HEALTH HISTORY QUESTIONNAIRE - OKLAHOMA SINUS CENTER

NAME: ____________________

ACCOUNT # : ____________________

DATE: ____________________

QUESTIONNAIRE REVIEWED WITH PATIENT OR REPRESENTATIVE AT VISIT: *YES* ☐ *NO* ☐

____________________ *(Physician Signature)* __________ *(Date)*

1. PERSONAL INFORMATION:

AGE: _____ WEIGHT: _______ HEIGHT: _________

CURRENT PHYSICIANS: ____________________

PHARMACY: _______ PHARMACY LOCATION: _________

PHARMACY PHONE: _________

2. YOUR MEDICAL ILLNESSES: *(Check all that apply)*

YES	*NO*	
☐	☐	ALLERGY
☐	☐	ASTHMA
☐	☐	EMPHYSEMA / LUNG DISEASE
☐	☐	STROKE
☐	☐	HEART ATTACK
☐	☐	HEART RHYTHM ABNORMALITIES
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HEARING LOSS
☐	☐	DEPRESSION
☐	☐	HEADACHE / MIGRAINE
☐	☐	SKIN CANCER
☐	☐	CANCER *(Other)* ____________
☐	☐	OBSTRUCTIVE SLEEP APNEA / INSOMNIA
☐	☐	ANEMIA / BLOOD DISORDERS
☐	☐	THYROID DISEASE
☐	☐	DIABETES
☐	☐	KIDNEY DISEASE
☐	☐	HIV / HEPATITIS
☐	☐	HORMONE DYSFUNCTION

OTHER *(Please list)* ____________

3. PREVIOUS SURGERIES:

	Date:
____________________	_______
____________________	_______
____________________	_______

4. CURRENT MEDICATIONS: *(Please list names and dosing)*

____________	____________
____________	____________
____________	____________
____________	____________

5. MEDICATION ALLERGIES: ________ ________

6. SOCIAL HISTORY: *(Do you use any of the following)*

YES	*NO*		
☐	☐	ALCOHOL	*(DRINKS/WEEK ___)*
☐	☐	CIGAR / CIGARETTES	*(PACKS/DAY_____)*
☐	☐	CHEWING TOBACCO	
☐	☐	HERBAL MEDICINES	*(TYPE:________)*

7. FAMILY HEALTH HISTORY:

	Sibling	*Parent*	*Grand Parent*
HIGH BLOOD PRESSURE	☐	☐	☐
STROKE	☐	☐	☐
HEART ATTACK	☐	☐	☐
MIGRAINE	☐	☐	☐
DIABETES	☐	☐	☐
ASTHMA	☐	☐	☐
ALLERGY	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐
CANCER (TYPE):__________	☐	☐	☐
__________	☐	☐	☐

8. REVIEW OF SYMPTOMS: *(Check all that apply)*

YES	*NO*		
☐	☐	INSOMNIA	*(Gen)*
☐	☐	FATIGUE	
☐	☐	FEVER	
☐	☐	WEAKNESS	
☐	☐	RASH	*(Skin)*
☐	☐	DERMATITIS / ITCHING	
☐	☐	EAR PAIN	*(Ear)*
☐	☐	HEARING LOSS	
☐	☐	RINGING IN THE EAR	
☐	☐	PROBLEMS HEARING IN CROWDS	
☐	☐	TELEVISION TURNED UP TOO LOUD	
☐	☐	DOUBLE VISION	*(Eye)*
☐	☐	DRY EYES	
☐	☐	NASAL INFECTIONS	*(Nose)*
☐	☐	NASAL CONGESTION	
☐	☐	SNEEZING	
☐	☐	SORE THROAT	*(Mouth)*
☐	☐	SNORING	
☐	☐	HOARSENESS	
☐	☐	COUGH	*(Pulm)*
☐	☐	SHORTNESS OF BREATH	
☐	☐	CHEST PAIN	
☐	☐	HEART RHYTHM ABNORMALITIES	*(Cardiac)*
☐	☐	CHEST PAIN WITH EXERTION	
☐	☐	ANTIBIOTICS BEFORE PROCEDURES	
☐	☐	HEADACHE OR MIGRAINE	*(Neuro)*
☐	☐	NUMBNESS IN EXTREMITIES	
☐	☐	CHANGE IN MOOD	
☐	☐	DIFFICULTY SWALLOWING	*(GI)*
☐	☐	HEARTBURN / REFLUX	
☐	☐	INDIGESTION	
☐	☐	DIARRHEA / CONSTIPATION	
☐	☐	ABNORMAL BLEEDING	*(Heme)*
☐	☐	HISTORY OF ANEMIA	
☐	☐	WEIGHT GAIN / LOSS	*(Endo)*
☐	☐	THINNING HAIR	
☐	☐	FREQUENT URINATION	*(Urol)*
☐	☐	DIFFICULTY URINATING	
☐	☐	PAIN ON URINATION	
☐	☐	SWELLING IN THE NECK	*(Neck)*
☐	☐	NECK PAIN	
☐	☐	LYMPH NODE ENLARGEMENT	
☐	☐	JOINT PAIN	*(MS)*
☐	☐	MUSCLE FATIGUE	
☐	☐	UNSTEADINESS WHEN WALKING	

OKLAHOMA
SINUS CENTER

405-562-6362 Main
405-607-3557 Fax

DATE	NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
___________	________________________________	____________	______________________

1. **DESIGNATE A HEALTHCARE REPRESENTATIVE**

PLEASE IDENTIFY ANY OTHER INDIVIDUALS THAT YOU WOULD LIKE TO ALLOW ACCESS TO YOUR HEALTHCARE. BY DESIGNATING THOSE INDIVIDUALS BELOW, WE WILL BE ABLE TO RELEASE RECORDS TO THAT INDIVIDUAL ON YOUR BEHALF, RELAY RESULTS OF TESTS OR ASSESSMENTS, AND DISCUSS YOUR MEDICAL CONCERNS. BY DESIGNATING A REPRESENTATIVE BELOW, YOU WILL BE FULLY RESPONSIBLE FOR CHARGES INCURRED BY DECISIONS THAT THEY MAY BE AUTHORIZED TO MAKE. *PLEASE LEAVE THIS SECTION BLANK IF YOU DO NOT WISH TO DESIGNATE A REPRESENTATIVE.*

DESIGNATED REPRESENTATIVE	RELATIONSHIP	FINANCIAL RECORDS ONLY	ALL ASPECTS OF MEDICAL CARE
___________________________	________________	☐	☐
___________________________	________________	☐	☐
___________________________	________________	☐	☐

_____________________________________ *PATIENT SIGNATURE*

____ *PARENT / LEGAL GAURDIAN FOR MINOR*

2. **ACCESS TO HIPAA / PATIENT RIGHTS AND RESPONSIBILITY *AND* OUR SPECIFIC CLINIC POLICIES**

OKLAHOMA OTOLARYNGOLOGY ASSOCIATES, LLC AND OKLAHOMA HEARING CENTER CLOSELY FOLLOW NATIONAL GUIDELINES REGARDING PATIENT PRIVACY AND PATIENT RIGHTS / RESPONSIBILITIES IN HEALTHCARE. ADDITIONALLY, FOR YOUR BENEFIT, WE HAVE CLEARLY STATED DOCUMENTS DETAILING OUR FINANCIAL POLICIES AND OUR DISCLOSURE OF OWNERSHIP. THESE DOCUMENTS ARE PROVIDED AT THE INITIAL VISIT, AND WHEN UPDATES TO PATIENT FORMS IS REQUIRED. THESE DOCUEMENTS ARE **ALWAYS** AVAILABLE TO THE PATIENT UPON REQUEST. BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE RECEIVED AND READ A COPY OF OKLAHOMA OTOLARYNGOLOGY ASSOCIATES AND/OR OKLAHOMA HEARING CENTER'S *HIPAA DOCUMENTATIONS, FINANCIAL POLICY,* AND *OWNERSHIP DISCLUSURE POLICY.*

_____________________________________ *PATIENT SIGNATURE*

____ *PARENT / LEGAL GAURDIAN FOR MINOR*

3. **PROCEDURAL CONSENT AND AUTHORIZATION**

OKLAHOMA OTOLARYNGOLOGY ASSOCIATES REQUIRES AUTHORIZATION TO PERFORM PROCEDURES IN THE OFFICE THAT ARE NECESSARY TO ADEQUATELY EXAMINE EACH PATIENT'S CONCERNS. THIS MAY INCLUDE PROCEDURES SUCH AS OFFICE ENDOSCOPY OF THE NOSE OR THROAT OR WAX REMOVAL FROM THE EAR. THESE PROCEDURES ARE REFLECTED IN OUR REPORTING TO YOUR INSURANCE COMPANY AND ARE TYPICALLY APPLIED TO INDIVIDUAL DEDUCTIBLES OR CO-INSURANCE. THESE OFFICE PROCEDURES ARE VITAL IN AN EFFORT TO PROVIDE YOU A THOROUGH EXAMINATION. DECLINING THESE PROCEDURES MAY LEAD TO MIS-DIAGNOSIS OR FAILURE TO IDENTIFY THE UNDERLYING SOURCE FOR YOU CONCERN. A SIGNATURE IS REQUIRED TO AUTHORIZE THESE EXAMINATIONS ON YOUR BEHALF.

_____________________________________ *PATIENT SIGNATURE*

____ *PARENT / LEGAL GAURDIAN FOR MINOR*

OKLAHOMA SINUS CENTER

Patient Information:				
Last Name:	First Name:		MI:	Acct #:
Mailing Address:	City, State, Zip:		Home Phone: Cell Phone:	
D.O.B:	SS#:	Marital Status:	Sex: (M/F)	Referring Physician:
Employer: Employer Phone #:	**Meaningful Use Verification:** Preferred Language ___________________________________ **Race:** ☐ White ☐ American Indian/Alaskan Native ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latino ☐ Asian ☐ Other Race			
Email Address:				

Responsible Party: ***NO MINORS*** **can be listed as responsible party** **Guardian present and signing paperwork and all adults over 18 years of age will be listed as SELF for responsible party**		
Name:	Employer:	D.O.B:
Mailing Address:	City, State, Zip:	Phone: SS#:

Primary Insurance:			
Name & Phone number of Insurance:	Insurance ID Number:		
Insurance Address:	Group #:		
Policy Holder Information:			
Name (Last, First, MI):	Relationship to Patient:	Phone #:	
Subscriber SS#:	Sex (M/F):	D.O.B:	Employer:
Secondary Insurance:			
Name & Phone Number Of Insurance:	Insurance ID Number:		
Insurance Address:	Group #:		
Policy Holder Information:			
Name (Last, First, MI):	Relationship to Patient:	Phone #:	
Subscriber SS#:	Sex (M/F):	D.O.B:	Employer:
Any Additional Insurance:			
Name & Phone Number of Insurance: Name of Policy Holder:	Insurance ID Number: Group :		

Emergency Contact: NOT AT THE SAME ADDRESS AS PATIENT		
Name:	Phone #:	Relationship:
Address:	City, State, Zip:	

All charges are due at the time of service. All services rendered are charged to the patient or their responsible party. I understand that I am responsible for any amount not covered by my insurance. Therefore I hereby authorize the doctors of Oklahoma Sinus Center to furnish information to insurance carriers concerning my illness and treatment. The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, HIV, etc. I assign to the physician(s) all payments for medical services rendered to myself.

Signature:____ Date: ____