# CUMBERLAND VALLEY EAR, NOSE, & THROAT CONSULTANTS

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## YEARLY MEDICAL HISTORY UPDATE

First Name: _____ MI: ____ Last Name: _____

**Date of Last Visit:**_____

Any new medical problems since your last visit? ☐ No ☐ Yes if yes, please list:

_____ _____
_____ _____
_____ _____

Any new medication allergies since your last visit? ☐ No ☐ Yes If yes, please list:

_____ _____
_____ _____

Have you had a flu shot in the past year? ☐ No ☐ Yes If yes, please give date: ____

Have you ever had a pneumonia shot? ☐ No ☐ Yes If yes, please give year: ____

List **ALL** medications you are currently taking. (Or give list to nurse)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any new surgeries since your last visit? ☐ No ☐ Yes If yes, please list:

_____ _____
_____ _____

Please list your preferred pharmacy:

| | Pharmacy Name | Street | City & State |
|---|---|---|---|
| Local Pharmacy | _____ | _____ | _____ |
| Mail Order Pharmacy | _____ | _____ | _____ |