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

_____

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: _____)

SOCIAL HISTORY:

Do you smoke or use tobacco products? ☐ No ☐ Yes

Do you drink alcohol beverages ☐ No ☐ Yes

Employment:

☐ Full Time ☐ Part Time ☐ Disabled ☐ Retired ☐ Student ☐ Unemployed

Occupation: _____

SURGICAL HISTORY:

Please check **ANY** surgeries you have had in your lifetime.

☐ No Previous Surgery

ENT Related:
- ☐ Adenoidectomy
- ☐ Ear Drum Repair
- ☐ Ear Tubes
- ☐ Mastoidectomy
- ☐ Septoplasty
- ☐ Sinus Surgery:

Year & Where_____
- ☐ Tonsillectomy

- ☐ Appendectomy
- ☐ Back Surgery (Disc)
- ☐ Breast Biopsy
- ☐ Cardiac Pacemaker
- ☐ Cardiac Stenting
- ☐ Carotid Endarterectomy
- ☐ Cataract
- ☐ Colectomy
- ☐ Coronary Artery Bypass

Year: _____
- ☐ Defibrillator
- ☐ Gallbladder
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Hysterectomy
- ☐ Knee Arthroscopy
- ☐ Knee Replacement
- ☐ Lobectomy
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Nephrectomy (kidney removed)
- ☐ Oophorectomy
- ☐ Oral Surgery
- ☐ Ovarian Cyst
- ☐ Prostate – Biopsy
- ☐ Prostatectomy
- ☐ Skin Biopsy
- ☐ Splenectomy
- ☐ Thyroidectomy
- ☐ Other: _____

_____

_____

_____

MEDICATIONS:

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

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PHARMACIES:

Please list your preferred pharmacy.

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