Central Coast
Head and Neck Surgeons

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Monterey Ph (831) 649-4000 • Fax (831) 649-0268
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Medical History

Patient Name: _____ DOB: _____ Age: _____

Height: _____ Weight: _____ Preferred Pharmacy and Location: _____

Referring Physician: _____

Reason for your visit today: _____

Do you have any significant medical conditions (such as high blood pressure, heart disease, diabetes, etc.)?

_____

Drug Allergies (What medications are you allergic to?):

Medication Allergy	Reaction

Current Medications:

Medication	Dose and Directions	Reason

Surgical History:

Surgery (type)	Age or Year	Surgeon (if known)	Facility (if known)

Alcohol/Tobacco Use (please check):

Alcohol Intake:	☐ None	☐ Occasional	☐ Regular	☐ Heavy
Tobacco Use:	☐ None	☐ Occasional	☐ Regular	☐ Heavy

Years smoked:	Packs per day:	If quit, what year?

Family Medical History (list any medical conditions such as high blood pressure, heart disease, diabetes, etc.):

Maternal side:	Paternal side:
Brother(s):	Sister(s):