

JACKSONVILLE OTOLARYNGOLOGY & FACIAL  
PLASTIC SURGERY, P.A.

OFFICE HISTORY FORM

NAME \_\_\_\_\_

D.O.B. \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

PAST MEDICAL/SURGICAL HISTORY: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ALLERGIES: \_\_\_\_\_

CURRENT MEDICATION: (Please include Vitamins, Herbal Supplements, Over-the-Counter products, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

FAMILY HISTORY: (Please include Bleeding disorders, Anesthesia complications)

\_\_\_\_\_  
\_\_\_\_\_

SOCIAL HISTORY: (Tobacco use, Alcohol consumption, Other Drugs)

\_\_\_\_\_

I hereby acknowledge that the above information is complete and accurate to the best of My knowledge \_\_\_\_\_ (Patient/Parent/Guardian)

Doctor Notes: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_