Kinston Head & Neck Physicians and Surgeons

Date: _____ **Name:** _____ **DOB:** _____

Please List Any Surgeries you have had in the past:

_____

_____

_____

Height: _____ **Weight:** _____

Do you have trouble with any of the following medical problems:

	NO	YES
Abdominal Pain		
Altered Taste or Smell		
Anemia		
Arthritis		
Asthma		
Chest Pain		
Diabetes		
Difficulty Swallowing		
Enlarged Lymph Glands		
Fever		
Glaucoma		
Hay Fever		
Heart Attack		

	NO	YES
Hepatitis		
High Blood Pressure		
HIV		
Hives		
Kidney Stones		
Muscle Weakness		
Prostate		
Seizures		
Shortness of Breath		
Stomach Ulcer		
Visual Change		
Vomiting		
Weight Loss		

Family Medical History

- ☐ Allergies
- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Stroke
- ☐ Tuberculosis

Social History:

- ☐ Alcohol use
- ☐ Tobacco use
- ☐ Other: _____

Drug Allergies:

_____

_____

_____

_____

_____

In the past year have you had any of the following:

_____ Flu Vaccine

_____ Pneumonia vaccine

Current Medications

Medication: _____ Dosage: _____ How Often: _____

Medication: _____ Dosage: _____ How Often: _____

Medication: _____ Dosage: _____ How Often: _____

Medication: _____ Dosage: _____ How Often: _____

Medication: _____ Dosage: _____ How Often: _____

Medication: _____ Dosage: _____ How Often: _____

Medication: _____ Dosage: _____ How Often: _____

Medication: _____ Dosage: _____ How Often: _____

I authorize Kinston Head & Neck Physicians and Surgeons, P.A. to furnish information to insurance carriers concerning my illness and treatments. I authorize insurance payments directly to the physician. I understand I am responsible for any amount not covered by insurance.

Signature: _____ **Date:** _____