DISEASES AND SURGERY OF
EAR, NOSE, AND THROAT
FACIAL AND PLASTIC RECONSTRUCTIVE SURGERY

☐ JOEL LUBRITZ, M.D., F.A.C.S, F.A.A.P.

☐ Phillip Say, M.D.
☐ Ryan Winters, M.D.

3201 S. Maryland Parkway, Suite 300
Las Vegas, NV 89109
By Appointment (702) 732-4491

3150 N. Tenaya Way, Suite 575
Las Vegas, NV 89128
By Appointment (702) 732-4491

Referred by Dr. _____
☐ Newspaper ☐ Insurance list ☐ Yellow Pages ☐ Friend
Friend's Name: _____
Friend's Address: _____
_____

PATIENT INFORMATION (Please print clearly)

Patient's Name_____Age_____Date of Birth_____

Home Address_____Apt #_____Social Security #_____-_____-_____

City_____State_____Zip_____ Male [ ] Female [ ]

Home Phone ( )_____-_____ Bus. Phone ( )_____-_____ Cell Phone ( )_____-_____

Marital Status_____Patient's Employer_____ Occupation_____

Email Address_____@_____.com

Spouse's Name_____Age_____Date of Birth_____

Home Address_____Apt #_____Social Security #_____-_____-_____

City_____State_____Zip_____ Employer _____

Home Phone ( )_____-_____ Bus. Phone ( )_____-_____ Cell Phone ( )_____-_____

PARENT RESPONSIBLE PARTY (if patient is a minor)

Mother's Name _____

Social Security #_____-_____-_____

Address_____

City_____ State_____ Zip_____

Cell Phone _____- _____Work Phone _____-_____

Employer _____Occupation_____

Date of Birth_____

Father's Name _____

Social Security #_____-_____-_____

Address_____

City_____ State_____ Zip_____

Cell Phone _____- _____Work Phone _____-_____

Employer _____Occupation_____

Date of Birth_____

INSURANCE INFORMATION (Please bring cards to window for copies)

Primary Insurance Co._____Phone # (___)_____ -_____Group#_____

Name of Insured_____SS#_____-_____ -_____

Insurance Address_____City_____State_____Zip_____

Secondary Insurance Co._____Phone # (___)_____ -_____Group#_____

Name of Insured_____SS#_____-_____ -_____

Insurance Address_____City_____State_____Zip_____

ADDITIONAL INFORMATION

Nearest Friend or Relative (Not living with you)_____Phone # (___)_____-_____

Address_____City_____State_____Zip_____

Is visit due to a work injury? Yes { } No { } Was an incident report filed with your employer? Yes { } No { }

Workman's Compensation Network MCO Name_____

POLICY OF THIS OFFICE

1. All first time visits must be paid for unless you can provide proof from your insurance company showing that your deductible has been met.
2. Co-Payments must be paid at the time of visit.
3. If we are not a contracted provider for your insurance company, you will be expected to pay 30% of the total charges if your deductible has been met.
4. Medicare patients will be expected to pay 20% of the allowable charges if they do not carry supplemental insurance.
5. Insurance forms are the patient's responsibility to obtain and submit to us completely filled out and signed. If you do not have an insurance form to obtain reimbursement, reimbursement is then paid directly to you.
6. A surgery deposit and an assignment of insurance is required prior to admission to the hospital and day-surgery.
7. Dr. Lubritz is an investor in Universal Health Service, Humana, Sierra Health, Medical Care International, Las Vegas Surgical Center, Sahara and Flamingo surgical centers.

INSURANCE ASSIGNMENT AND MEDICAL RECORDS RELEASE

I, the undersigned do hereby authorize my insurance carrier(s) to pay directly to_____the insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-pay and/or deductible amounts. If for any reason the said insurance carrier(s) has not paid within 60 days from the date of service rendered, an interest charge of 1½ % monthly, 18% annually, will be automatically charged to an unpaid patient balance. I, the undersigned do hereby also give my permission to_____to furnish my insurance carrier(s), also the above name referring doctor, any and all information pertaining to my medical records.

_____ Date _____- _____-_____

Patient's signature or Authorized Person

LUBRITZ & NASRI, PLLC

INSURANCE & PATIENT RESPONSIBILITIES

WELCOME TO OUR PRACTICE, AS YOU MAY KNOW, HEALTHCARE IS BECOMING MORE COMPLICATED EVERY DAY. WE WOULD LIKE TO TAKE THIS OPPORTUNITY TO ADVISE YOU OF YOUR. PATIENT RESPONSIBILITIES. WHILE MANY PATIENTS DO NOT UNDERSTAND THE BILLING OF INSURANCE, AND THE PROCESSING OF CLAIMS IS A COURTESY THAT WE EXTEND TO OUR PATIENTS.

THIS OFFICE WILL ATTEMPT TO VERIFY YOUR BENEFITS ON EACH VISIT. IT IS OUR GOAL TO PROVIDE YOU WITH THE MOST ACCURATE INFORMATION IN REGARD TO: AUTHORIZATIONS, DEDUCTIBLES, COPAYS AND CO-INSURANCE RESPONSIBILITIES.

PATIENT RESPONSIBILITIES ARE DUE AT THE TIME OF SERVICE.

PLEASE BE ADVISED YOU WILL RECEIVE A STATEMENT FROM THIS OFFICE SO LONG AS THERE IS A BALANCE ON YOUR ACCOUNT. IF YOUR ACCOUNT BALANCE FALLS IN THE 60 DAY OR OLDER CATEGORY, NOTED AT THE BOTTOM OF YOUR STATEMENT, PLEASE CONTACT OUR BILLING OFFICE AT (702) 732-4491.

A STATEMENT IS NOT ALWAYS' A DEMAND FOR PATIENT PAYMENT.

THANK YOU FOR YOUR COOPERATION. PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND OUR OFFICE ' POLICIES.

_____ _____

PATIENT OR GUARANTOR DATE

Notice of Privacy Practices

Effective Date: September, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Erina Savage, Practice Manager, Lubritz & Nasri, PLLC, 702-732-4491.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information[1] to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious *Threat to Health or Safety.* We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, *Medical Examiners and Funeral Directors.* We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate, of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief, We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Erina Savage, Practice Manager, Lubritz & Nasri, PLLC 3201 S. Maryland Parkway #300, Las Vegas, NV 89109. We have up to 30 days to make your Protected Health information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state *of* federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome *of* the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost- based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment., you must make your request, in writing, to Erina Savage, Practice Manager, Lubritz & Nasri, PLLC 3201 S Maryland Parkway #300, Las Vegas, NV 89109.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Erina Savage, Practice Manager, Lubritz & Nasri, PLLC 3201 S Maryland Parkway #300, Las Vegas, NV 89109.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Erina Savage, Practice Manager, Lubritz & Nasri, PLLC 3201 S Maryland Parkway #300, Las Vegas, NV 89109. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full, if we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Erina Savage, Practice Manager, Lubritz & Nasri, PLLC

3201 S Maryland Parkway #300, Las Vegas, NV 89109. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. "You *may* ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask the receptionist

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our *current* notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Erina Savage Practice Manager, Lubritz & Nasri, PLLC 3201 S Maryland Parkway #300, Las Vegas, NV 89109. All complaints must be made in writing. You will not be penalized for filing a complaint.

Acknowledgement

I hereby acknowledge that. I have been presented this Notice of Privacy Practices.

Signature: _____

Date _____-_____ -_____

Printed Name: _____

****

Acknowledgement of Refused

On this date the undersigned patient refused or failed to acknowledge receipt of this Notice of Privacy Practices.

Date _____-_____ -_____

Name of patient: _____

Reason for refusal: _____

Signature of Employee: _____

Joel Lubritz, M.D.
Sina Nasri, M.D.

Joel Lubritz. M.D.. F.A.C.S.. F.A.A.P.
Former Vice President & Secretary/Treasurer
of Nevada State Board of Medical Examiners
Diseases & Surgery of the
Ear. Nose. Throat Sinuses
Snoring & Apnea

3201 S. Maryland Parkway. Suite 300
Las Vegas. Nevada 89109
Telephone (702) 732-4491
Fax (702) 732-1036

G. Chad Daniels, Au.D., CCC-A
Doctor of Audiology

David Hardy, M.S.
Clinical Audiologist

Sina Nasri, M.D., F.A.C.S., F.A.A.C.S., F.A.C.P.S.
Facial Plastic and Reconstructive Surgery
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Disease of Ear, Nose, Throat & Sinuses
Snoring & Apnea

Please make a list of the person(s) we can speak to at home regarding any of your personal or medical information, (ex: roommate, spouse, friends, etc.)

I, _____ authorize information to be given to the
(Patient/Responsible Party)
following individuals.

	Name	Relationship to the Patient
1.	_____	
	_____	
2.	_____	
	_____	
3.	_____	
	_____	
4.	_____	
	_____	
5.	_____	
	_____	

Signature:_____ Date: _____-_____-

_____
(Patient/Responsible Party)

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I, _____, authorize _____
patient name facility name

Fax #: _____ to release my records to Lubritz and Nasri,

PLLC. the office of Dr. Lubritz, Dr. Nasri, Dr. Winters & Dr. Say.

These records are being requested to provide continued care for my medical conditions.

Patient Name: _____

DOB:_____/_____/_____

Patient Signature: _____

Date: _____

Please fax records to (702) 732-1036, attention: _____

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Dear Patient,

Our office requires 24 hour notice for cancellations and rescheduling of appointment.

Please be advised that without proper notice you will be assessed a $25.00 fee. This fee will also apply to no show appointments.

Thank you for your understanding in this matter.

_____

Patient signature date

SLEEP DISORDERED BREATHING
SCREENING QUESTIONNAIRE

NAME:_____DATE:_____

HEIGHT:_____WEIGHT:_____NECK CIRCUMFERENCE:_____AGE_____M/F

EPWORTH SLEEPINESS SCALE

Please answer the following questions based on this scale:

0. Would never fall asleep
1. Slight chance of dozing
2. Moderate chance of dozing
3. High chance of dozing

Situation	Chance of Dozing
Reading	_____
Watching TV	_____
Sitting in a public place (e.g. Theather or meeting place)	_____
Driving a car, stopped at a traffic light	_____
As a passenger in a car for an hour without a break	_____
During quiet time after lunch without alcohol	_____
Lying down to rest when circumstances permit	_____
Total Score:	_____

Epworth score <8 = normal, 8-10 mild risk SDB, 11-16 moderate risk SDB, >17 significant risk SDB.

CLINICAL OBSTRUCTIVE SLEEP APNEA QUESTIONNAIRE

1.	Has anyone told you that you snore?	YES	NO
	If yes, how loud? 1 2 3 4 5 6 7 8 9 1 0		
2.	Does your snoring ever bother anyone?	YES	NO
3.	Have you ever been told that you stop breathing while you sleep?	YES	NO
4.	Do you awaken gasping, choking, or have shortness of breath?	YES	NO
5.	Do you have trouble staying asleep once you fall asleep?	YES	NO
6.	Do you have morning or daytime headaches?	YES	NO
	Do you feel tired or fatigued throughout the day?	YES	NO
S.	Have you ever nodded off or fallen asleep while driving?	YES	NO
c	Do you have high blood pressure?	YES	NO
10.	Do you have indigestion?	YES	NO
11.	Have you have memory loss?	YES	NO
12.	Do you ever awaken with intense anxiety?	YES	NO
13.	Do you ever experience depressed feelings?	YES	NO
14.	Do you notice a decrease ability to think effectively?	YES	NO
15.	Do you ever take naps?	YES	NO
	If yes how often per week? 1 2 3 4 5 6 7		
16.	Do you notice a decreased sexual interest?	YES	NO
17.	Do you smoke?	YES	NO
18.	Are you overweight?	YES	NO

Points for responses to the previous questions: yes = 1, no = 0. Based on patient's responses to the above questions, the RISK of the diagnosis of sleep-disorder breathing (obstructive sleep apnea) is...

LOW	MODERATE	HIGH	VERY HIGH
0-2	3-4	5-8	9-18

PT. NAME:_____ DATE:_____

Over the past *ONE* month, how much of a problem were the following conditions for you?

Please circle the most correct response

	Not a Problem	*Very Mild Problem*	*Moderate Problem*	*Fairly Bad Problem*	*Severe Problem*
1. Nasal congestion or stuffiness	0	1	2	3	4
2. Nasal blockage or obstruction	0	1	2	3	4
3. Trouble breathing through my nose	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

5 Minute Hearing Test

Date: _____

Patient Name:_____

	Almost Always	Half the Time	Occasionally	Never
	3	2	1	0
I have a problem hearing over the telephone.				
I have trouble following the conversation when 2 or more people are talking at the same time.				
People complain that I turn the TV volume too high.				
I have to strain to understand conversations.				
I rniss hearing some common sounds like the phone or door-hell ringing.				
I have trouble hearing conversations in s noisy background such as a party				
I get confused about where sounds come from.				
I misunderstand some words in a sentence and need to ask people to repeat themselves.				
I especially have trouble understanding the speech of women and children.				
I have worked in noisy environments (near assembly lines, jackhammer, jet engines, etc.)				
Many people I talk to seem to mumble.				
People get annoyed because I misunderstand what they say.				
I misunderstand what others are saying and make inappropriate responses.				
I avoid social activities because I cannot hear well and fear that Til reply improperly.				
To be answered by a family member or friend: Do you think this person has a hearing loss?				

Scoring

To calculate your score, give yourself 3 points for every time you checked the "Almost Always" column.
2 for every "Half the Time'[1], 1 for every' "Occasionally", and 0 for every "Never". If you have a blood relative who has a hearing loss, add another 3 points. Then total your points.

The American Academy of Otolaryngology - Head and Neck Surgery recommends the following:

- 0 to 5 - Your hearing is fine. No action is required.
- 6 to 9 - Suggest you see an ear, nose, and throat (ENT) specialist.
- 10 and above - strongly recommended you see an ear physician.

Date :_____ Name:_____

1. Who referred you to this office? _____
2. Who is your personal doctor (PCP)?_____

   Address:

   _____

MEDICAL HISTORY

1. History of past illness:

   A. Operations: List all operations in chronological order giving the year in which the surgery was performed.

   _____

   _____

   B. Medical Conditions: _____

2. Family History:

   Age of Father_____ Alive / Deceased _____

   Age of Mother _____ Alive / Deceased_____

   Number of Brothers _____ Condition of health or cause of death _____

   Number of Sisters_____Condition of health or cause of death _____

   Diseases and conditions that run in your family: _____

3. Social History:

   A. Where were you born? _____What was your last grade completed in school'? _____

      Are you married?_____ Divorced? _____ Single? _____

   B. Habits:

      Do you smoke? _____ !f cigarettes, how many packs a day? _____ if quit, how long ago?_____

      Do you drink alcoholic beverages? _____Type _____How much?_____

   C. Hobbies:_____

4. Medications:

   List all prescription medications:_____

   _____

   List all vitamins and over the counter medications:_____

   Do you take Aspirin: Ibuprofen, or any other blood thinners? ☐ Yes ☐ No

5. Bleeding Tendency: Yes_____ No_____
6. Allergies: _____
7. History of HIV? Yes ___ No_____ History of Hepatitis? Yes ____ No_____ What Type?_____
8. History of Chemotherapy: _____
9. History of Radiation Therapy:_____

10. System Review: Circle yes or no for the following:

RESPIRATORY			SYSTEMIC		
Pneumonia	YES	NO	Weight Loss If yes, how much? ___How Long?_____	YES	NO
Pleurisy	YES	NO	Weight Gain If yes, how much? ___How Long?_____	YES	NO
Shortness of breath	YES	NO	Anemia	YES	NO
Cough	YES	NO	Tiredness	YES	NO
Spiting up blood	YES	NO	Weakness	YES	NO
Chest Pain	YES	NO			
CARDIOVASCULAR			INTEGUMENTARY		
Murmur	YES	NO	Skin Infection	YES	NO
High blood pressure	YES	NO	Rash	YES	NO
Palpitations	YES	NO	Breast Mass	YES	NO
Heart Attack If yes, when?_____	YES	NO	Skin Cancer	YES	NO
			Dermatitis	YES	NO
			Breast Cancer	YES	NO
GASTROINTESTINAL			ENDOCRINE		
Difficulty swallowing	YES	NO	Thyroid Disease	YES	NO
Indigestion	YES	NO	Diabetes If yes, what type?_____	VES	NO
Excess Gas	YES	NO	Thyroid Cancer	YES	NO
Bloating after meals	YES	NO	Heat Cold Insensitivity	YES	NO
Diarrhea	YES	NO	Explain _____		
Nausea	YES	NO			
Blood in stools	YES	NO	HEMATOLOGIC		
Ulcer	YES	NO			
Herronhoids	YES	NO	Bleeding Disorder	YES	NO
Hepatitis If yes, what type?_____	YES	NO	Lymphoma	YES	NO
Liver Disease	YES	NO	Low Blood Count	YES	NO
Jaundice	YES	NO	Leukemia	YES	NO
Heartburn	YES	NO	Easy Bruising	YES	NO
Gallbladder Disease	YES	NO	Low Iron	YES	NO
Constipation	YES	NO			
Vomiting	YES	NO	ALLERGY / IMMUNOLOGY		
Black tarry stool	YES	NO			
Abdominal pain	YES	NO	Environmental Allergies	YES	NO
			Immune Disorders	YES	NO
GENITOURINARY			Lupus	YES	NO
			Rheumatoid Arthritis	YES	NO
Kidney infection	YES	NO	HIV Infections	YES	NO
Kidney stone	YES	NO			
Urinate at night If yes, how often? ____	YES	NO			
Blood in urine	YES	NO	NEUROMUSCULAR		
Bladder infection	YES	NO			
Are your periods regular?	YES	NO	Rheumatism	YES	NO
Age of menstruation_____			Ruptured Disc	YES	NO
Last period _____			Back Trouble	YES	NO
Number of Pregnancies _____					

Examined and Reviewed By: _____

Signature: _____ Date: _____