PERMANENT HISTORY Patient Name: \_\_\_\_ DOB: Date of **Permanent Diagnosis** Date Location Ear, Nose, & Throat Surgeries Service Date of **Anesthetic Complications** Service Pacemaker? YES NO **Family History General Surgeries** Location Date Allergies: & Hospitalizations Asthma: Bleeding Disorders: Cancer: Cardiovascular: Diabetes: Hearing Loss: Other: **Patient Social History** Occupation: Pregnant? Due Date: Breast Feeding? Started: Do you drink alcohol? How much? Do you smoke or use tobacco? How much? How long?

Have you ever smoked or chewed?

Drug abuse history?