www.SmartSinus.com

13908 Quailbrook Dr
Quailbrook Medical Center BLDG C
Oklahoma City, OK 73134
405-655-5113

1100 E. Woodfield Rd
Suite 140
Schaumburg, IL 60173
847-813-7564

The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. Answer the questions, rating to the best of your ability the problem you have experienced over the past two weeks.

Patient Name: ___________________________

Sino-Nasal Outcome Test (SNOT-20)

Date: ___________________________

1. Consider 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. 2. Please mark the most important items affecting your health (maximum of 5 items).	No problem	Very mild problem	Mild or light problem	Moderate problem	Severe problem	Problem as bad as it can be		5 most important items
1. Need to blow nose	0	1	2	3	4	5		◯
2. Sneezing	0	1	2	3	4	5		◯
3. Running Nose	0	1	2	3	4	5		◯
4. Cough	0	1	2	3	4	5		◯
5. Post-nasal discharge	0	1	2	3	4	5		◯
6. Thick nasal discharge	0	1	2	3	4	5		◯
7. Ear fullness	0	1	2	3	4	5		◯
8. Dizziness	0	1	2	3	4	5		◯
9. Ear pain	0	1	2	3	4	5		◯
10. Facial pain/pressure	0	1	2	3	4	5		◯
11. Difficulty falling asleep	0	1	2	3	4	5		◯
12. Wake up at night	0	1	2	3	4	5		◯
13. Lack of sleep	0	1	2	3	4	5		◯
14. Wake up tired	0	1	2	3	4	5		◯
15. Fatigue	0	1	2	3	4	5		◯
16. Reduced productivity	0	1	2	3	4	5		◯
17. Reduced concentration	0	1	2	3	4	5		◯
18. Frustrated/Restless/Irritable	0	1	2	3	4	5		◯
19. Sad	0	1	2	3	4	5		◯
20. Embarrassed	0	1	2	3	4	5		◯

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PATIENT INFORMATION

Patient Name: ____ **Date of Birth:** _________________________

(LAST) (FIRST) (M.I.)

Sex: ☐Male ☐Female **SSN #:** ________ - ________ - ________

Address / Apt #: ____

City: _________________________ **State:** _________________________ **Zip Code:** _______________

Home Phone #: ___________________________ **Cell Phone #:** (___) ________________________

Email: _____________________________ **Preferred Contact Method:** ☐Home Phone ☐Cell Phone ☐Email

Marital Status: ☐Single ☐Divorce ☐Separated ☐Widowed ☐Married

Race: _____________ **Ethnicity:** ☐Hispanic ☐Non-Hispanic ☐Unknown **Preferred Language:** _____________

Employer Name: _______________________________________ **Occupation:** _______________________________

Relationship to Patient: ______________________ **Responsible Party Phone:** (___) ________________________

Responsible Party Address / Apt # (if different than above): ____

City: _____________ **State:** _____________ **Zip Code:** ________ **Responsible Party Date of Birth:** _____________

PRIMARY INSURANCE INFORMATION (In order for us to file a claim on your behalf, this section must be completed in its entirety by the patient.)

Primary Insurance Name: ____

ID#: ___________________________ **Group/Policy #:** _________________________________

Subscriber Name: ___________________________________ **Subscriber's Date of Birth:** _____________

Relationship to Patient: ____________________ **Subscriber's SSN #:** ________ - ________ - ________

HMO Primary Care Doctor (if applicable): ____

SECONDARY INSURANCE INFORMATION (In order for us to file a claim on your behalf, this section must be completed in its entirety by the patient.)

Primary Insurance Name: ____

Insurance Number: _______________________ **Group/Policy ID:** _______________________________

Subscriber Name: ___________________________________ **Subscriber's Date of Birth:** _____________

Relationship to Patient: ____________________ **Subscriber's SSN #:** ________ - ________ - ________

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Smart Sinus and Allergy (ENT)

Acknowledgement of Receipt of Information Practices Notice:
I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that the above listed information may be used to:

- Conduct, plan, and direct my treatment and follow up care among multiple healthcare providers, applicable
- Obtain payment from 3rd party payers
- Conduct normal healthcare operations such as quality assessment and physician certifications

I understand that I may request in writing to have the use or disclosure of my private information restricted in regards to treatment, payment, and healthcare operations. I also understand that **Smart Sinus and Allergy (ENT)** is not required to agree to my requested restrictions. In the case that **Smart Sinus and Allergy (ENT)** does agree to any restriction requested, we are bound to abide by them as stated by you.

Contact Permission:
In the event that **Smart Sinus and Allergy (ENT)** needs to contact you (patient) regarding an appointment, lab results, medication or any other reason, it's permitted to:

Check all that apply:
- ☐ Speak only with patient
- ☐ Leave a message on on answering machine
- ☐ Speak with spouse / significant other
- ☐ Speak with other family members

Cancellation:
If the patient cannot attend a scheduled appointment, it is the patient's responsibility or responsible party to call the office to cancel 24 hours prior to scheduled appointment.

Authorisation / Assignment / Financial Responsibility:
By signing below, I certify that I, or my dependent, have benefits issues by the above listed insurance plan(s) as completed by me, and hereby assign directly to **Smart Sinus and Allergy (ENT)** any benefit for services rendered. I authorise the release of information when necessary to secure the payment of such benefits to **Smart Sinus and Allergy (ENT)**. I authorise the use of the signature below on all insurance submissions as required. I fully understand that I am responsible for any and all charges and/or fees associated with services rendered and/or efforts by **Smart Sinus and Allergy (ENT)** to collect on monies owned by me. If any count balance should remain unpaid and the account is referred to a collection agency, I agree to pay any applicable collection fee and I understand that such fees may be added to the account balance.

My signature below indicates that I have read and understood the above statements and agreed upon them.

Patient Name: ____

Patient Signature (or Responsible Party): _______________________________ **Date:** _____ / _____ / ________

Relationship to Patient: ______________________________

(Office use only)
I attempted to obtain the patient's signature but was unable to do so as documented below:
Date: __________________ Initials: ____________ Reason: ____

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PATIENT REVIEW OF SYSTEMS

Please check all the symptoms you are CURRENTLY experiencing:

EYES	• Blurred vision • Itchy, watery eyes	• Painful Eyes • Other: ___________	• Sensitivity to light
EARS, NOSE, THROAT, AND MOUTH	• Runny nose • Ringing in the ears • Facial pain/ pressure • Pain in ___________	• Blocked nose • Painful swallowing • Difficulty swallowing • Lump in neck	• Post nasal drip • Pressure/fullness in ears • Hoarseness/Change of voice • Other___________________
CARDIOVASCULAR (HEART)	•Palpitations/Fluttering of heart • Shortness in breath while exercising	•Pain in chest •Other: ___________	
RESPIRATORY (LUNGS)	• Wheezing • Blood from throat	• Cough • Other: ___________	• Shortness of breath
GASTROINTESTINAL (STOMACH)	• Heartburn • Constipation	• Hiatal hernia • Nausea/vomiting	• Abdominal pain • Other: ______________________
GENITOURINARY	• Pain when urinating • Hesitation when urinating	• Urination at Night • Other: ___________	• Pregnancy
MUSCULOSKELETAL	• Soreness • Other: __________________	• Weakness	• Cramping
INTEGUMENTARY (SKIN)	• Itchy skin • Dry skin	• Lesions on Skin • Other: ___________	• Bleeding
NEUROLOGICAL (NERVES)	• Headaches • Abnormal movements	• Ringing in ears • Imbalance	• Dizziness/ Vertigo • Other: ______________________
PSYCHIATRIC	• Mood Swings	• Situational Stress	• Depression
ENDOCRINE	• Hot Flashes • Weight gain/loss	• Hair loss/ growth • Other: ___________	• Bleeding
HEMATOLOGIC/ LYMPH NODES	• Bleeding easily • Other: __________________	• Night Sweats • Location: _________	• Swollen lymph nodes
ANESTHESIA	• Never had anesthesia • Chipped/ loose teeth	• Nausea/Vomiting • Difficult airway	• No history of anesthesia reaction • Malignant hyperthermia

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PATIENT NAME: _______________________________ AGE: __________ DATE: ____________________

NAME OF PRIMARY PHYSICIAN: ____

NAME OF REFERRING PHYSICIAN/SPECIALIST: ____

REASON FOR TODAY'S VISIT: ____

PATIENT HISTORY

Have you ever had, or do you have...

□ Hearing loss
□ Nasal Allergies
□ Obstructive Sleep Apnea
□ Dizziness/ Meniere's Dx
□ Asthma
□ Thyroid Problem
□ Rheumatic Fever
□ Heart Disease/failure
□ Diabetes
□ CORD/Emphysema
□ Epilepsy/ Seizures
□ Glaucoma
□ High Blood Pressure
□ Liver infection/hepatitis
□ Bleeding Disorder
□ Mental Illness
□ Stroke
□ Anemia
□ Tuberculosis
□ Migraine Headache
□ Kidney stones
□ Sexually Transmitted Dx
□ Kidney Disease
□ Other: _______________
____
□ Cancer: ______________
____

Past Surgical History: (Please circle all that apply): None
Appendix Removed Bladder Removed Mastectomy (Right, Left, Bilateral) Lumpectomy (Right, Left, Bilateral) Breast Reduction Breast Implants Colectomy Valve Replacement Heart Transplant Angioplasty Pacemaker Placement Coronary Artery Bypass Ovaries Removed Hysterectomy Kidney Transplant TURP Tonsillectomy Prostate Removed: Prostate Cancer Hip (Right, Left, Bilateral) Spleen Removed Gallbladder Removal Chemo Therapy Radiation Joint Replacement (If yes, please describe: ____________________________________)
Other:____

Do you or your family members have any anesthesia complications? Yes___ No___ If yes, which ones?__________

Sinus/ Allergy Questionnaire

What are your sinus symptoms? ____
____
How long have you had these problems for? ____
How many infections do you get a year? ________________
What antibiotics have you tried? ____
When did you complete your most recent antibiotic? ____
Have you ever been given Prednisone or steroids before? Yes___ No___
Have you ever had head or neck surgery? ____
How is your sense of taste/ smell? ____
Have you been allergy tested in the past? Yes___ No___ If yes, was it blood or skin testing? ___________________

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CURRENT MEDICATIONS (YOU MAY ATTACH YOUR MEDICATION LIST) (Please list all)

1. ______________________ **2.** ______________________ **3.** ______________________
4. ______________________ **5.** ______________________ **6.** ______________________
7. ______________________ **8.** ______________________ **9.** ______________________

MEDICATION ALLERGIES? •YES •NO IF YES, WHICH MEDICATIONS AND TYPE OF REACTION?

1. ______________________ **2.** ______________________ **3.** ______________________
4. ______________________ **5.** ______________________ **6.** ______________________

FAMILY HISTORY

Has anyone in your immediate family (Parent, Siblings or Children) had...

- Hearing loss
- Dizziness/ Meniere's
- Thyroid Problem
- Migraine Headache
- COPD/ Emphysema
- Diabetes
- Stroke
- Epilepsy/ Seizures
- High blood pressure
- Birth Defects
- Bleeding Disorder
- Angina/ heart attack
- Asthma
- Kidney Disease
- Cancer: ________ ____________________

SOCIAL HISTORY

Occupation________________________________ **If retired, former occupation**______________________________
Military Service: Yes/No **If yes, # of years**____________________
Noise Exposure: Yes/No **If yes, type?** ________________________

Do you... (please check or circle all that apply)
• Use Alcohol **•Use Drugs**
• Use Tobacco currently or recently quit? When did you quit? # years ________ #packs _____________

REVIEWED BY: ____ **DATE:** _____________________________

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Consent for Endoscopy Sinus CT Scan Procedure

________ Flexible / Fiber Optic Laryngoscope

________ Nasal Endoscopy

________ CT Scan

____
Patient Name

By signing this form I consent to undergo the above named procedures and administration of topical aesthetics if necessary.

I have been informed that rare; the possible risks are anaesthesia reactions or bleeding. Benefits to this procedures are improved visualisation for diagnostic purposes.

This is considered a procedure and will be billed through my insurance. I understand that, subject to insurance or payer contract terms, I am responsible for charges not paid by insurance or other payer. I understand that images from my exam may be recorded for documentation and education purposes.

_____________________ _____________________________________
Date Patient's signature

Authorised to sign on behalf of patient: _______________________________________

Relationship to patient: ______________________