PERMANENT HISTORY

Patient Name: ______________________ DOB: ______________

Date of Service	Permanent Diagnosis

Date of Service	Anesthetic Complications

Family History
Allergies:
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?	

Date	Location	Ear, Nose, & Throat Surgeries
Pacemaker? YES NO		

Date	Location	General Surgeries & Hospitalizations