Patient Number: ___________________
Name: ____________________________
Date of Birth: ______________________

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

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?

☐ High blood pressure
☐ Heart disease
☐ Diabetes, ☐ Thyroid or ☐ other Endocrine.
☐ Musculoskeletal or Arthritis
☐ Other (if other is checked, please list):
____
____
____

☐ Urinary or ☐ Kidney
☐ Eye disorder or
☐ Glaucoma
☐ Reflux disease
☐ Gastrointestinal (Stomach)
☐ Nerves (Psychiatric)
☐ Neurological

☐ Allergies
☐ Asthma, lung disease, ☐ persistent cough
☐ AIDS
☐ Immunological
☐ Blood Problems
☐ Cancer
☐ Pacemaker
☐ Hepatitis
☐ Bleeding problems

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

Please list the REASONS for any other previous hospitalizations:
__________________________ Age________
__________________________ Age________
__________________________ Age________
__________________________ Age________
Any complications?____

Please list any previous surgeries:
__________________________ Age________
__________________________ Age________
__________________________ Age________
__________________________ Age________

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 Much Per Day? ________ How long? _______________
Do you drink alcohol? ☐ Yes ☐ No How much per day?_________ How long? _______________

Family History

Are there any medical problems in your family? ☐ Yes ☐ No
If yes, please list
____

Please list current medications including mg and dosage amount:

Medication Name	Mg (Strength of Medication)	Dosage per Day

Allergic To:____