Neal M. Lofchy, M.D. Joseph P. Allegretti, M.D. Jay M. Dutton, M.D.

University Head and Neck Associates

THE MIDWEST SINUS CENTER

Dear Patient: _____

Thank you for scheduling an appointment with our group. We have enclosed some pre-appointment paperwork for you to complete. It is important that you bring this **completed** paperwork with you to your visit.

ARRIVE 30 MIN PRIOR TO YOUR APPOINTMENT TIME

Please note: All copays are collected at the time of service before you see the physician. For your convenience, we accept cash, check, MasterCard, Visa and Discover.

Bring with you to your appointment the following items:

Photo ID
Insurance Card(s)
Referral Form, if you have an HMO, BCBS Community, Meridian
List of all Medications
Copies of your most recent CT/MRI (CD DISKS ARE NEEDED AT THE APPOINTMENT, PLEASE OBTAIN PRIOR)
Most recent progress note from PCP & all labs and testing pertaining to your visit, which may include:

CT, MRI, SLEEP STUDY, SWALLOW STUDY, AUDIOGRAM, PATHOLOGY, BIOPSY RESULTS

Your appointment is with Dr. _____ on _____

At_____ in our_____ office.

Thank you and we look forward to seeing you soon!

3000 N. Halsted Ave., Suite 721
Chicago, IL. 60657
(312) 563-9805

3800 Highland Ave., Suite 105
Downers Grove, IL. 60515
(630) 574-8222

18210 S. LaGrange Rd., Suite 206
Tinley Park, IL. 60487
(708) 444-1530

MIDWEST SINUS CENTER – UNIVERSITY HEAD & NECK ASSOCIATES REGISTRATION FORM

LAST NAME:_____ FIRST NAME:_____ M.I._____

DATE OF BIRTH:_____ GENDER:_____

STREET ADDRESS: _____

CITY:_____ STATE: _____ ZIP:_____

HOME PHONE #:_____ CELL PHONE #:_____

EMPLOYER:_____

OCCUPATION:_____ BUSINESS PHONE #:_____

SPOUSE'S NAME:_____ SPOUSE'S PHONE #:_____

EMERGENCY INFORMATION—IN THE EVENT OF AN EMERGENCY PLEASE NOTIFY:

NAME:_____ RELATIONSHIP:_____PHONE #:_____

INSURANCE INFORMATON—POLICY HOLDER

NAME OF POLICY HOLDER: _____RELATIONSHIP_____DATE OF BIRTH: _____

HOW WERE YOU REFERRED/HOW DID YOU FIND OUR PRACTICE?

☐INSURANCE PLAN ☐INTERNET SEARCH ☐FRIEND/RELATIVE

☐PHYSICIAN/HOSPITAL(NAME)_____ ☐OTHER_____

CONSENT FOR TREATMENT/AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

-I consent to examination and treatment that may be required during my office visit. I authorize any emergency care that is deemed necessary by the physician during the visit.

-I authorize University Head and Neck Associates to release to my insurance company or its representatives, any information regarding my diagnosis and/or records of any treatment or examination rendered to me that is required to process my claims for benefits.

-I authorize and request my insurance company pay directly to University Head and Neck Associates the amount due to me in pending claims for medical treatment/services, by reason of such treatments or services rendered to me. This assignment will remain in effect until revoked by me in writing.

-It is understood that I am directly responsible for services rendered which is not paid by insurance. I certify to the best of my knowledge, the information contained on this Patient Registration Form is correct and true. I will notify University Head and Neck Associates in the event of any changes in the information contained on any/all form(s) completed.

X_____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

RECEIPT OF PRIVACY NOTICE/HEALTH INFORMATION USE NOTICE

I acknowledge receipt of University Head and Neck Associates *Notice of Privacy Practices*. The *Notice of Privacy Practices* provides detailed information about how University Head and Neck Associates may use and disclose a patient's protected health information.

X_____

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

We would like to be able to correspond with your primary care physician. We would also like to correspond with any other referring physicians who might be instrumental in your professional health care. Please supply us with the information needed below:

PATIENT NAME: _____

PRIMARY CARE PHYSICIAN:

NAME:_____

ADDRESS_____

CITY:_____STATE:_____ZIP CODE:_____

PHONE:_____FAX:_____

NPI(OFFICE USE ONLY):_____

REFERRING PHYSICIAN:

NAME: _____

ADDRESS_____

CITY:_____STATE:_____ZIP CODE:_____

PHONE:_____FAX:_____

NPI(OFFICE USE ONLY):_____

PREFERRED PHARMACY:

NAME: _____

ADDRESS_____

CITY:_____STATE:_____ZIP CODE:_____

PHONE:_____FAX:_____

Patient EMAIL ADDRESS: _____

University Head and Neck Associates

THE MIDWEST SINUS CENTER

Medical Information/HIPAA Release Form

NAME:_____ **Date of Birth:**_____

[ ] I authorize the release of information including diagnosis, records, appointments, lab/x ray results, medications, surgeries and claims information. This information may be released to:

Name: _____ **Phone Number:** _____

Relationship: _____

Name: _____ **Phone Number:** _____

Relationship: _____

Name: _____ **Phone Number:** _____

Relationship: _____

[ ] Information is NOT to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing or until my death.

Messages

Please call [ ] **my home** [ ] **my work** [ ] **my cell phone** @ _____

If unable to reach me:

[ ] you may leave a detailed message on my voicemail.

[ ] please leave a message asking me to return your call.

The best time to reach me is (day)_____ between (time) _____

Signed:_____ **Date:**_____

*****ALL CHANGES TO THIS POLICY, MUST BE MADE IN WRITING*****

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

CHIEF COMPLAINT

WHAT ARE YOU BEING SEEN FOR TODAY? _____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

WHO IS YOUR REFERRING DOCTOR? _____

PAST MEDICAL HISTORY

- DO YOU HAVE ANY SENSITIVITY OR ALLERGIC REACTIONS TO ANY MEDICATIONS OR FOODS?
  ☐ YES ☐ NO
- IF YES, PLEASE LIST THE NAME OF EACH AND YOUR TYPE OF REACTION:

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

- DO YOU HAVE AN ALLERGY TO LATEX? ☐ YES ☐ NO
- DO YOU HAVE ANY IMPLANTS SUCH AS AN ARTIFICIAL HEART VALVE OR HIP PROSTHESIS?
  ☐ YES ☐ NO IF YES, WHAT TYPE? _____
- PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON FOR HOSPITALIZATION	DATE	COMPLICATIONS

- PLEASE LIST ANY OTHER MAJOR ILLNESSES AND/OR INJURIES: _____

_____

_____

MEDICATIONS

- PLEASE LIST YOUR CURRENT MEDICATIONS. INCLUDE ANY BIRTH CONTROL PILLS, STEROIDS, ANY OVER-THE-COUNTER MEDICATIONS OR ANY RECREATIONAL DRUGS

CURRENT MEDICATIONS	DOSE	FREQUENCY

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

FAMILY HISTORY

PLEASE CIRCLE ANY MEDICAL PROBLEMS THT RUN IN YOUR FAMILY (GRANDPARENTS, PARENTS, SIBLINGS, OR CHILDREN)

DIABETES	ARTHRITIS	PROBLEMS WITH ANESTHESIA	TUBERCULOSIS
HEART DISEASE/HEART ATTACKS	KIDNEY DISEASE	BLEEDING PROBLEMS	IMMUNE DISORDER
HYPERTENSION	THYROID DISEASE (GOITER, ETC.)	CANCER-TYPE:_____	HEARING LOSS
MIGRAINES	ASTHMA	HAY FEVER	SEIZURES
STROKES/TIA'S	BIRTH DEFECTS	OTHER-EXPLAIN:	

SOCIAL HISTORY

- WHAT TYPE OF WORK DO YOU DO? _____
- DO YOU CURRENTLY DRINK OR HAVE YOU EVER USED ALCOHOLIC BEVERAGES IN THE PAST?

  ▫ YES ▫ NO IF YES, WHAT? _____ AMOUNT? _____HOW OFTEN? _____ LAST TIME USED? _____
- DO YOU USE / OR HAVE YOU USED TOBACCO IN ANY FORM? ▫ YES ▫ NO

  IF YES, WHAT? _____ AMOUNT? _____HOW OFTEN? _____ LAST TIME USED? _____

  DO YOU WANT HELP TO STOP? ▫ YES ▫ NO
- FOR PEDIATRIC PATIENTS:

  ARE ALL IMMUNIZATIONS UP TO DATE? ▫ YES ▫ NO

  IS THE CHILD EXPOSED TO TOBACCO SMOKE IN THE HOME OR DAYCARE? ▫ YES ▫ NO

  IS THE CHILD IN DAYCARE? ▫ YES ▫ NO

REVIEW OF SYSTEMS

ARE YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH:

	YES	NO
CONSTITUTIONAL		
NIGHT SWEATS	▫	▫
RECURRENT FEVERS	▫	▫
WEIGHT LOSS IN THE LAST SIX MONTHS	▫	▫
WAS THE WEIGHT LOSS INTENTIOAL?	▫	▫
WHAT IS YOUR USUAL WEIGHT? _____LBS.		
EYES		
DOUBLE VISION	▫	▫
INJURIES	▫	▫
GLAUCOMA	▫	▫
WEARING GLASSES/CONTACTS - DATE OF LAST EXAM: _____	▫	▫
EARS, NOSE, THROAT		
WEARING HEARING AIDS - DATE OF LAST EXAM: _____	▫	▫
HEARING LOSS	▫	▫
EAR PAIN	▫	▫
EAR INFECTIONS	▫	▫
RINGING IN EARS CIRCLE: LEFT RIGHT BOTH	▫	▫
DRAINAGE FROM EARS CIRCLE: LEFT RIGHT BOTH	▫	▫
BALANCE PROBLEMS (VERTIGO OR SPINNING)	▫	▫
NOSE BLEEDS	▫	▫
NASAL CONGESTION	▫	▫

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

EARS, NOSE, THROAT (CONT'D)	YES	NO
NASAL DRAINAGE	☐	☐
INABILITY TO SMELL	☐	☐
SINUS PROBLEMS	☐	☐
SORE THROATS	☐	☐
MOUTH SORES	☐	☐
HOARSENESS	☐	☐
DIFFICULTY SWALLOWING	☐	☐
SEASONAL ALLERGIES (HAYFEVER)	☐	☐
CARDIOVASCULAR		
CHEST PAIN OR ANGINA - DATE OF LAST EKG: _____	☐	☐
HIGH BLOOD PRESSURE	☐	☐
IRREGULAR PULSE	☐	☐
HEART MURMUR	☐	☐
ABNORMAL HEART ANATOMY	☐	☐
HAS A PHYSICIAN EVER RECOMMENDED ANTIBIOTICS PRIOR TO SURGICAL PROCEDURES (DENTAL WORK) OR BECAUSE OF A HEART MURMUR OR IMPLANT?	☐	☐
RESPIRATORY		
ASTHMA	☐	☐
CHRONIC COUGH	☐	☐
EMPHYSEMA	☐	☐
SHORTNESS OF BREATH	☐	☐
BRONCHITIS/PNEUMONIA	☐	☐
LUNG CANCER	☐	☐
BLOODY SPUTUM	☐	☐
TUBERCULOSIS	☐	☐
DATE OF LAST CHEST X-RAY: _____		
GASTROINTESTINAL		
INDIGESTION OR PAIN WITH EATING	☐	☐
CHRONIC NAUSEA/VOMITING	☐	☐
LIVER DISEASE (HEPATITIS)	☐	☐
JAUNDICE	☐	☐
ULCERS OR GASTRITIS	☐	☐
COLON OR STOMACH CANCER	☐	☐
GENITOURINARY		
RECURRENT URINARY TRACT INFECTIONS	☐	☐
BLOOD IN YOUR URINE	☐	☐
PROSTATE CANCER (MALES)	☐	☐
UTERINE OR CERVICAL CANCER (FEMALES)	☐	☐
MUSCULOSKELETAL		
BROKEN BONES - LIST: _____	☐	☐
CHRONIC ARM OR LEG WEAKNESS	☐	☐
ARTHRITIS	☐	☐
INTEGUMENTARY		
SKIN CANCER	☐	☐
SKIN DISEASE	☐	☐

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

	YES	NO
NEUROLOGICAL		
FAINTING SPELLS OR "BLACKING OUT"	☐	☐
SEIZURES	☐	☐
DIFFICULTY WITH YOUR SPEECH	☐	☐
FREQUENT HEADACHES OR MIGRAINES	☐	☐
STROKES	☐	☐
PSYCHIATRIC		
ANXIETY	☐	☐
DEPRESSION	☐	☐
OTHER PSYCHIATRIC DISORDER/TREATMENT: _____	☐	☐
ENDOCRINE		
DIABETES	☐	☐
THYROID DISEASE	☐	☐
EXCESSIVE THIRST OR URINATION	☐	☐
HORMONE PROBLEMS	☐	☐
ARE YOU PREGNANT OR BREASTFEEDING? (FEMALES)	☐	☐
HEMATOLOGIC/LYMPHATIC		
ANEMIA	☐	☐
HEMOPHILIA/EASY BLEEDING TENDENCIES	☐	☐
PERSISTENT SWOLLEN GLAND OR LYMPH NODES	☐	☐
BLOOD TRANSFUSIONS - IF YES, WHEN? _____	☐	☐
IMMUNOLOGIC		
IMMUNOLOGICAL DISORDERS (IMMUNE DEFICIENCY)	☐	☐

HAVE YOU EVER HAD ANY RADIATION TREATMENT?
IF YES, PLEASE EXPLAIN: _____

SIGNATURE _____ DATE: _____
(PATIENT/PERSON COMPLETING FORM)

RELATIONSHIP TO PATIENT: _____

REVIEWING STAFF SIGNATURE	DATE	NO CHANGES	CHANGES AS NOTED
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

COMMENTS:

I.D.:_____ **SINO-NASAL OUTCOME TEST (SNOT-22)** 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 your 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 often 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 bad as it can be		5 Most Important Items
1. Need to blow nose	**0**	**1**	**2**	**3**	**4**	**5**		O
2. Nasal Blockage	**0**	**1**	**2**	**3**	**4**	**5**		O
3. Sneezing	**0**	**1**	**2**	**3**	**4**	**5**		O
4. Runny nose	**0**	**1**	**2**	**3**	**4**	**5**		O
5. Cough	**0**	**1**	**2**	**3**	**4**	**5**		O
6. Post-nasal discharge	**0**	**1**	**2**	**3**	**4**	**5**		O
7. Thick nasal discharge	**0**	**1**	**2**	**3**	**4**	**5**		O
8. Ear fullness	**0**	**1**	**2**	**3**	**4**	**5**		O
9. Dizziness	**0**	**1**	**2**	**3**	**4**	**5**		O
10. Ear pain	**0**	**1**	**2**	**3**	**4**	**5**		O
11. Facial pain/pressure	**0**	**1**	**2**	**3**	**4**	**5**		O
12. Decreased Sense of Smell/Taste	**0**	**1**	**2**	**3**	**4**	**5**		O
13. Difficulty falling asleep	**0**	**1**	**2**	**3**	**4**	**5**		O
14. Wake up at night	**0**	**1**	**2**	**3**	**4**	**5**		O
15. Lack of a good night's sleep	**0**	**1**	**2**	**3**	**4**	**5**		O
16. Wake up tired	**0**	**1**	**2**	**3**	**4**	**5**		O
17. Fatigue	**0**	**1**	**2**	**3**	**4**	**5**		O
18. Reduced productivity	**0**	**1**	**2**	**3**	**4**	**5**		O
19. Reduced concentration	**0**	**1**	**2**	**3**	**4**	**5**		O
20. Frustrated/restless/irritable	**0**	**1**	**2**	**3**	**4**	**5**		O
21. Sad	**0**	**1**	**2**	**3**	**4**	**5**		O
22. Embarrassed	**0**	**1**	**2**	**3**	**4**	**5**		O

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

Nasal Obstruction Symptom Evaluation (NOSE) Assessment

PATIENT'S NAME: _____ TODAY'S DATE: _____

Please help us to better understand the impact of nasal obstruction on your quality of life by completing the following survey.

Over the past ONE month, how much of a problem were the following conditions for you?
Please (**circle**) the most correct response for each category.

	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
Total Score					
NOSE Score (Multiply your total score x5)					

A score of 0 means no problems with nasal obstruction and a score of 100 means the worst possible problems with nasal obstruction. Instrument was not designed to be used with individual patient data or to predict outcome on individuals. *Otolaryngology–Head and Neck Surgery*. 162-163 STEWART et al February 2004.

NAME: _____ DATE: _____

1. OVERALL, HOW WOULD YOU RATE YOUR HEALTH?

2. _____EXCELLENT
3. _____VERY GOOD
4. _____FAIR
5. _____POOR

2. PLEASE INDICATE THE OVERALL AMOUNT OF DISTURBANCE OR "BOTHER" THAT YOU EXPERIENCE IN YOUR LIFE AS A RESULT OF YOUR RHIOSINUSITIS PROBLEMS:

1. _____NOT BOTHERED
2. _____BOTHERED A LITTLE, BUT NOT A LOT
3. _____BOTHERED MORE THAN A LITTLE, BUT NOT A LOT
4. _____BOTHERED A LOT
5. _____EXTREMELY BOTHERED

3. HOW LONG HAVE YOU BEEN EXPERIENCING YOUR CURRENT SYMPTOMS?

1. _____I AM NOT EXPERIENCING ANY SYMPTOMS NOW.
2. _____2-4 WEEKS.
3. _____GREATER THAN 4 WEEKS BUT LESS THAN 6 WEEKS
4. _____6 WEEKS TO 3 MONTHS
5. _____GREATER THAN 3 MONTHS
6. _____UNSURE

4. WHAT RHINOSINUSITIS MEDICATIONS OR TREATMENTS ARE YOU USING NOW OR HAVE USED SINCE DEVELOPING YOUR PRESENT SYMPTOMS? (PLEASE CHECK ALL THAT APPLY)

0. _____NONE
1. _____NON-DRUG METHODS (EXAMPLES: STEAM INHALATIONS, WARM PACKS)
2. _____SALINE NASAL SPRAYS, DROPS, OR NASAL EMOLLIENTS.
3. _____"OVER THE COUNTER" DECONGESTANT NASAL SPRAYS OR DROPS (EXAMPLES: NEOSYNEPHRINE, AFRIN)
4. _____DECONGESTANTS (EXAMPLES: SUDAFED)
5. _____ANTIHISTAMINES (EXAMPLES: BENADRYL, CLARITIN, CLARINEX, ALLEGRA, ZYRTEX)
6. _____BOTH ANTIHISTAMINE AND DECONGESTANT (EXAMPLES: CLARITIN-D, ALLEGRA-D)
7. _____ANTIBIOTICS (EXAMPLES: AMOXICILLIN, ERYTHROMYCIN, CEFTIN, LEVAQUIN, Z-PACK, BIAXIN)
8. _____ORAL STEROIDS (EXAMPLES: PREDNISONE, MEDROL)
9. _____NASAL CROMOLYN SPRAYS (EXAMPLE: NASALCROM)
10. _____NASAL STEROID SPRAYS (EXAMPLES: FLONASE, NASONEX, RHINOCORT)
11. _____ALLERGY SHOTS

5. HAVE YOU EVER HAD SINUS OR NOSE SURGERY? IF SO, PLEASE DESCRIBE:

DATE	TYPE
_____	_____
_____	_____