



## Patient Intake Forms

Patient name: \_\_\_\_\_ Referring MD: \_\_\_\_\_

DOB: \_\_\_\_\_

### (Pre) BALANCE & DIZZINESS QUESTIONNAIRE

Your appointment is scheduled for \_\_\_\_\_

What has been done for your dizziness/imbalance thus far? (Doctors/Clinics & Dates)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### MEDICAL HISTORY:

- Circulatory/Vascular
  - \_ Diabetes
- Stroke/neurological condition
  - \_ Seizures/convulsions
- Loss of consciousness
  - \_ Trauma or blow to the head
- Kidney Disease
- Cardiac/Heart Disease
  - \_ High \_ Low blood pressure
- Pain in shoulders or neck
 

Orthopedic conditions:
- Surgeries
 

Type:

- Ear infections (please specify)
  - \_ recent \_ past \_ childhood
- Headaches (please specify)
  - \_ recent \_ past \_ migraines
- Vision
  - \_ Glaucoma \_ Other \_\_\_\_\_
  - \_ Cataracts-R \_ Cataracts-L
- Corrected with:
  - \_ surgery
  - \_ monofocals \_ bifocals \_ trifocals
- Dizziness/Vertigo
  - \_ recent \_ past \_ motion sickness
  - \_ family history
- Flu/Virus (please specify)
- Cancer
 

Type:

Please list current medications: \_\_\_\_\_

Please list any medication(s) you have tried in past for balance problem: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you had any recent changes in your ears?

	Right	Left	Both
Distortion in hearing?			
Difficulty hearing?			
Pressure/pain in your ears?			
Drainage from your ears?			
Noise in your ears?			
Describe:			



## Patient Intake Forms

### PERSONAL HABITS:

Average hours of sleep each night? \_\_\_\_\_

Caffeine intake (coffee, tea, soda) \_\_\_\_\_ cups/glasses per day

Alcohol intake \_\_\_\_\_ drinks per day

Recreational or illicit drug use \_\_\_\_\_

Tobacco use \_\_\_\_\_ pack(s) per day

Aerobic exercise \_\_\_\_\_ times per week

Exposure to loud noises? \_\_\_\_\_

Exposure to toxic substances? \_\_\_\_\_

### SYMPTOMS:

When did you first notice a problem with your imbalance/dizziness? (Please give a date)

\_\_\_\_\_

Please describe your original onset of imbalance/dizziness. (lightheaded, swimmy, disoriented, spinning, tumbling, rocking, tilted, giddy)

\_\_\_\_\_

Has this changed since the problem began? If so, how would you describe it now?

\_\_\_\_\_

Prior to experiencing these symptoms, what was your level of function?

- Independent with all activities
- Needed minimal assistance with activities of daily living
- Needed moderate assistance with activities of daily living
- Needed total assistance with activities of daily living

Rate your current symptoms:

Dizziness:

No symptoms [ \_ 1 \_ 2 \_ 3 \_ 4 \_ 5 \_ 6 \_ 7 \_ 8 \_ 9 \_ 10 ] Severe symptoms

Imbalance:

No symptoms [ \_ 1 \_ 2 \_ 3 \_ 4 \_ 5 \_ 6 \_ 7 \_ 8 \_ 9 \_ 10 ] Severe symptoms

Are your symptoms: \_ constant \_ occurring in attacks \_ with warning \_ without warning

If you have dizziness/imbalance in between your attacks, describe

\_\_\_\_\_

When was your last attack/episode? \_\_\_\_\_

How often do the attacks occur? \_\_\_\_\_

How long do they last? \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

Have you had difficulty speaking?  Yes  No

Have you had numbness of the hands, feet, mouth, or face?  Yes  No



## Patient Intake Forms

**HEADACHE**

Do you have frequent headaches? \_\_\_\_\_

Is the pain worst usually on one/both sides of the head? \_\_\_\_\_

Is it always on the left/right side? \_\_\_\_\_

Are your headaches associated with nausea/vomiting/dizziness? \_\_\_\_\_

Do any foods or drinks cause your headache? \_\_\_\_\_

How often do you take medication for headaches? (daily/ per week/ per month ) \_\_\_\_\_

How long do your headaches last? \_\_\_\_\_

When did you first start getting headaches? \_\_\_\_\_

Are headaches related to your menstrual cycle? \_\_\_\_\_

Have you been diagnosed with migraine headaches? \_\_\_\_\_

PRIOR TESTING	Yes	No	Normal	Abnormal
Audiogram (Hearing test)?				
MRI with injection of the brain?				
MRI of the neck?				
Electronystagmography (ENG/VNG)?				
Electrocochleography (ECoG)?				
Electroencephalography (EEG)?				
ABR/BSER?				
Tilt table test?				
Rotational chair testing?				
Lumbar puncture (spinal tap)?				
Platform posturography?				
Ultrasound study (for blood flow)?				
Blood tests for:				
Syphilis?				
Lyme disease?				
Thyroid function?				
HIV?				
Blood count (anemia)?				
Other?				



## Patient Intake Forms

Does looking up increase your problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Does bending over increase your problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Does turning over in bed increase your problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have trouble getting into/out of bed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do they occur in any other positions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Have you had any recent changes in your vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
	<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Double vision	<input type="checkbox"/> Other

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Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have difficulty reading?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Is it difficult for you to concentrate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you have difficulty in any of the following activities?	<input type="checkbox"/> church	<input type="checkbox"/> car –driver	<input type="checkbox"/> car-passenger
Do you find yourself more tired/fatigued?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Have you ever stumbled or fallen because of your symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes

\_\_\_\_\_How often? \_\_\_\_\_Which direction do you fall?

<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Front	<input type="checkbox"/> Back
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Do quick movements of your head increase your problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Does performing more ambitious activities like sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Is it difficult for you to walk by yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Does walking down a sidewalk increase your problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Is it difficult for you to walk around your house in the dark?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes

Because of your problem:

Do you feel frustrated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you feel handicapped?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometime
Are you afraid to leave your home without someone to accompany you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Are you embarrassed in front of others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Are you afraid people may think you are intoxicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Are you afraid to stay home alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Are you depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Interfere with your job or household responsibilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Place stress on your relationships with family or friends?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you avoid heights?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you restrict your participation in social activities such as going out to dinner, dancing or to parties?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
Do you restrict your travel for business or recreation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes



## Patient Intake Forms

### SOCIAL HISTORY

Occupation: \_\_\_\_\_

Job responsibilities: \_\_\_\_\_

With whom do you live?

Alone       Spouse       Other

If you live alone, do you have assistance from anyone?

Yes       No

You require assistance for what activities:

Do you use a:

Walker       Cane       Wheelchair

### OTHER

**Your Home:**

Apartment       House 1-story       House Multi-story       Other

If you live in a multi-story home, on which floor is your bedroom?  
on which floor [s] is your bathroom?

1       2       3  
 1       2       3

### Stairs

Entrance steps

# \_\_\_\_\_ Railings?       0       1       2

Inside steps

# \_\_\_\_\_ Railings?       0       1       2

### Bathroom:

Shower

Tub without seat       Tub with seat

Grab bars

Yes       No

Non-skid mats/abrasive strips

Yes       No

Nightlights

Yes       No

Portable Phones

Yes       No

Throw Rugs

Yes       No

Safety Items

portable phone       emergency plan in place  
 nightlight       emergency call system

### CONFIDENCE & ADLs/IADLs:

If you are INDEPENDENT and CONFIDENT in all of your activities and self care you may stop here. If not, continue with the questions below so that we may better assist you.

**Please check the box that applies for each activity:**

- |                                              |                                        |                                          |                                              |
|----------------------------------------------|----------------------------------------|------------------------------------------|----------------------------------------------|
| 1. Using the telephone                       | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |
| 2. Getting to places beyond walking distance | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |
| 3. Grocery shopping                          | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |
| 4. Preparing meals                           | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |
| 5. Doing housework and handyman work         | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |
| 6. Doing laundry                             | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |
| 7. Taking medications                        | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |
| 8. Managing money                            | <input type="checkbox"/> needs no help | <input type="checkbox"/> needs some help | <input type="checkbox"/> unable to do at all |

*Permission obtained from M.Powell Lawton,PhD,Philadelphia Geriatric Center, Philadelphia, PA—may be used freely for patient assessment according to Dr. Lawton, formatted and posted to the World Wide Web by Robert S. Stall, MD on posted 5/25/96.*

Is there anything else that you would like to tell us about your problem today?

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## Patient Intake Forms

Balance Point  
6640 Parkdale Place Suite O  
Indianapolis, IN 46254  
317-803-3084  
877-218-9721 toll free

### Balance Point Assessment Insurance Information

Your doctor has recommended Balance Function Testing to help determine the cause of your symptoms of dizziness, motion sickness, and/or unsteadiness. The findings help guide your doctor in choosing the best form of treatment.

The testing is described briefly on the next page. Balance Function Testing appointments are scheduled for 3 hours, though many patients will finish in less time.

As the testing proceeds, the results are evaluated and decisions are made about how much additional testing should be performed. One or more tests may not be completed if it is determined that they are not needed, or if the patient is unable to perform them. Depending on the number of tests required, the cash fee for Balance Function Testing ranges from \$1,430.00 to \$2,090.00.

Most insurance companies cover all of these tests. If you have concerns about whether your insurance company will pay for these tests, it is your responsibility to contact them. To assist you with this, we have listed all the CPT procedure codes used in Balance Function Testing below. The insurance company will need these code numbers to answer your questions.

Both Medicare and Medicaid approve Balance Function testing.

CPT Code #	Description	Fee Per Unit	# of Units Tested
92557	comprehensive hearing test	105	0-1
92567	tympanometry	24	0-1
96150	health assessment/counseling	59	0-2
92541	spontaneous nystagmus	90	1
92542	positional nystagmus	108	1
92543	caloric irrigation	75	2-4
92544	optokinetics	50	1
92545	oscillating tracking	63	1
92546	sinusoidal rotation	126	1-4
92547	use of vertical electrodes	20	1
92548	computerized dynamic posturography	200	1
97001	physical therapy evaluation	150	0-1
97112	neuromuscular reeducation	45	0-2
97535	Self care (home) management training	67	0-1
92585	CHAMP Study (ABR)	284	1
92586	VEMP Study	125	1

If you have had balance testing elsewhere within the past year, please bring copies of the test results with you. We will look at these results and decide if any of the tests do not need to be repeated.

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### **PLEASE READ AND FOLLOW THESE INSTRUCTIONS BEFORE TESTING**

#### **Do not take the following medications for 24 hours before your tests:**

tranquilizers, sleeping aids, drugs for dizziness, drugs for allergies, and any medications which make you feel very sleepy. If you are taking drugs for diabetes, heart disease, high blood pressure, or seizures, **DO NOT STOP**, take them as usual. If you are unsure which of your medications to stop, please call Balance Point and speak with Michelle. If she is unavailable don't worry, just continue taking your medications as usual, and we will try to work around any possible problems they may cause during testing.

- Do not drink any alcohol for 48 hours before testing
- Do not drink caffeine (coffee, tea, or soda) for 24 hours before testing.
- Do not smoke for 2 hours prior to testing.
- It is best not to eat for 3 hours prior to testing. If you are diabetic, please eat as you usually do.
- Please do not wear contact lens.
- Do not wear make-up or earrings, as they will interfere with testing.
- Wear loose comfortable clothes, no dresses or high heels.
- You may feel more comfortable bringing someone with you who can drive home if you feel dizzy after the testing.
- Please bring a list of all the prescription medications you take.
- Please bring copies of any doctor's notes and test reports that were done for you balance problem within the last year.
- If you have ear tubes or perforations in your eardrums, please call Balance Point at number listed below.

### **DESCRIPTION OF BALANCE TESTING**

You use information from your eyes, your feet, and the balance organs in your ears to help keep you balance. Balance tests help your doctor to determine what parts of the balance system may be causing your symptoms. The tests are painless, but some of them may make you feel unsteady, dizzy, or rarely nauseated for a few minutes. This does not happen to every patient, and most do not have any trouble with the testing. If you have bothersome symptoms during testing, we will give you a break so that they can go away. The typical balance tests battery lasts 2 to 3 hours.

#### **The following are descriptions of balance function tests you may receive:**

You will be asked to stand as steadily as you can, first on a firm floor, then with the walls and/or the floor moving slightly around you. You will wear a safety harness so that you cannot fall. These tests give us information about how well you can keep your balance under changing conditions.

You may also be sitting in a dark room for a short time in a chair, which moves slowly from side to side in a rocking motion. During this test, the examiner will be talking with you and watching you with a camera.

Special goggles with tiny cameras will be used to record your eye movements while you watch moving lights and rocking side to side

Tiny stickers or special goggles will be used to record your eye movements while you watch moving lights. You will be asked to move into various positions while lying on a bed. For the final part of the test, the examiner will put warm and/or cool water into your outer ear while you are lying down. This is not painful, but can make you feel lightheaded or dizzy for a minute or two.



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877-218-9721 toll free

### Payment/Cancellation Policy

We have allotted time in our schedule for you to have certain testing ordered by your physician. If you are unable to keep this appointment you should notify us at least **24 hours in advance**. If you fail to keep the appointment or give us less than 24 hours notice **you are subject to a missed appointment charge of \$25.00-\$50.00** depending on the length of your appointment.

### PAYMENT POLICY:

Prior to your admission to Balance Point, we will contact your insurance company to verify your benefits. This is not a guarantee of payment by your insurance company. At Balance Point our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, you are personally responsible for knowing your policy benefits and any amount not covered by your insurance.

**OTOLARYNGOLOGY ASSOCIATES**

PHYSICIAN \_\_\_\_\_

(FOR OFFICE USE ONLY)

PATIENT NAME \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE)

PATIENT ADDRESS \_\_\_\_\_

ZIP \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

 SINGLE  MARRIED  SEPERATED  DIVORCED  WIDOWED AGE \_\_\_\_\_ SEX: M / F (CIRCLE ONE)SPOUSE \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)CHILD'S MOTHER \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)CHILD'S FATHER \_\_\_\_\_ / \_\_\_\_/\_\_\_\_  
(LAST) (FIRST) (M.I.) (S.S.#) (DATE OF BIRTH)

ADDRESS IF DIFFERENT THAN PATIENT'S \_\_\_\_\_

REFERRING M.D. \_\_\_\_\_ / \_\_\_\_\_  
(ADDRESS)FAMILY M.D. \_\_\_\_\_ / \_\_\_\_\_  
(ADDRESS)

CHIEF COMPLAINT OR REASON BEING SEEN TODAY \_\_\_\_\_

NOTIFY IN CASE OF EMERGENCY \_\_\_\_\_ / \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_  
(RELATIONSHIP)

PATIENT EMPLOYER NAME \_\_\_\_\_

\_\_\_\_\_  
(STREET) (ZIP) (CITY) (STATE) SPOUSE  STEP/MOM  STEP/DAD EMPLOYER \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_\_\_\_\_\_  
(STREET) (ZIP) (CITY) (STATE)**\*\*THIS SECTION MUST BE COMPLETED IN FULL, EVEN IF CARD IS COPIED\*\*****PRIMARY INSURANCE CO.** \_\_\_\_\_

ADDRESS OF INSURANCE CO. \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

 PATIENT  SPOUSE  FATHER  MOTHER  STEPPARENT POLICY HOLDER'S NAME \_\_\_\_\_**SECONDARY INSURANCE CO.** \_\_\_\_\_

ADDRESS OF INSURANCE CO. \_\_\_\_\_

POLICY NO. \_\_\_\_\_ GROUP NO. \_\_\_\_\_ POLICY HOLDER'S DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

 PATIENT  SPOUSE  FATHER  MOTHER  STEPPARENT POLICY HOLDER'S NAME \_\_\_\_\_I AUTHORIZE THE RELEASE OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE INSURANCE CARRIER(S) VIA FAX OR MAIL. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE PHYSICIAN FOR SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF THE ABOVE PATIENT'S MEDICAL RECORDS TO THE PHYSICIANS INVOLVED IN THE CARE VIA FAX OR MAIL. I FURTHER AUTHORIZE OTOLARYNGOLOGY ASSOCIATES TO LEAVE THE RESULTS OF THE ABOVE PATIENT'S EXAMINATIONS AND TESTS, INCLUDING MESSAGES, APPOINTMENT REMINDERS, LABORATORY TESTS AND X-RAYS, ON THE ANSWERING MACHINE/VOICE MAIL AT THE PHONE NUMBER PROVIDED. I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS OF THE HEALTH SERVICES FOR THE ABOVE PATIENT, AND FOR REIMBURSEMENT AND PAYMENT OF CLAIMS FROM THE INSURANCE COMPANY. I UNDERSTAND THE DOCTOR'S CHARGE MAY EXCEED THE INSURANCE CARRIER'S PAYMENT AND IF THE CHARGE IS MORE THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THE DIFFERENCE IF FOR ANY REASON THE ABOVE PATIENT'S ACCOUNT SHOULD BECOME DELINQUENT, I AGREE TO PAY FOR ALL COLLECTION, ATTORNEY FEES, AND COURT COSTS.

DATE \_\_\_\_\_ (SIGNATURE OF PATIENT OR RESPONSIBLE PARTY)

**INSURANCE REGULATIONS REQUIRE OUR OFFICE TO UPDATE THIS INFORMATION ANNUALLY**HOW DID YOU FIND OUT ABOUT OUR PRACTICE?  DOCTOR  FRIEND/FAMILY MEMBER  HOSPITAL REFERRAL  YELLOW PAGES  OTHER

**HEALTH HISTORY DATA SHEET**

(Complete this form in ink) **Please Print**

- \_\_\_ TJS      \_\_\_ TEM      \_\_\_ JDG
- \_\_\_ JDM      \_\_\_ MWM      \_\_\_ LAP
- \_\_\_ VAB      \_\_\_ RAJ      \_\_\_ DJF
- \_\_\_ RJB      \_\_\_ EYK      \_\_\_ NRK
- \_\_\_ JJG      \_\_\_ THF      \_\_\_ BJC
- \_\_\_ MSN      \_\_\_ HMD      \_\_\_ CJM

DATE \_\_\_\_\_ HEIGHT \_\_\_\_\_

AGE \_\_\_\_\_ WEIGHT \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SEX  MALE  FEMALE

NAME \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

**CHECK (√) BELOW ANY ILLNESSES YOU HAVE HAD.**

- |                         |                         |                              |                                  |
|-------------------------|-------------------------|------------------------------|----------------------------------|
| ___ Allergies           | ___ Epilepsy            | ___ Irritable Bowel Syndrome | ___ Sexually Transmitted Disease |
| ___ Asthma              | ___ Eye Disease         | ___ Kidney Disease           | ___ Stroke                       |
| ___ Bleeding Tendencies | ___ Gastroesophageal    | ___ Liver Disease            | ___ Thyroid                      |
| ___ Bronchitis          | Reflux                  | ___ Measles                  | ___ Tuberculosis                 |
| ___ Cancer - Tumors     | ___ Glaucoma            | ___ Mumps                    | ___ Ulcers (Leg)                 |
| Type _____              | ___ Gout                | ___ Mononucleosis            | ___ Ulcers (Duodenal)            |
| ___ Chicken Pox         | ___ Heart Disease       | ___ Neuritis                 | List Other Illnesses             |
| ___ Depression/Anxiety  | ___ Hemorrhoids         | ___ Obstructive Sleep Apnea  | _____                            |
| ___ Diabetes            | ___ Hepatitis           | ___ Osteoarthritis           | _____                            |
| ___ Diverticulosis      | Type _____              | ___ Pancreatitis             | _____                            |
| ___ Eczema              | ___ Hernia              | ___ Polio                    | _____                            |
| ___ Emphysema           | ___ High Blood Pressure | ___ Rheumatic Fever          | _____                            |

**MEDICATIONS**

Are you currently taking any medications?  Yes  No  
**Please Print List Below**

Are you currently taking any vitamins, herbal supplements or over the counter medications?  Yes  No **Please Print List Below**

_____	_____
_____	_____
_____	_____
_____	_____

**OPERATIONS Please Print**

TYPE	MONTH - YEAR	NAME OF HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FRACTURES Please Print**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**ALLERGIES CHECK (√) BELOW IF YOU ARE ALLERGIC TO:**

- |                |              |                                                                       |
|----------------|--------------|-----------------------------------------------------------------------|
| ___ Penicillin | ___ Aspirin  | <b>Please Print Other Drug Allergies Not Listed On The Left</b> _____ |
| ___ Sulfa      | ___ Morphine |                                                                       |
| ___ Codeine    | ___ Latex    |                                                                       |
| ___ Demerol    |              |                                                                       |

**FAMILY HEALTH DATA SHEET**

FAMILY HISTORY (CHECK (√) BELOW IF ANY OF THE CONDITIONS HAVE OCCURRED ON EITHER SIDE OF PATIENT'S FAMILY)

- \_\_\_\_\_ Allergies
- \_\_\_\_\_ Bleeding Tendencies
- \_\_\_\_\_ Blood Disease
- \_\_\_\_\_ Bone Disease
- \_\_\_\_\_ Cancer or Tumors
- \_\_\_\_\_ Cardiovascular Disease (Heart)
- \_\_\_\_\_ Congenital Deformities

- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Gastrointestinal Disease
- \_\_\_\_\_ Kidney Disease
- \_\_\_\_\_ Mental Disease
- \_\_\_\_\_ Pulmonary Disease
- \_\_\_\_\_ Thyroid Disease
- \_\_\_\_\_ Tuberculosis

**List Any Other Illnesses**

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Do you have a pacemaker?       Yes     No

Are you HIV positive               Yes     No

Do you currently use tobacco       Yes     No      If yes, do you smoke       Cigarettes       Cigars       Chew tobacco

Past history of tobacco use (amount / years) \_\_\_\_\_

Amount per day \_\_\_\_\_

Do you use alcohol                   Yes     No      Amount per day \_\_\_\_\_

Do you use illegal substances       Yes     No

Have you or anyone in your family had problems with anesthesia?       Yes     No

**ROS** CHECK (√) BOX IF YOU HAVE HAD THESE SYMPTOMS IN THE PAST YEAR

- Constitutional:     Weight Loss     Fatigue     Fever
- Eyes:     Double or Blurry Vision     Blindness     Red Eyes
- Cardiovascular:     Chest Pain     Shortness of Breath on Exertion     Cyanosis     Ankle Edema
- Frequent Urination at Night
- Respiratory:     Shortness of Breath     Cough     Coughing Blood     Wheezing     Use Oxygen
- GI:     Difficulty Swallowing     Nausea     Vomiting     Vomiting Blood     Diarrhea     Indigestion
- GU:     Blood in Urine     Burning     Urinary Infections
- Musculoskeletal:     Muscle Weakness     Pain     Tenderness     Joint Swelling
- Skin:     Rash     Lumps     Sores     Loss of Hair
- Neuro:     Headaches     Blackouts     Paralysis     Numbness     Head Injury
- Psychiatric:     Nervousness     Anxiety     Memory Loss     Sleep Disturbances
- Hematology / Lymphatic:     Anemia     Bruise Easy     Enlarged Lymph Nodes
- Endocrine:     Excessive Thirst     Intolerance of Heat or Cold     High Blood Sugar
- Allergy / Immunologic:     Inhalant or Food Allergy     Itchy     Frequent Infections

Have you ever taken Cortisone?     Yes     No  
                                                   Orally                     Injection

If yes,    Month \_\_\_\_\_    Year \_\_\_\_\_

**Please**    Month \_\_\_\_\_    Year \_\_\_\_\_

**Print**      Month \_\_\_\_\_    Year \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**VACCINATIONS (Please circle the ones you have had)**

Mumps      Tetanus      Rubella      Influenza

Pneumococcal      Hepatitis

**For Office Use**

PFSH and Ros reviewed and updated.

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# O·tō·laryn·gol'ō·gy As·sō'ci·ates

OA Physician: \_\_\_\_\_

## Contact Information for Protected Health Information

I, \_\_\_\_\_ (patients name) DOB: \_\_\_\_\_, request

That the following information be followed for the disclosure of my Protected Health Information (Protected Health Information would include your name, diagnosis (es), test results, dates of service as described in the Notice of Privacy Practices).

Please check all that apply

- You may disclose, **via phone**, information to people designated below.  
(please list name, phone number and relationship) **THIS DOCUMENT DOES NOT ALLOW THE PERSON LISTED BELOW TO SIGN FOR OR RECEIVE MEDICAL RECORDS A RELEASE OF INFORMATION FORM MUST BE SIGNED BY THE PATIENT OR THE POWER OF ATTORNEY.**

Name	Phone Number	Relationship

- You may leave Protected Health Information on my answering machine/voicemail  
phone number: \_\_\_\_\_
- Other \_\_\_\_\_

NOTE: Document is good for one year from date signed.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Patient's Signature (or Guardian if a minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date