CUMBERLAND VALLEY EAR, NOSE, & THROAT CONSULTANTS

Angela C. Stonebraker, MD
A.Christopher Manilla, DO
Michelle Garrett, AuD, CCC-A, FAAA
Margaret T. Eackles, AuD, CCC-A
Jennifer L. Campbell, AuD, CCC-A

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: _____

<u>PHARMACIES</u>:

Please list your preferred pharmacy.

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

Drug Allergies: _____ No Yes (if yes, list reaction) _____

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	☐ COPD	☐ Heart Failure (Congestive)	☐ Osteoporosis
☐ Acid Reflux	☐ Coronary Artery Disease	☐ Heart Attack(Year:_____)	☐ Panic Disorder
☐ Alcoholism	☐ Degenerative Disc Disease	☐ Hepatitis	☐ Prostate Enlargement
☐ Alzheimer's Disease	☐ Depression	(Circle:) A B C	☐ Seasonal Allergies
☐ Anemia	☐ Diabetes Type I(Insulin Dep)	☐ High Blood Pressure	☐ Seizure Disorder
☐ Anxiety	☐ Diabetes Type II(Non-Insulin)	☐ High Cholesterol	☐ Sleep Apnea
☐ Arthritis/ Rheumatoid	☐ Drug Abuse	☐ High Triglycerides	☐ Stomach Ulcers
☐ Asthma	☐ Eczema	☐ HIV	☐ Stroke (Year:_____)
☐ Atrial Fibrillation	☐ Emphysema	☐ Kidney Disease	☐ Thyroid Problems
☐ Bipolar Disorder	☐ Fibromyalgia	☐ Macular Degeneration	☐ TIA (Year: _____)
☐ Cancer (Year:_____) Type: _____	☐ Glaucoma ☐ Hearing Loss	☐ Migraine/Headaches ☐ Obesity	☐ Other: _____ _____

ALLERGIES:

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	□ Depression _____	□ Migraine Headaches _____
□ Alcoholism _____	□ Diabetes _____	□ Osteoporosis _____
□ Alzheimer's Disease _____	□ Emphysema _____	□ Parkinson's Disease _____
□ Arthritis _____	□ Glaucoma _____	□ Thyroid Problems _____
□ Asthma _____	□ Heart Disease _____	□ Unknown

□ Bleeding Disorder _____ □ High Cholesterol _____ □ Other _____

□ Cancer (Type): _____ □ Hypertension _____ _____

□ Congestive Heart Failure _____ □ Kidney Disease _____

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:
□ Appendectomy	□ Ear Drum Repair	□ Mastectomy	Year & Where: _____
□ Back Surgery (Disc)	□ Ear Tubes	□ Mastoidectomy	□ Skin Biopsy
□ Breast Biopsy	□ Gallbladder	□ Nephrectomy (kidney removal)	□ Splenectomy
□ Cardiac Pacemaker	□ Herniorrhaphy (Hernia)		□ Thyroidectomy

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

□ Cardiac Stenting

□ Carotid Endarterectomy

□ Cataract

□Colectomy (Partial/Complete Removal of Colon

□ Hip Replacement

□ Hysterectomy

□ Knee Arthroscopy

□ Knee Replacement

□ Oophorectomy

□ Oral Surgery

□ Ovarian Cyst

□ Prostate – Biopsy

□Tonsillectomy

□ Other:

_____

_____

MEDICATIONS:

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

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

REVIEW OF SYSTEMS: