CUMBERLAND VALLEY EAR, NOSE, & THROAT CONSULTANTS

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PATIENT SELF HISTORY SHEET

Date: _____

First Name: _____ MI: _____ Last Name: _____

SEX: MALE / FEMALE

Who told you to see us today? □ Family Doctor: (Dr Name):_____ □ ER/ Urgent Care □ Self □ Other

Chief Complaint (**briefly** describe): _____

Location (Where is the problem?): _____

Date symptoms(s) began: _____

Frequency of Symptoms: □ _____x per day □ _____x per week □_____x per month □_____x per year

□ Constant □ Intermittent □ Occasional □ Rare □ Recurrent □ Other

Intensity of Symptoms: □ Mild □ Moderate □ Severe □ Other: _____

How did symptoms start? □ Gradually □ Suddenly □ Other: _____

How long do symptoms last? _____

What brings it on? _____

What makes it worse? _____

What relieves it? _____

Associated Symptom(s): _____

_____

If symptoms include pain, check the one(s) that best describe the kind of pain:

□ Aching □ Continuous □ Deep □ Gnawing □ Intermittent □ Periodic □ Shifting □ Sudden □ Mild

□ Burning □ Cramping □ Dull □ Gradual □ Moderate □ Sharp □ Stabbing □ Superficial □ Other : _____

Any prior treatment by another physician for this problems? □ No □ Yes, if so please explain:

_____

Any prior test(s) ordered by another physician for this problems? □ No □ Yes, if so what test(s).

_____

For Office Use Only:
Weight: **Height:**

Name: _____ **Date:** _____

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 History
□ Acid Reflux (530.81)
□ Alcoholism (305.00)
□ Alzheimer's Disease (294.1)
□ Anemia (285.9)
□ Anxiety (300.00)
□ Arthritis (715)
□ Asthma (493)
□ Atrial Fibrillation (427.31)
□ Bipolar Disorder (296.40)
□ Cancer
Type: _____
Year: _____
□ Carpal Tunnel Syndrome (354)
□ Cataracts (366)
□ Chronic Constipation (564.00)
□ Coronary Artery Disease (414.00)
□ Degenerative Disc Disease (722.22)
□ Depression (311)
□ Diabetes Type I (250.1)
□ Diabetes Type II (250.0)
□ Drug Abuse (305.90)
□ Eczema (692.9)
□ Emphysema (492)
□ Erectile Dysfunction (607.84)
□ Fibromyalgia (729.1)
□ Glaucoma (492)
□ Hearing Loss (389.9)
□ Heart Failure (Congestive) (428.0)
□ Heart Attack (410)
Year:_____
□ Hemorrhoids (455)
□ High Blood Pressure (401.1)
□ High Cholesterol (272.0)
□ High Triglycerides (272.1)
□ Irritable Bladder (596.59)
□ Irritable Bowel Syndrome (564.1)
□ Kidney Stones (274.11)
□ Macular Degeneration (362.50)
□ Migraine Headaches (346)
□ Obesity (278.0)
□ Overactive Thyroid (240.0)
□ Panic Disorder (300.21)
□ Prostate Enlargement (600)
□ Seasonal Allergies (477.0)
□ Seizure Disorder (345)
□ Sleep Apnea (786.03)
□ Stomach Ulcers (533.9)
□ Stroke (434.91)
Year:_____
□ Tension Headaches (784.00)
□ Transient Ischemic Attack (435.9) Year: _____
□ Underactive Thyroid (244.9)
□ 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 (if yes, when did you receive it) Date: _____
Have you ever received a Pneumonia Vaccine? □ No □ Yes (if yes, when did you receive your last one) Date: _____

FAMILY HISTORY:

Please check any medical conditions/diseases in your 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
□ Abdominal Aortic Aneurysm _____
□ Alcoholism _____
□ Alzheimer's Disease _____
□ Arthritis _____
□ Asthma _____
□ Cancer (Breast) _____
□ Cancer (Colon) _____
□ Cancer (Lung) _____
□ Cancer (Ovarian) _____
□ Cancer (Prostate) _____
□ Cataracts _____
□ Cirrhosis _____
□ Congenital Heart Disease _____
□ Congestive Heart Failure _____
□ Depression _____
□ Diabetes _____
□ Emphysema _____
□ Glaucoma _____
□ Gout _____
□ Heart Disease _____
□ Hemophilia (Bleeding Disorder) _____
□ High Cholesterol _____
□ Hypertension _____
□ Kidney Failure _____
□ Kidney Stones _____
□ Migraine Headaches _____
□ Osteoporosis _____
□ Overactive Thyroid _____
□ Parkinson's Disease _____
□ Underactive Thyroid _____
□ 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	_____	_____

Name: _____ **Date:** _____

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

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

Have you ever used recreational 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

MEDICATIONS:

Please list all MEDICATIONS, their dosage, and other pills that you take including supplements and herbals:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SURGICAL HISTORY:

Please check ANY surgeries you have had in your lifetime.

□ No Previous Surgery	□ C-Section	□ Laparoscopy (incision into the abdomen)	□ Splenectomy (Removal of Spleen
□ Adenoidectomy	□ D & C	□ Lithotripsy (crushing stone in urinary bladder)	□ Thyroidectomy
□ Appendectomy	□ Defibrillator (Placement)	□ Lobectomy (removal of lung/ all or part)	□Tonsillectomy
□ Back Surgery (Disc)	□ Delivery (Vaginal)	□ Lumpectomy	□Tonsils & Adenoids
□ Breast Augmentation	□ Ear Drum Repair	□ Mastectomy	□ Tubal Ligation
□ Breast Biopsy	□ Ear Tubes	□ Mastoidectomy	□ TURP
□ Breast Reduction	□ Fulguration of Endometriosis Surgery	□ Nephrectomy (kidney removal)	□ Vasectomy
□ Bunionectomy (foot)	□ Gallbladder	□ Oophorectomy (removal of ovary)	□ Other: _____
□ Cardiac Pacemaker	□ Hammer Toe	□ Oral Surgery	_____
□ Cardiac Stenting	□ Hemorrhoidectomy	□ Ovarian Cyst	_____
□ Carotid Endarterectomy	□ Herniorrhaphy (Hernia)	□ Plantar Wart	_____
□ Carpal Tunnel Release	□ Hip Replacement	□ Prostate – Biopsy	_____
□ Cataract	□ Hysterectomy (removal of uterus)	□ Prostatectomy (Removal of Prostate)	_____
□ Cervical Cone Biopsy	□ Laparoscopically Assisted Vaginal Hysterectomy	□ Salpingoophorectomy (Removal of tubes and ovaries)	_____
□ Colectomy (Partial/Complete Removal of Colon	□ Knee Arthroscopy	□ Septoplasty	_____
□)Colonoscopy	□ Knee Replacement	□ Sinus Surgery	_____
□ Coronary Artery Bypass Year: _____	□ Laminectomy	□ Skin Biopsy	_____

Name: _____ **Date:** _____

REVIEW OF SYSTEMS:

GENERAL	SKIN	HEENT	NECK
□ Fever □ Chills □ Night Sweats □ Weight Gain □ Unexplained Weight 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		

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	_____	_____	_____