CUMBERLAND VALLEY EAR, NOSE, & THROAT CONSULTANTS

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PATIENT SELF HISTORY SHEET

Name: _____ **SEX: MALE / FEMALE** Last 4 SS# _____

Who Referred you to CVENT? **(choose one)**
☐ Family Dr Name: _____ ☐ UC Dr Name _____
☐ ER Dr Name: _____ ☐ Self Referred

Main Reason for today's visit: (**Describe in ONE Sentence)**: _____

_____

Location (Where is the problem?): _____

Date symptom(s) began: _____

Frequency of Symptoms: ☐ Constant ☐Intermittent ☐ Occasional ☐ Rare

Intensity of Symptoms: ☐ Mild ☐ Moderate ☐ Severe

How did symptoms start? ☐ Gradual ☐ Suddenly

Associated Symptom(s): _____

_____

Have you taken any medications for this problem? ☐ No ☐ Yes, if so please list:

_____

Have you had any Labs, X-Ray, CT, MRI or Ultrasounds for this problem? ☐ No ☐ Yes, if so what test(s) & where

_____

HEARING HEALTH CARE

Hearing Loss? YES or NO (If yes…) **Which Ear?** ☐ Right ☐ Left ☐ Both

Family History of Hearing Loss? ☐ Mother ☐ Father ☐ Siblings ☐ Grandparents ☐ None

Tinnitus ("Ringing Noise in Ears") ☐ **Which Ear?** ☐ Right ☐ Left ☐ Both
How long? _____ yrs. _____ mos.

Exposure to Noise Trauma ☐ Concerts ☐ Jet Engines ☐ Firearms ☐ Musical Instruments
☐ Other: _____

PHARMACIES:

Please list your preferred pharmacy.

	Pharmacy Name	Street Name	City, State
Local Pharmacy	_____	_____	_____
Mail Order Pharmacy	_____	_____	_____

PAST/PRESENT MEDICAL HISTORY:

Please check any ongoing medical conditions that you have already been diagnosed by doctors, including serious illness of the past. DO NOT check any problems which have not yet been addressed by a doctor.

☐ No Past/Present Medical Hx
☐ Acid Reflux
☐ Alcoholism
☐ Alzheimer's Disease
☐ Anemia
☐ Anxiety
☐ Arthritis/ Rheumatoid
☐ Asthma
☐ Atrial Fibrillation
☐ Bipolar Disorder
☐ Cancer (Year:_____)
Type: _____
☐ COPD
☐ Coronary Artery Disease
☐ Degenerative Disc Disease
☐ Depression
☐ Diabetes Type I(Insulin Dep)
☐ Diabetes Type II(Non-Insulin)
☐ Drug Abuse
☐ Eczema
☐ Emphysema
☐ Fibromyalgia
☐ Glaucoma
☐ Hearing Loss
☐ Heart Failure (Congestive)
☐ Heart Attack(Year:_____)
☐ Hepatitis
(Circle:) A B C
☐ High Blood Pressure
☐ High Cholesterol
☐ High Triglycerides
☐ HIV
☐ Kidney Disease
☐ Macular Degeneration
☐ Migraine/Headaches
☐ Obesity
☐ Osteoporosis
☐ Panic Disorder
☐ Prostate Enlargement
☐ Seasonal Allergies
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke (Year:_____)
☐ Thyroid Problems
☐ TIA (Year: _____)
☐ Other: _____
_____

ALLERGIES:

Latex Allergy: _____ No _____ Yes (if yes, list reaction) _____
Drug Allergies: _____ No _____ Yes (if yes, list **drug** and type of **reaction** below)

_____ _____
_____ _____
_____ _____

IMMUNIZATIONS:

Have you received an Influenza Vaccine this year? □ No □ Yes (Date: _____)
Have you ever received a Pneumonia Vaccine? □ No □ Yes (Date: _____)

FAMILY HISTORY:

Please check any medical conditions/diseases in your IMMEDIATE family. These should be serious illnesses of mother, father, or siblings. Please indicate beside the illness, **F=Father**, **M= Mother**, **B= Brother, S= Sister**

□ No Known Family History
□ Alcoholism _____
□ Alzheimer's Disease _____
□ Arthritis _____
□ Asthma _____
□ Bleeding Disorder _____
□ Cancer (Type): _____
□ Congestive Heart Failure _____
□ Depression _____
□ Diabetes _____
□ Emphysema _____
□ Glaucoma _____
□ Heart Disease _____
□ High Cholesterol _____
□ Hypertension _____
□ Kidney Disease _____
□ Migraine Headaches _____
□ Osteoporosis _____
□ Parkinson's Disease _____
□ Thyroid Problems _____
□ Unknown
□ Other _____
_____

SOCIAL HISTORY:

Do you smoke or use tobacco products?				Amount	Duration
Cigarettes	□ Never	□ Currently	□ Previously	_____	_____
Chews	□ Never	□ Currently	□ Previously	_____	_____
Cigar	□ Never	□ Currently	□ Previously	_____	_____
Pipe	□ Never	□ Currently	□ Previously	_____	_____
Dips Snuff	□ Never	□ Currently	□ Previously	_____	_____
Vape	□ Never	□ Currently	□ Previously	_____	_____

Do family members smoke/vape outside? □ No □ Yes
Do family members smoke/vape inside? □ No □ Yes

Do you drink alcohol beverages? □ No □ Yes, if so, how many drinks per week: _____,

Have you ever used recreational/illicit drugs?

Marijuana	□ Never	□ Currently	□ Previously
Heroin	□ Never	□ Currently	□ Previously
Cocaine	□ Never	□ Currently	□ Previously

Marital Status:

□ Single □ Married □ Widowed □ Divorced □ Separated

Employment:

□ Full Time □ Part Time □ Disabled □ Retired □ Student □ Unemployed

Occupation: _____

Do you have animals in your home? □ No □ Yes If yes, what type? _____

Is Daycare used? □ No □ Yes

SURGICAL HISTORY:

Please check ANY surgeries you have had in your lifetime.

□ No Previous Surgery	□ Coronary Artery Bypass Year: _____	□ Lobectomy (removal of lung/ all or part)	□ Prostatectomy
			□ Septoplasty
□ Adenoidectomy	□ Defibrillator (Placement)	□ Lumpectomy	□ Sinus Surgery: Year & Where: _____
□ Appendectomy	□ Ear Drum Repair	□ Mastectomy	
□ Back Surgery (Disc)	□ Ear Tubes	□ Mastoidectomy	□ Skin Biopsy
□ Breast Biopsy	□ Gallbladder	□ Nephrectomy (kidney removal)	□ Splenectomy
□ Cardiac Pacemaker	□ Herniorrhaphy (Hernia)		□ Thyroidectomy
□ Cardiac Stenting	□ Hip Replacement	□ Oophorectomy	□Tonsillectomy
□ Carotid Endarterectomy	□ Hysterectomy	□ Oral Surgery	□ Other:
□ Cataract	□ Knee Arthroscopy	□ Ovarian Cyst	_____
□ Colectomy (Partial/Complete Removal of Colon	□ Knee Replacement	□ Prostate – Biopsy	_____

MEDICATIONS:

Please list all MEDICATIONS including supplements, herbals, CBD products and/or medical marijuana usage.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

REVIEW OF SYSTEMS:

GENERAL	SKIN	HEENT	NECK
□ Fever	□ Skin Rashes	□ Headaches	□ Swollen Glands
□ Chills	□ Itchy Skin	□ Voice Changes	□ Neck Mass
□ Night Sweats	□ Bruising	□ Blindness	
□ Weight Gain/ Loss			□ None
□ None	□ None	□ None	
RESPIRATORY	**CARDIOVASCULAR**	**GASTRO-INTESTINAL**	**NEUROLOGICAL**
□ Cough	□ Irregular Heartbeats	□ Abdominal Pain	□ Seizures
□ Shortness of Breath	□ Chest Pains	□ Nausea	□ Fainting
□ Wheezing	□ Blood Clots	□ Vomiting	□ Disorientation
		□ Reflux	
□ None	□ None	□ None	□ None
PSYCHIATRIC	**ENDOCRINE**		
□ Anxiety	□ Diabetes		
□ Excessive Stress	□ Thyroid Problems		
□ Panic Attacks	□ Excessive Urination		
□ Depression			
□ None	□ None		