

Patient Number: _____
Name: _____
Date of Birth: _____

Cumberland Otolaryngology Date _____
Consultants, P.S.C.
Kevin T. Kavanagh, M.D., F.A.C.S.

GENERAL INFORMATION

Reason for Visit: _____
Height _____ Weight _____ Referring Physician _____
Occupation _____ Your Family Physician _____

PERSONAL HISTORY

Do you have (or have you had) any health problems with?

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urinary or Kidney | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Eye disorder or
Glaucoma | <input type="checkbox"/> Asthma, lung disease,
persistent cough |
| <input type="checkbox"/> Diabetes, Thyroid or
other Endocrine. | <input type="checkbox"/> Gastrointestinal
(Stomach Problems) | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Musculoskeletal or
Arthritis | <input type="checkbox"/> Nerves (Psychiatric) | <input type="checkbox"/> Immunological |
| <input type="checkbox"/> Other (if other is checked, please list):

_____ | <input type="checkbox"/> Neurological | <input type="checkbox"/> Blood Problems |
| | | <input type="checkbox"/> Cancer |
| | | <input type="checkbox"/> Pacemaker |
| | | <input type="checkbox"/> Hepatitis |
| | | <input type="checkbox"/> Bleeding problems |

Are you allergic to: Penicillin Iodine Tetracycline Insect bites
 Sulfa Novocain Codeine Stings
 Other (medicine, food, inhalants, etc.) _____

Please list any previous surgeries:

_____	Age _____
_____	Age _____
_____	Age _____
_____	Age _____

Please list the REASONS for any other previous hospitalizations:

_____	Age _____
_____	Age _____
_____	Age _____
_____	Age _____

Any complications? _____

Social History

Occupation/School _____ Marital Status _____

Have you ever smoked cigarettes? Yes No
How long? _____ Packs per day? _____ Do you still smoke? Yes No
When started _____ When stopped _____

Do you chew tobacco? Yes No How long? _____

Do you drink alcohol? Yes No How much per day? _____

Family History

Are there any medical problems in your family? Yes No

If yes, please list

-