Adult Health History Form

Please enter the patients information.

Patient First Name: ______
Patient Middle Initials: ______
Patient Last Name: ______
Date of Birth: ______
SSN: ______

Gender:
- ○ Female ○ Male

Marital Status:
- ○ Single ○ Married
- ○ Domestic Partner
- ○ Separated ○ Divorced
- ○ Widowed

Ethnicity:
- ☐ Hispanic/Latino
- ☐ Non Hispanic Latino
- ☐ Decline

Race:
- ☐ White
- ☐ American Indian
- ☐ Alaska Native
- ☐ African American
- ☐ Native Hawaiian
- ☐ Asian ☐ Other
- ☐ Decline

Street Address: ______
Apt./Unit #: ______
City: ______
State: ______
Zip Code: ______

Mobile Phone: ______
Home Phone: ______
Work Phone: ______

Email: ______

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone ○ Email ○ Text

Occupation ______

Can we leave a confidential voicemail??
☐ Yes ☐ No

Language: ______

Reason for visit: ______

Is the patient under the age of 18 years old?

○ Yes ○ No

RESPONSIBLE PARTY (IF PATIENT IS A MINOR) Minors must be accompanied by a parent or legal guardian (please bring guardianship paperwork to the appointment).

Parent/Guardian First Name: ______
Parent/Guardian Last Name: ______
Date of Birth: ______
SSN: ______

Street Address: ______
Apt./Unit #: ______
City: ______
State: ______
Zip Code: ______

Mobile Phone: ______
Home Phone: ______
Work Phone: ______

Emergency Contact Name (First and Last): ______
Emergency Contact Phone: ______

Emergency Contact Relationship
☐ Spouse/Domestic Partner ☐ Child ☐ Parent ☐ Sibling ☐ Friend ☐ Grand Parent ☐ Other Family Member

Pharmacy Name: Pharmacy Phone:

Provide us with the pharmacy address to ensure prescriptions are sent to the correct location, if applicable.

How did you find us?

☐ Referring Provider/Primary Care Provider
☐ Insurance Company
☐ Social Media (Instagram, Facebook, Nextdoor, etc..
☐ Family/Friend
☐ Yelp
☐ Google
☐ Breathe Clear Institute Website
☐ Previous Patient
☐ Other (please explain below)

Please provide us with the referring provider information so we can keep them informed about your/patient care:

Referring Providers Name (First and Last) Referring Providers Phone

Referring Providers Address (Some providers practice in multiple locations)

Is the referring provider the same provider as the primary care provider?

○ Yes ○ No ○ N/A (No PCP)

Do you have a primary care provider?

○ Yes ○ No

Primary Care Physician (First and Last Name): Primary Care Provider Phone:

Primary Care Providers Address (some providers provide care at multiple locations):

Do you/patient have health insurance?

○ Yes ○ No

Primary Insurance Information, please bring a photo ID and insurance card(s) to the appointment. Be sure to read the financial policy section regarding our in-network status with insurance carriers.

Primary Insurance Company Member ID / Policy # Group Number

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name (First and Last): Insured Date of Birth Insured Gender
○ Female ○ Male

Secondary Insurance

Secondary Insurance Company ____________________ Member ID / Policy # ____________________ Group Number ____________________

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name (First and Last): ____________________ Insured Date of Birth ____________________ Insured Gender ○ Female ○ Male

Is there someone other than yourself that you give us permission to speak to regarding appointments, billing and health information?

○ Yes ○ No

Please list individuals (and relationship) with whom you allow us to share your health information, billing information and appointment information with:

	Name	Relationship
1		
2		
3		

Acknowledgement of Protected Health Information (PHI) and Notice of Privacy Practices (NPP) Receipt The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Breathe Clear Institute in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information, the Patient has a right to review this document prior to signing this consent. This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice. Patient acknowledges and agrees that this Organization may disclose the Patient's protected health information and/or medical record - billing information to the following individual(s) who are the Patient's family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient. You can read the Notice of Privacy Practices attached to this intake form or you can also ask for a copy in our office Notice of Privacy Practices

____________________ Signature ____________________ Date

HEALTH QUESTIONNAIRE

Do you/patient take any over the counter medications, prescription medication, blood thinning medications or supplements?

○ Yes ○ No

List all prescription medications, over the counter medications, vitamins and minerals that you/patient are CURRENTLY taking:

	Medications		Medications
1		2	
3		4	

You can upload the medication list or bring in a copy

Medication Allergies?

○ Yes ○ No Known Allergy

If yes, please list including reaction:

	Allergy	Reaction
1		
2		
3		

Allergic reaction to Shellfish, Iodine, IV contrast and/or Latex?

○ Yes ○ No

If yes, list allergen and reaction:

____

Have you/patient ever had surgery?

○ Yes ○ No

Surgical History?

☐ Adenoidectomy ______________ ☐ Tonsillectomy ______________ ☐ Ear surgery ______________

☐ Sinus/Nose Surgery (Please explain) ______________ ☐ Throat Surgery (Please explain) ______________ ☐ Oral Surgery ______________

☐ Head/Neck Surgery (Please explain) ______________ ☐ Heart Surgery (Please explain) ______________ ☐ Other Surgery (see below): ______________

If other, specify:

____

Have you/patient ever had problems with anesthesia?

○ Yes ○ No ○ Not sure

If yes, please describe:

____

Do you/patient have any metal fragments or any surgically implanted devices, plates, oral appliances, prosthesis, stents, bands, etc..

☐ Yes ☐ No

If yes, please describe:

____

Medical conditions you/patient have or have had:

☐ Allergies
☐ Asthma
☐ Coronary Artery Disease/CAD
☐ Congestive Heart Failure (CHF)
☐ Congenital Heart Condition
☐ COPD/Emphysema
☐ Cystic Fibrosis
☐ CVA/Stroke
☐ Deviated Septum
☐ Diabetes Type I
☐ Diabetes Type II
☐ Frequent epistaxis/bloody nose
☐ Gastroesophageal Reflux\GERD
☐ Glaucoma
☐ Hepatitis
☐ Hearing Loss
☐ Heart Attack/MI
☐ HIV
☐ History of blood clots/Bleeding disorder
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Hypertension/High Blood Pressure
☐ Immunological disorder
☐ Irregular Heartbeat
☐ Kidney/Renal Failure
☐ Liver disease
☐ Migraines/Headaches
☐ Pacemaker
☐ Seizures/Epilepsy
☐ Sleep Apnea/OSA
☐ Tuberculosis
☐ None/Non-contributory

Please list any additional medical conditions:

____

If you/patient have cancer or are in remission, use the space below to provide us with additional information.

____

____

____

____

Please provide us with type of cancer and additional details

____

Do you/patient smoke cigars, cigarettes and/or E-cigarettes)?

○ Yes ○ No ○ Not Anymore

What do you smoke?	# Packs a day:	# Times a day	# Times a week	Year started:

Year stopped:

____

Have you/patient ever been exposed to second hand smoke?

○ Yes ○ No

Fall Risk: Have you/patient fallen lately?

○ Yes ○ No

Vitals - Height/Weight

Height ______________________ Weight ______________________

Do you/patient have problems breathing through your nose?

○ Yes ○ No

Do you/patient have a runny nose or postnasal drip?

○ Yes ○ No

Do you/patient sneeze or have an itchy nose and/or eyes?

○ Yes ○ No

Do you/patient have facial pain/pressure, excessive mucous production, and/or reduced sense of smell?

○ Yes ○ No

What have you tried in the past to alleviate your sinus, nose and/or allergy symptoms?

☐ Nasal lavage (Neilmed or Neti pot) ☐ Intranasal corticosteriods (Nasacort, Rhinocort, Flonase, etc...) ☐ Antihistamines (Allegra, Zyrtec, Xyzal, etc..) ☐ Antibiotic therapy ☐ Decongestants ☐ Nothing

What tests have you had in the past? Please bring previous doctors notes, CT scans, MRI's and/or Allergy testing to your appointment.

☐ CT Scan ☐ MRI ☐ Allergy Testing ☐ None

How many sinus infections have you had over the past year?

____

How long did the sinus infections last each time?

____

Do you/patient snore and/or have problems with excessive sleepiness during the day?

○ Yes ○ No

Do you/patient have any issues with your ears?

○ Yes ○ No

Do you/patient have any of the following issues in regards to hearing?

	Check if yes	Please Select
Ringing in ear(s)		
If you have ringing, is it bothersome?		
Hearing Loss		
Trouble hearing in noise		
NONE		

How many ear infections has the patient had over the past year?

____

Any other specific concerns about your/patient health?

____

____

____

____

Consent to Treatment I consent to receiving medical care from Steven E. Davis MD, Inc. medical care includes exams, testing, appropriate immunizations and medical treatment. My consent covers care from the medical staff and employees of Steven E. Davis MD Inc. No one has guaranteed me that the medical care will have certain results. I have the right (i) to make decisions about my health care, (ii) to refuse medical care, and (iii) to revoke this consent at any time except to the extent medical care has already been provided. I consent to let the medical staff document my condition upon and during my admission, including taking photographs moving pictures, or other pictures or videotapes. The patient or the authorized parent, guardian, responsible party or surrogate of the patient must give consent.

____________________________   ________________

Signature   Date

RCAT - RHINITIS CONTROL ASSESSMENT TEST (This questionnaire is for evaluating symptom control in patients with rhinitis)

Please select the category that bests answers the questions below:	5=Never	4=Rarely	3=Sometimes	2=Often	1=Extremely Often
During the past week, how often did you have nasal congestion?	Never	Rarely	Sometimes	Often	Extremely Often
During the past week, how often did you sneeze?	Never	Rarely	Sometimes	Often	Extremely Often
During the past week, how often did you have watery eyes?	Never	Rarely	Sometimes	Often	Extremely Often
During the past week, to what extent did your nasal or other allergy symptoms interfere with your sleep?	Never	Rarely	Sometimes	Often	Extremely Often

During the past week, how often did you avoid any activities (for example, visiting a house with a dog or cat, gardening) because of your nasal or other allergy symptoms?	Never	Rarely	Sometimes	Often	Extremely Often
During the past week, how well were your nasal or other allergy symptoms controlled?	Completely	Very	Somewhat	A little	Not at all

SNOT-22 SINO-NASAL OUTCOME TEST (22 QUESTIONS) (section) 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.

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:	0=No problem	1=Very mild problem	2=Mild or slight problem	3=Moderate problem	4=Severe problem	5=Problem as bad as it can be
Need to blow nose	0	1	2	3	4	5
Sneezing	0	1	2	3	4	5
Runny nose	0	1	2	3	4	5
Cough	0	1	2	3	4	5
Post nasal discharge (dripping at the back of your nose)	0	1	2	3	4	5
Thick nasal discharge	0	1	2	3	4	5
Ear fullness	0	1	2	3	4	5
Dizziness	0	1	2	3	4	5
Ear pain	0	1	2	3	4	5
Facial pain/pressure	0	1	2	3	4	5
Difficulty falling asleep	0	1	2	3	4	5
Waking up at night	0	1	2	3	4	5
Lack of a good night’s sleep	0	1	2	3	4	5
Waking up tired	0	1	2	3	4	5
Fatigue during the day	0	1	2	3	4	5
Reduced productivity	0	1	2	3	4	5
Reduced concentration	0	1	2	3	4	5
Frustrated/restless/irritable	0	1	2	3	4	5
Sad	0	1	2	3	4	5

Embarrassed	0	1	2	3	4	5
Decreased sense of taste/smell	0	1	2	3	4	5
Nasal blockage/congestion	0	1	2	3	4	5

Most Important 5 Items from above:

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rTNSS Questionnaire

Reflect over the past 1 week, please rate your rhinitis symptoms (select one rating per line):	0=No Symptoms	1=Mild Symptoms (Present but easily tolerated)	2=Moderate Symptoms (Present & bothersome, but tolerable)	3=Severe Symptoms (Present & interfere with daily living and/or sleep)
Runny Nose/Post Nasal Drip	0	1	2	3
Stuffy Nose	0	1	2	3
Nasal itching	0	1	2	3
Sneezing	0	1	2	3

NASAL OBSTRUCTION AND SEPTOPLASTY EFFECTIVENESS SCALE

Over the past ONE month, how much of a problem were the following conditions for you? Please choose the most correct response.	Not a Problem	Very Mild Problem	Moderate Problem	Fairly Bad Problem	Severe Problem
Nasal congestion or stuffiness	0	1	2	3	4
Nasal blockage or obstruction	0	1	2	3	4
Trouble breathing through my nose	0	1	2	3	4
Trouble sleeping	0	1	2	3	4
Unable to get enough air through my nose during exercise or exertion	0	1	2	3	4

Multiply score by 5 and enter total

EUSTACHIAN TUBE DYSFUNCTION Patient Questionnaire (ETDQ-7) - (This questionaire helps us assess your symptoms and treatment in Eustachian tube dysfunction (ETD). Please complete the following questionnaire if you are or have had issues with your ears in the past month.

During the past 1 month, how much of a problem was each of the following? Next to each question, select the number that best describes how you feel.	1=No Problem	2	3	4=Moderate Problem	5	6	7=Severe Problem
Pressure in the ears?	1	2	3	4	5	6	7
Pain in the ears?	1	2	3	4	5	6	7

A feeling that your ears are clogged or “under water”?	1	2	3	4	5	6	7
Ear problems when you have a cold or sinusitis?	1	2	3	4	5	6	7
Crackling or popping sounds in the ears?	1	2	3	4	5	6	7
Ringing in the ears?	1	2	3	4	5	6	7
A feeling that your hearing is muffled?	1	2	3	4	5	6	7

Do you/patient get these symptoms in one ear only or both ears?

☐ Left ear only ☐ Right ear only ☐ Both ears

☐ None

Score: (Total Score ÷ 7)

____

Adult epworth sleepiness scale - This questionnaire is to determine the level of daytime sleepiness in individuals.

Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies:	0=Would never doze	1=Slight chance of dozing	2=Moderate chance of dozing	3=High chance of dozing
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3