Giulio Cavalli, M.D.
195 South Street
Pittsfield, MA 01201

PATIENT INFORMATION

Name _____ Address _____

City_____State_____ZipCode_____Telephone#_____

Mobile Telephone#_____Work Telephone #_____

Social Security#_____Date of Birth_____Sex_____Referred By_____

Parent/Guardian (if minor)_____Address_____

Employer_____

MEDICAL INFORMATION

Reason for visit:_____

Primary Care Physician_____Work related_____Date of injury_____

Motor vehicle accident_____ Date of injury_____

INSURANCE INFORMATION

Insurance company_____ID#_____

Subscriber name_____Date of birth_____SS#_____

Employer_____Address_____

Secondary insurance_____ID#_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize and direct my insurance company to pay Giulio Cavalli, MD, PC any benefits due to me under the terms of my policy.

Insured signature_____Date_____

I AM AWARE THAT IF MY INSURANCE COMPANY DOES NOT MAKE FULL PAYMENT, I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES. IF I AM NOT COVERED BY INSURANCE, I WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF THE VISIT.

Patient signature_____Date_____

Name:_____ DOB:_____

Please list any medications or supplements that you may be taking:

Medication & Allergies

Medication	Dosage/ How often											

Please list any Allergies that you might have:

Medication Allergy	Reaction	Date of onset (if known)	Medication Allergy	Reaction	Date of onset (if known)

Food Allergy:_____

Environmental Allergy:_____

Pharmacy:_____

Mail away pharmacy
(if you have one)_____

Giulio Cavalli, M.D.,P.C.
Medical History

NAME_____

Date of Birth_____ Date_____

Present Illness_____

PERSONAL HISTORY:

Medical: Please list any personal history of the following:

Diabetes____ Asthma____ Arthritis____ Heart Problems____ Cancer____

Cancer____ Tuberculosis____ High Cholesterol____ High/Low BloodPressure____

Other_____

Height_____ Weight_____

Surgeries: Please list **ANY SURGERY** you have had, year of surgery (if you can recall), and if you had any problems with surgery, anesthesia or bleeding.

Surgery	Date	Issue with Anesthesia/Bleeding

Habits:

Tobacco- Have you ever smoked_____ Do you now smoke any form of tobacco product_____
Type of tobacco product: Cigarette_____ Cigar_____Pipe_____ Chewing Tobacco_____

Please indicate how much you smoke:_____a day or _____ a week

How long you have been smoking:_____

If you quit please indicate how much you smoked prior to quitting:_____
(example- 1 pack per day X 20 years)

When you quit:_____

Alcohol- Do you drink alcoholic beverages_____ If so how often_____ How much_____

Name_____ Date of Birth_____

Review of Systems-

Fever														
Chills														
Weight Loss														
Weight Gain														
Blurred Vision														
Double Vision														
Poor Vision														
Glasses														
Ringing in Ears														
Hearing Loss														
Discharge from Ears														
Nasal Congestion														
Sinus Congestion														
Sinus Headache														
Sneezing														
Hoarseness														
Sore Throat														
Trouble Swallowing														
Snoring/Apnea														
Chest Pain														
Irregular Heartbeat														
Palpitations														
Cough														
Shortness of Breath														
Difficulty Breathing														
Heartburn														
Bloody Stools														
Constipation														
Diarrhea														
Urinary Burning														
Frequent Urination														
Incontinence														

Name:_____ DOB:_____

Joint Pain														
Muscle Weakness														
Joint Stiffness														
Masses														
Sores														
Rashes														
Scars														
Tremors														
Numbness														
Dizziness														
Depression														
Mood Swings														
Anxiety														
Hair Loss														
Excessive Thirst														
Fatigue														
Leg Swelling														
Bleeding Tendency														
Bruise Easily														
Pregnant														
Birth Control Pills														
Hormone Therapy														
Menopausal														

Other:_____

Family History: Please list any family history of the following and specify the relationship to you (mother, father, sister, brother, ect.)

Cancer_____ Diabetes_____ Heart Problems_____

Respiratory Problems_____ Kidney Problems_____

Other_____

I certify that the above information is correct to the best of my knowledge and will not hold my doctor or members of his staff responsible for any error or ommision that I may have made in the completion of this form.

Patient Signature_____ Physician Signature_____

Name: Birthdate:

	yes	no
Have you worked in a noisy environment without the regular use of earplugs or other hearing protection?		
Have you had a hearing test in the past 5 years?		
Do you wear a hearing aid?		
Do you have a blood relative with a hearing loss?		

Please mark the column that best describes the frequency with which you experience each situation or feeling listed below.	Almost always (3)	Half the time (2)	Occasionally (1)	Never (0)
I have a problem hearing over the telephone				
I have trouble following the conversation when two or more people are talking at the same time.				
I have trouble understanding things on TV.				
I have to strain to understand conversations				
I have to worry about missing a telephone ring or doorbell				
I have trouble hearing conversations in a noisy background such as a crowded room or restaurant				
I get confused about where sounds come from				
I misunderstand some words in a sentence and need to ask people to repeat themselves				
I especially have trouble understanding the speech of women and children				
I have trouble understanding the speaker in a large room such as a meeting or a church				
Many people I talk to seem to mumble. (or don't speak clearly)				
People get annoyed because I misunderstand what they say				
I misunderstand what others are saying and make inappropriate responses				
I avoid social activities because I cannot hear well and fear I will reply improperly				
Family members and friends have told me they think I may have a hearing loss.				

For office use only
Total score: