

What is the reason for your visit today? _____

How tall are you? _____

How much do you weigh? _____

List all current medications, including any over the counter (OTC) medications or supplements

Not taking any medications

Name of Medication and Dosage

List any drug allergies or medicines you cannot take

No known drug allergies

Name of Medication	Type of Reaction

Have you ever had allergy testing?

No

Yes

Results:

Negative

Positive To:

Animals

Dust

Grass

Molds

Trees

Weeds

Are you allergic to any of the following?

Latex

Tape

Foods _____

Other _____

Have you ever taken allergy shots?

No Yes

Are you currently taking shots?

No When did you stop taking shots? _____

Where they helpful? _____

Yes. When did you start shots? _____

Are they helpful? _____

Past Health History

Please indicate any diseases that you have had or been diagnosed with by a doctor

No Major Illnesses

Childhood Diseases

- Chicken Pox
 Measles
 Mumps
 Other _____

Ears, Nose & Throat

- Ear Infections
 Hearing Loss
 Sinus Infections
 Sleep Apnea
 TMJ Dysfunction
 Other _____

Digestive

- Diverticulitis
 Hemorrhoids
 Hepatitis – Type: A B C
 Irritable Bowel Syndrome
 Reflux
 Gallbladder Disease (Stones)
 Other _____

Brain/Nervous System

- Alzheimer's/Dementia
 Seizures
 Multiple Sclerosis
 Stroke
 Headache
 Other _____

Allergies/Immune System

- AIDS/HIV
 Autoimmune disorder
 Lupus
 Other _____

Cancer

- Breast
 Leukemia
 Lung
 Other _____

Heart

- Angina (chest pain)
 Heart Attack
 Hypertension
 Murmur
 Mitral Valve Prolapse
 Other _____

Bones/Joints

- Arthritis
 Osteo Rheumatoid
 Osteoporosis
 Other _____

Mental/Emotional Health

- Anxiety Disorder
 Bi-Polar
 Depression
 Other _____

History of any Other Condition Not Listed

- _____

Congenital (Birth) Problems

- Congenital Malformation
 Down's Syndrome
 Prematurity
 Other _____

Lungs

- Asthma
 COPD
 Cystic Fibrosis
 Tuberculosis
 Other _____

Skin

- Rosacea
 Acne
 Eczema
 Psoriasis
 Other _____

Glands/Hormones

- Diabetes
 Type I Type II
 Grave's Disease
 Thyroid Disease
 Hyper Hypo
 Other _____

Female Patients Only: Are you pregnant? Yes No Possibly / Not Sure

Please indicate any major surgeries you have had

No Surgery

(If you choose other please describe)

Eyes	<input type="checkbox"/> Cataract	<input type="checkbox"/> LASIK	<input type="checkbox"/> Other
Ears	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Other	
Nose	<input type="checkbox"/> Rhinoplasty	<input type="checkbox"/> Septoplasty	<input type="checkbox"/> Sinus <input type="checkbox"/> Other
Mouth /Neck	<input type="checkbox"/> Tonsil / Adenoid	<input type="checkbox"/> Thyroid Total or Partial?	<input type="checkbox"/> Other
Heart	<input type="checkbox"/> Bypass	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Transplant <input type="checkbox"/> Other
Lungs / Chest	<input type="checkbox"/> Esophagus	<input type="checkbox"/> Lungs	<input type="checkbox"/> Other
Digestive	<input type="checkbox"/> Hernia	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Appendectomy <input type="checkbox"/> Other
Female/Male Health	<input type="checkbox"/> Prostatectomy Simple or Radical	<input type="checkbox"/> C-section	<input type="checkbox"/> Hysterectomy
	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Bladder	<input type="checkbox"/> Kidney <input type="checkbox"/> Other
Other	<input type="checkbox"/> Any other major surgery? Please Describe		

Have you ever had problems with anesthesia (being put to sleep for surgery)?

No Yes _____
(Please describe)

Have you ever had a serious injury? No Yes _____
(Please describe)

Family History

Please list any of your **BLOOD RELATIVES** who have a history of any of the following and give their relationship to you:

Family history unknown

	<input type="checkbox"/> No	<input type="checkbox"/> Yes	RELATIONSHIP
Problems/Complications with Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Problems (Including Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding/Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glands/Hormones (Diabetes)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
			(Please describe)
Other Major Health Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
			(Please describe)

Social History

Current Occupation: _____ Disabled Retired Student

Marital status: Single Married Divorced Widowed Cohabiting

Tobacco use?

Never Yes: Cigarette Cigar Pipe Chew

When did you start? Age: _____ or Year: _____

Average use per day _____

Quit

When did you start? Age: _____ or Year: _____

When did you stop? Age: _____ or Year: _____

Average use per day _____

Alcohol use? No Yes

Types & average number per week? Beer: _____ Wine: _____ Wine Coolers: _____ Mixed Drinks or Liquor _____

Have you ever been dependent on or addicted to any drugs?

No

Yes _____ Prefer to discuss with doctor

(Please describe)

Sacramento Ear, Nose & Throat Surgical and Medical Group, Inc.
And S.E.N.T. Hearing Aid Center
Privacy Consent Form

Sacramento Ear, Nose & Throat Surgical and Medical Group, Inc. and S.E.N.T. Hearing Aid Center (collectively "SacENT") recognizes and respects the fact that all patients have the right to inspect and obtain a copy of their own records (Protected Health Information).

With my consent SacENT may use and disclose any Protected Health Information (PHI) about myself (or my child) to carry out treatment, payment, to collect any outstanding charges, and healthcare operations. Please refer to SacENT's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the notice of Privacy Practices prior to signing this consent. Our office reserves the right to revise its notice of Privacy Practices at anytime.

With my consent, this office may mail to my home or other designated location or leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminders, insurance items payment items, and any call pertaining to my clinical care, including laboratory results and information among others.

With my consent, the doctors office may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and other healthcare operations, such as appointment reminder cards, patient statements, and any other information regarding my (or my child's) healthcare as long as they are marked "Personal and Confidential".

With my consent, SacENT may e-mail any information regarding my (or my child's) healthcare, treatment, payment, and appointments to me.

I have the right to request that SacENT restricts how it uses and discloses my healthcare information to carry out treatment and payment. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am authorizing SacENT to use and disclose my PHI to carry out treatment, payment, and other healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SacENT may decline to provide treatment to my child or me.

To protect patient's privacy, no camera devices are permitted.

I have read and received a copy of the brochure Privacy Practices.

Print Patient Name

Date of Birth

Signature of Patient or Legal Guardian

Date

The doctor may release PHI to:

Spouse
Partner
Guardian

**Sacramento Ear, Nose and Throat
Surgical and Medical Group, Inc**

Patient Communication Disclosure

Please **initial** by each form of communication by which we can contact patient.

_____ The practice may **call my home or cellular phone** at the following number and leave the appointment date and time on my telephone answering machine, voicemail, or with whomever answers my phone if I am not available. I understand that other individuals may have access to the information left by this method. I understand that no other information will be provided in granting permission to leave the date and time.

Telephone number on which **messages** can be left: _____

_____ The practice may email **my home** or other **email address** regarding any information that will assist the practice and physician with the treatment, payment, and health care operations for the patient. This can include appointment reminders, statements, insurance information, and any information concerning my clinical care.

Email Address to which information can be sent: _____

_____ The practice may send a **text message** to my cellular phone regarding appointment reminders, cancellations, or time changes. This form of communication will be for the use of the Appointment Desk and not private or clinical information. **Your telephone provider will charge you for this service.**

Cellular Phone to which information may be **texted:** _____

I understand that I have the right to a written request to restrict how SacENT may use or disclose my protected health information to complete treatment, payment, and health care operations. SacENT is not required to agree to my requested restrictions, but if my request is granted it is bound by that agreement. I further understand that I may revoke this authorization at any time in writing to the practice. At any time, I can change the way in which I am contacted. I have read, agree and given consent to the practice to communicate with me in the above method (s).

Patient / Legal Guardian Signature

Date