLEASE EXPLAIN.

Have you ever had **DIFFICULTY** with **ANESTHESIA?** **YES** **NO**
If yes explain _____
Have you ever been diagnosed with a **BLEEDING DISORDER?** **YES** **NO**
If yes explain _____
Are you presently under the care of a **CARDIOLOGIST?** **YES** **NO**
If yes explain _____
Name & Phone number of Cardiologist _____

Do you smoke tobacco products?	YES	NO		
If YES what products do you use?				
Cigarettes			_____# Packs per day	_____Years
Cigars or a Pipe?			_____ Per day	_____ Years
Did you ever smoke and quit?	YES	NO	_____# Years Ago _____ # Packs per day	_____Years
Do you chew tobacco or dip?	YES	NO	_____ Years	Quit, how long? _____
Do you drink alcoholic beverages?	YES	NO	Occasionally _____	Frequently _____
Do you use or have you ever used street drugs?	YES	NO	What? _____	How long? _____
Do you drink caffeine products?	YES	NO	What? _____	# Per day _____

COMMENTS / IMPORTANT FACTS FOR THE DOCTOR: _____
_____