



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 # \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work/Cell Phone # \_\_\_\_\_ (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 condition? \_\_\_\_\_ 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.

Table with 3 columns: Medication Name, Dosage, Reason for Taking

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

Table with 2 columns: 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.



## Sinus/Allergy Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

How long have you had allergy/sinus symptoms? \_\_\_\_\_

### What symptoms do you experience? (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Nasal congestion      | <input type="checkbox"/> Sneezing         | <input type="checkbox"/> Post nasal drainage  |
| <input type="checkbox"/> Runny nose            | <input type="checkbox"/> Cough            | <input type="checkbox"/> Sore throat          |
| <input type="checkbox"/> Fever                 | <input type="checkbox"/> Pressure in ears | <input type="checkbox"/> Facial pain/pressure |
| <input type="checkbox"/> Headache              | <input type="checkbox"/> Hoarseness       | <input type="checkbox"/> Snoring              |
| <input type="checkbox"/> Change in smell/taste | <input type="checkbox"/> Other: _____     |   |

### What have you taken OVER THE COUNTER in the past for your symptoms? (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Claritin/Loratadine    | <input type="checkbox"/> Allegra/Fexofenadine | <input type="checkbox"/> Zyrtec/Cetirizine    |
| <input type="checkbox"/> Benadryl               | <input type="checkbox"/> Afrin Nasal Spray    | <input type="checkbox"/> Flonase              |
| <input type="checkbox"/> Xyzal/Levocetirizine   | <input type="checkbox"/> Saline Nasal Spray   | <input type="checkbox"/> Zicam Allergy Relief |
| <input type="checkbox"/> Neti Pot               | <input type="checkbox"/> Ayr                  | <input type="checkbox"/> Advil Cold and Sinus |
| <input type="checkbox"/> Tylenol Cold and Sinus | <input type="checkbox"/> Sudafed              | <input type="checkbox"/> DayQuil/Nyquil       |

### What PRESCRIPTIONS have you taken in the past for your symptoms? (check all that apply)

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Dymista          | <input type="checkbox"/> Nasonex          | <input type="checkbox"/> Patanase     |
| <input type="checkbox"/> QNasal           | <input type="checkbox"/> Astepro          | <input type="checkbox"/> Astelin      |
| <input type="checkbox"/> Levaquin         | <input type="checkbox"/> Cipro            | <input type="checkbox"/> Augmentin    |
| <input type="checkbox"/> Amoxicillin      | <input type="checkbox"/> Zithromax Z-Pack | <input type="checkbox"/> Predinsone   |
| <input type="checkbox"/> Medrol Dose Pack | <input type="checkbox"/> Avelox           | <input type="checkbox"/> Doxycycline  |
| <input type="checkbox"/> Cephalixin       | <input type="checkbox"/> Keflex           | <input type="checkbox"/> Atrovent     |
| <input type="checkbox"/> Ceftin           | <input type="checkbox"/> Omnicef/Cefdinir | <input type="checkbox"/> Other: _____ |

### Antibiotic History

How many times were you treated with an antibiotic therapy in the past 12 months? \_\_\_\_\_

What pharmacy do you usually fill prescriptions at? \_\_\_\_\_

### Testing/Surgery

Have you had any of the following tests or surgeries?:

- o Allergy Testing (if you have a copy, please bring to appointment):
  - Date of Test: \_\_\_\_\_
  - Test Results: \_\_\_\_\_
  - Did you do allergy desensitization (allergy injections)? Yes / No
    - ✓ If yes, for how long? \_\_\_\_\_
- o Sinus CT (if you have a copy of your images and report, please bring to appointment):
  - Date of Test: \_\_\_\_\_
  - Test Results: \_\_\_\_\_
  - Any surgery performed? Yes / No
    - ✓ If yes, what was performed? \_\_\_\_\_

# SINO-NASAL OUTCOME TEST (SNOT-20)

Name: \_\_\_\_\_

Date: \_\_\_\_\_

We would like to know more about your sinusitis and would appreciate your answering the following questions to the best of your ability.

Below you will find a list of symptoms and social/emotional consequences of your sinusitis. 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.

**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	<input type="radio"/>
Sneezing	0	1	2	3	4	5	<input type="radio"/>
Runny nose	0	1	2	3	4	5	<input type="radio"/>
Cough	0	1	2	3	4	5	<input type="radio"/>
Post-nasal discharge	0	1	2	3	4	5	<input type="radio"/>
Thick nasal discharge	0	1	2	3	4	5	<input type="radio"/>
Ear fullness	0	1	2	3	4	5	<input type="radio"/>
Dizziness	0	1	2	3	4	5	<input type="radio"/>
Ear Pain	0	1	2	3	4	5	<input type="radio"/>
Facial pain/pressure	0	1	2	3	4	5	<input type="radio"/>
Difficulty falling asleep	0	1	2	3	4	5	<input type="radio"/>
Wake up at night	0	1	2	3	4	5	<input type="radio"/>
Lack of a good night's sleep	0	1	2	3	4	5	<input type="radio"/>
Wake up tired	0	1	2	3	4	5	<input type="radio"/>
Fatigue	0	1	2	3	4	5	<input type="radio"/>
Reduced productivity	0	1	2	3	4	5	<input type="radio"/>
Reduced concentration	0	1	2	3	4	5	<input type="radio"/>
Frustrated/restless/irritable	0	1	2	3	4	5	<input type="radio"/>
Sad	0	1	2	3	4	5	<input type="radio"/>
Embarrassed	0	1	2	3	4	5	<input type="radio"/>

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

# Patient Health History



INDICATION OF FEED

## Marking Instructions

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

Correct Mark  Incorrect Marks

**1. Are you allergic to any of the following?**

	<b>Yes</b>		<b>Yes</b>
Adhesive tape	<input type="radio"/>	Metal	<input type="radio"/>
Iodine	<input type="radio"/>	Seafood	<input type="radio"/>
Latex	<input type="radio"/>	Contrast Dye	<input type="radio"/>

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

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

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

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unspecified Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Loss before age 20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Loss after age 20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding/Clotting Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Name: \_\_\_\_\_

Date of Appt: \_\_\_\_\_

**4. Mark if retired.** **Yes**

**5. Tobacco Use:**  
**Mark your tobacco use.**  
 None  Cigarettes  
 Smokeless Tobacco  Cigars

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**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

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**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

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

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

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

	Yes	No
Change in sense of smell	<input type="radio"/>	<input type="radio"/>
Change in sense of taste	<input type="radio"/>	<input type="radio"/>
Headache	<input type="radio"/>	<input type="radio"/>
Severe face pain	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>
Tremor	<input type="radio"/>	<input type="radio"/>
Appetite is increased	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>
Cold feeling	<input type="radio"/>	<input type="radio"/>
Bleed excessively after injury	<input type="radio"/>	<input type="radio"/>
Bruise easily	<input type="radio"/>	<input type="radio"/>
Masses (lumps) in armpit	<input type="radio"/>	<input type="radio"/>
Masses (lumps) in neck	<input type="radio"/>	<input type="radio"/>
Masses (lumps) in groin	<input type="radio"/>	<input type="radio"/>
Hives	<input type="radio"/>	<input type="radio"/>
Sneezing	<input type="radio"/>	<input type="radio"/>

**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](http://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](http://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 \_\_\_\_\_