ST. LOUIS® SINUS CENTER

PATIENT HEALTH HISTORY

Date: _____

In order for us to obtain a complete medical history, it is important for you to fill out this form as completely as possible.

Name (First, middle initial, Last) _____ Home Phone #_____

_____ Work/Cell Phone #_____

Street City State Zip **(Please Circle One)**

Date of Birth _____ Age _____ Male ❑ Female ❑ Marital Status: S M D W

Social Security #_____ Pharmacy Preference (INCLUDE LOCATION & #)_____

Email _____Primary Care Physician_____ Referring Physician_____

Preferred Language: _____ Race:_____ Ethnicity: Hispanic / Latino / Non Hispanic / Non Latino

Guarantor (If patient is under 18): Name:_____ **DOB:**_____ **SS#:**_____

Primary Insurance:_____ **Secondary Insurance:**_____

ID#: _____ **Group#** _____ **ID#:**_____ **Group#:**_____

Subscriber Name:_____**DOB:**_____ **Subscriber Name:**_____**DOB:**_____

SS#:_____**Relation:**_____ **SS#:**_____**Relation:**_____

Reason for your visit today? _____ How did you hear about us? _____

Have you had imaging done for this problem?_____ **If so, where was it done?**_____

Are you taking **ANY** kind of medication now? (This includes prescription, over-the-counter or herbal medications)
❑ No ❑ Yes **If yes, please list below *include dosages*. Please continue on the back if necessary**.

Medication Name	Dosage	Reason for Taking

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑ No ❑ Yes If yes, please list below.

Name of Medication	Type of Reaction

SURGERIES AND HOSPITALIZATIONS:
Have had problems with anesthesia (being numbed or put to sleep)? ❑ No ❑ Yes

_____

Have you ever been hospitalized for non-surgical reasons?
❑ No ❑ Yes If so please explain:

_____

Have you had any or other surgeries? ❑ No ❑ Yes (type and date)
Please list ALL surgeries you have had.

_____

_____

_____

What Are You Seeing The Doctor For?

(check one)

❑ Chronic Sinusitis ❑ Recurrent Sinusitis ❑ Nasal Allergies

How long have you had this problem? _____

What symptoms do you get when having this problem? (check all that apply)

❑ Nasal congestion
❑ Runny nose
❑ Fever
❑ Headache
❑ Change in smell/taste
❑ Sneezing
❑ Cough
❑ Pressure in ears
❑ Hoarseness
❑ Other: _____
❑ Post nasal drainage
❑ Sore throat
❑ Facial pain/pressure
❑ Snoring

What have you taken OVER THE COUNTER in the past for this problem? (check all that apply)

❑ Claritin/Loratidine
❑ Benadryl
❑ Netty Pot
❑ Tylenol Cold and Sinus
❑ Allegra/Fexofenadine
❑ Afrin Nasal Spray
❑ Ayr
❑ Sudafed
❑ Zyrtec/Cetirizine
❑ Saline Nasal Spray
❑ Advil Cold and Sinus
❑ DayQuil/Nyquil
❑ Other: _____

What PRESCRIPTIONS have you taken in the past for this problem? (check all that apply)

❑ Flonase
❑ Qnasl
❑ Levaquin
❑ Amoxicillin
❑ Medrol dose pack
❑ Cephalexin
❑ Nasonex
❑ Astepro
❑ Cipro
❑ Zithromax Z-pack
❑ Avelox
❑ Keflex
❑ Patanase
❑ Astelin
❑ Augmentin
❑ Prednisone
❑ Doxycycline
❑ Dymista
❑ Other: _____

Antibiotic usage history

How many times were you treated with antibiotics in the past 3 months: _____
How many times were you treated with antibiotics in the past 6 months: _____
How many times were you treated with antibiotics in the past 12 months: _____

Testing – Have you had any of the following for this problem? (check all that apply)

❑ Allergy Testing (if you have a copy, please bring you to appointment):
- Date of testing: _____
- Doctor that ordered/performed testing: _____
- Results: _____

❑ Sinus CT (if you have a copy, please bring you to appointment)::
- Date of test: _____
- Doctor that ordered/performed testing: _____
- Results: _____

Patient Health History

2 - 1 1 0 3 5 8 6

DIRECTION OF FEED

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ● Incorrect Marks ⊘ ✓ ✗

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Adhesive tape	○	Metal	○
Iodine	○	Seafood	○
Latex	○	Contrast Dye	○

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	○	Gastrointestinal Reflux	○
Lung Cancer	○	Hepatitis	○
Skin Cancer	○	Stomach Ulcer	○
Throat Cancer	○		
Prostate Cancer	○		
Other Cancer	○	Are you pregnant?	○
		Prostate Enlargement	○
Migraine Headache	○	Renal Failure	○
Cataracts	○	Stroke	○
Glaucoma	○		
		Anxiety	○
Nasal Allergies	○	Depression	○
Sleep Apnea	○	Diabetes	○
		Thyroid Dysfunction	○
Blood Clots/DVT	○		
High/Elevated Cholesterol	○	Anemia	○
		Hemophilia	○
Heart Attack	○		
High Blood Pressure	○	HIV	○
Asthma	○		
Chronic Bronchitis	○		
Emphysema	○		
Tuberculosis	○		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	○	○	○	○	○
Thyroid Cancer	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Unspecified Cancer	○	○	○	○	○
Hearing Loss before age 20	○	○	○	○	○
Hearing Loss after age 20	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Asthma	○	○	○	○	○
Stroke	○	○	○	○	○
Diabetes	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

4. Mark if retired. Yes ○

5. Tobacco Use:
Mark your tobacco use.

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

○ Less than 12 drinks/yr
○ 1-13 drinks/mo
○ 4-14 drinks/wk
○ >2 drinks/day

6. Do you use drugs recreationally? Yes ○

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

○ None ○ 2-3 per day
○ 1 per day ○ 4 or more

8. Are you exposed to second hand smoke? Yes ○ No ○

9. Mark if patient attends daycare. Yes ○

10. Will you accept transfusion of blood products if necessary? Yes ○ No ○

11. Home Living Situation (mark all that apply).

○ Alone ○ With spouse
○ With children ○ In nursing home
○ With mother ○ With father
○ In assisted living ○ Other

1103586

1103586

12. Do you now have or have you recently had any of the following?

	Yes	No
Fever	○	○
Sleeping problems	○	○
Unintentional weight loss	○	○
Unintentional weight gain	○	○
Blurred vision	○	○
Itchy eyes	○	○
Loss of vision	○	○
Painful eye	○	○
Dizziness	○	○
Ear drainage	○	○
Hearing loss	○	○
Ear pain	○	○
Ringing in the ears	○	○
Nasal congestion	○	○
Frequent nosebleeds	○	○
Post-nasal drainage	○	○
Belching sour material into throat	○	○
Hoarseness or other voice changes	○	○
Mouth ulcers	○	○
Partials or dentures	○	○
Blacking out or fainting	○	○
Chest pain	○	○
Heart murmur	○	○
Irregular heartbeats	○	○
Leg cramps	○	○
Swelling of ankles	○	○
Frequent non-productive cough	○	○
Frequent productive cough	○	○
Shortness of breath	○	○
Snoring (excessive)	○	○
Wheezing	○	○
Abdominal pain	○	○
Diarrhea	○	○
Heartburn	○	○
Nausea	○	○
Trouble swallowing	○	○
Painful swallowing	○	○
Vomiting	○	○
Painful joints	○	○
Stiffness in joints	○	○
Swelling of joints	○	○

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes	No
Change in sense of smell	○	○
Change in sense of taste	○	○
Headache	○	○
Severe face pain	○	○
Seizures	○	○
Tremor	○	○
Appetite is increased	○	○
Fatigue	○	○
Cold feeling	○	○
Bleed excessively after injury	○	○
Bruise easily	○	○
Masses (lumps) in armpit	○	○
Masses (lumps) in neck	○	○
Masses (lumps) in groin	○	○
Hives	○	○
Sneezing	○	○

Thank you for completing this questionnaire!

SINO-NASAL OUTCOME TEST (SNOT-20)

NAME: _____ DATE: _____

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate you answering the following questions to the best of your ability. There are no right or wrong answers and only you can provide us with this information.

Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale:

	No Problem	Very Mild Problem	Mild or slight problem	Moderate Problem	Severe Problem	Problem as severe as it can get	**5 Most important items**
Need to blow nose	0	1	2	3	4	5	o
Sneezing	0	1	2	3	4	5	o
Runny nose	0	1	2	3	4	5	o
Cough	0	1	2	3	4	5	o
Post-nasal discharge	0	1	2	3	4	5	o
Thick nasal discharge	0	1	2	3	4	5	o
Ear fullness	0	1	2	3	4	5	o
Dizziness	0	1	2	3	4	5	o
Ear Pain	0	1	2	3	4	5	o
Facial pain/pressure	0	1	2	3	4	5	o
Difficulty falling asleep	0	1	2	3	4	5	o
Wake up at night	0	1	2	3	4	5	o
Lack of a good night's sleep	0	1	2	3	4	5	o
Wake up tired	0	1	2	3	4	5	o
Fatigue	0	1	2	3	4	5	o
Reduced productivity	0	1	2	3	4	5	o
Reduced concentration	0	1	2	3	4	5	o
Frustrated/restless/irritable	0	1	2	3	4	5	o
Sad	0	1	2	3	4	5	o
Embarrassed	0	1	2	3	4	5	o

2. Please mark the most important items affecting your health (maximum of 5 items)_____ ↑

CONSENT OF PRIVACY PRACTICES FOR
PURPOSES OF PROTECTED HEALTH INFORMATION
FOR USE, DISCLOSURE, TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATION

I, _____, consent to the use or disclosure of my Protected Health Information by St. Louis Sinus Center, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations by St. Louis Sinus Center. I understand that diagnosis or treatment of me by my physician may be conditional upon my consent as evidenced by my signature on this document. The release of Protected Health Information with regard to my medical treatment may be sent by fax, telephone, mail or email to other physicians, healthcare facilities or insurance companies.

I understand I have the right to request a restriction as to how my Protected Health Information is used or disclosed to carry out treatment, payment or healthcare operation of this practice. My treating physician at St. Louis Sinus Center is not required to agree to the restrictions that I, the patient, may request if the restriction falls within the exceptions to confidentiality by law. However, if St. Louis Sinus Center agrees to a restriction that I request, the restriction is binding on my treating physician.

I have the right to revoke this consent, in writing, at any time, except to the extent that St. Louis Sinus Center has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health insurance plan, my employer or a health care clearinghouse. This relates to my past, present or future physical or mental health or condition that may identify me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review and request a copy of the St. Louis Sinus Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information that will occur in my treatment, payment of my bills or in the performance of health care operations of St. Louis Sinus Center. The Notice of Privacy Practices for St. Louis Sinus Center is posted in the waiting room area (brochure) and on the St. Louis Sinus Center website at www.stlsinuscenter.com . This Notice of Privacy Practices also describes my rights and St. Louis Sinus Center's duties with respect to my Protected Health Information.

I have the right to request and be provided with a description of the procedures for exercising the following with respect to your Protected Health Information:

i.) Inspecting and copying;
ii.) Amending or correcting; and
iii.) An accounting of the disclosures of such information by St. Louis Sinus Center.

St. Louis Sinus Center may change its policies and procedures relating to Protected Health Information at any time. Should the Protected Health Information policies change, a revised notice will be available at St. Louis Sinus Center's office and posted on the James D. Gould, MD, PC's website at www.stlsinuscenter.com. If you believe that there has been a violation of your Privacy Rights, a complaint may be filed St. Louis Sinus Center, by contacting Paula Carrow, Privacy Official, 1390 Hwy. 61, Suite 3100, Festus, MO 63028 or at 314-4RELIEF (473-5433). Further, a complaint may be filed with the U.S. Department of Health and Human Services.

❑ **I have read and received a copy of the Notice of Privacy Practices.**

❑ **I have read and refuse to accept a copy of the Notice of Privacy Practices.**

Signed this _____ day of _____, 20_____.

_____
Patient's Signature

Test results may be left on answering machine. ❑ **Yes** ❑ **No**

Names(s) of person(s) authorized by this form to use and disclose the patient's Protected Health Information. (Example: spouse, child, parents).

_____

_____

Special Restrictions:

_____

This revised healthcare privacy rights policy is effective October, 2006.

OFFICE USE ONLY: Authorization verified by _____ *on* _____