Department of Otolaryngology-
Head and Neck Surgery

Division of Rhinology/Sinus Surgery

Cramblett Hall, Suite 4A
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http://sinus.osu.edu

New Patient Information

Patient Info:

Name: (Last, First, Middle Initial) ______________________________
Address: (Street) ______________________________
(City, State, Zip) ______________________________
Phone Number: ______________________________
Email: ______________________________

Sex: ☐ Male ☐ Female Age __________ Date of Birth: ______________
Name of legal guardian (if any): __________ Relation: ______________

Work Info:

Employer: ______________________________
Occupation: ______________________________
Work phone: ______________________________
Insurance Company: ______________________________

Referral Information:

Primary Care Doctor: ______________ Name of Practice: ______________
City, State: ______________
Specialty: ______________

Referring Doctor: ______________ Name of Practice: ______________
City, State: ______________
Specialty: ______________

How did you hear about our practice? ______________________
Have you seen/used any of the following?
☐ Website http://ent.osu.edu ☐Other internet listing ☐ Billboards ☐ Phonebook
☐ Print material ☐TV advertising

Did any of the following affect your decision to be seen at our practice?

Our Department is ranked in the top 20 in the nation? ☐ Yes ☐ No
Aware of national courses/presentations given by doctor? ☐ Yes ☐ No
Aware of advanced research performed by Department? ☐ Yes ☐ No
Word of mouth reputation of the practice or physician? ☐ Yes ☐ No
Other: ____

Insurance Information:

Patient's Insurance Company: ______________________
Patient's Policy Number: ______________________
Patient's Group Number: ______________________
Patient's Social Sec Number: ______________________

Is this a high-deductible policy? ☐ Yes ☐ No
Is visit related to on-the-job injury? ☐ Yes ☐ No
Is visit related to an accident? ☐ Yes ☐ No

Is your policy under someone else's name (ie parent, spouse, etc?)
If yes, complete the following information:

Responsible person (last, first, MI) ______________________
Address: (Street) ______________________
(City, State, Zip) ______________________
Date of Birth: ______________________
Social Security Number: ______________________

If more than one responsible person/insurance policy, please complete:

Responsible person (last, first, MI) ______________________
Address: (Street) ______________________
(City, State, Zip) ______________________
Date of Birth: ______________________
Social Security Number: ______________________

Guardian Information/Sharing Medical Information:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other
Person(s) ok to share health information with: ______________________
Relation: ______________________
Emergency Contact: ______________________
Phone: ______________________

Patient Name: ________________________ **Allergies to Medicines:** ______________________________

What problem are you here for today?(**Chief Complaint**)____

Past Medical History

	Yes	No	Explain
Previous Sinus Surgery	☐	☐	____________
Prev nasal fracture or surgery	☐	☐	____________
Nasal polyps	☐	☐	____________
Asthma	☐	☐	____________
Problems taking aspirin	☐	☐	____________
Nasal Allergies	☐	☐	____________
Food Allergies	☐	☐	____________
Hives	☐	☐	____________
Diabetes	☐	☐	____________
High blood pressure	☐	☐	____________
Cancer	☐	☐	____________
Anesthesia problems	☐	☐	____________
Bleeding problems	☐	☐	____________
Immune problems	☐	☐	____________
Heartburn or reflux	☐	☐	____________

Review of Systems

	Yes	No	Explain
Fever	☐	☐	____________
Weight loss	☐	☐	____________
Eye problems	☐	☐	____________
Ear problems	☐	☐	____________
Mouth problems	☐	☐	____________
Throat problems	☐	☐	____________
Lung problems	☐	☐	____________
GI problems	☐	☐	____________
Genitourinary prob	☐	☐	____________
Musculoskeletal pr	☐	☐	____________
Skin problems	☐	☐	____________
Nerve problems	☐	☐	____________
Mood Problems	☐	☐	____________
Hormone Problems	☐	☐	____________
Chronic Pain	☐	☐	____________

Other medical problems and previous surgeries: ______________________________________

____

Family History:
Please list all medical problems in your family including causes of death of any relatives:

____

____

Social History:
Are you presently employed ☐ homemaker ☐ retired ☐ receive disability ☐
Occupation and company (or previous occupation) ______________________________
Marital status: single ☐ married ☐ divorced ☐ separated ☐ widowed ☐
Do you have children? Yes ☐ No ☐ Do they have sinus problems? Yes ☐ No ☐ N/A ☐

Do you smoke?

- ☐ Yes, I've smoked _______ pack(s) of cigarettes per day for ________ years.
- ☐ Yes, I smoke cigarettes occasionally, but not everyday.
- ☐ Yes, I smoke cigars or a pipe.
- ☐ No, I quit smoking _____ years ago. At that time, I was smoking _____ pack(s) per day for _______ years.
- ☐ No, I have never smoked.

Caffeine intake per day: ______________ **Alcohol intake per day and type:** __________________

Have you used or tried recreational drugs?	**Yes☐**	**No☐**
Have you been exposed to chemicals at work?	**Yes☐**	**No☐**
Do you use afrin or other nasal decongestants on regular basis?	**Yes☐**	**No☐**
Have you tried nasal steroids in the past?	**Yes☐**	**No☐**
Do you bruise easily?	**Yes☐**	**No☐**
Do you problems with anesthesia?	**Yes☐**	**No☐**
Do you have snore/sleep problems?	**Yes☐**	**No☐**
Do you breathe poorly through your nose?	**Yes☐**	**No☐**
Have you had allergy testing?	**Yes☐**	**No☐**
Are you interested in cosmetic surgery for your nose or face?	**Yes☐**	**No☐**

Please bring a list of medications with you or write on back of sheet.

Reviewed by Subinoy Das, MD: ______________________ Date: __________________

Please complete the following:

Patient Name: ____________________ **Date:** ______________

Quality of Life Score:

In the last two weeks, has this been a problem?	NO 0	Mild/Slight 1	Moderate 2	Severe 3
Sneezing	☐	☐	☐	☐
Runny Nose	☐	☐	☐	☐
Need to blow nose	☐	☐	☐	☐
Facial pain/pressure	☐	☐	☐	☐
Thick-nasal drainage	☐	☐	☐	☐
Cough	☐	☐	☐	☐
Post-nasal drainage	☐	☐	☐	☐
Dizziness	☐	☐	☐	☐
Ear Pain	☐	☐	☐	☐
Ear Fullness	☐	☐	☐	☐
Difficulty falling asleep	☐	☐	☐	☐
Wake up at night	☐	☐	☐	☐
Wake up tired	☐	☐	☐	☐
Lack of good night's sleep	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Reduced productivity	☐	☐	☐	☐
Reduced concentration	☐	☐	☐	☐
Frustrated/restless/irritable	☐	☐	☐	☐
Sad	☐	☐	☐	☐
Embarrassed	☐	☐	☐	☐

Total Score: ____________

Wheezing during/after exercise	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Shortness of breath with exercise	☐	☐	☐	☐
Cough with exercise	☐	☐	☐	☐
Decreased sport performance	☐	☐	☐	☐
Fatigue easier with exercise	☐	☐	☐	☐
Weakness/loss of strength	☐	☐	☐	☐
Difficulty with exercise in a hot environment	☐	☐	☐	☐
Difficulty with exercise in a cold environment	☐	☐	☐	☐
Anxiety about fatigue during exercise	☐	☐	☐	☐

Total Score: ____________

Have you had allergy testing Yes ☐ No ☐ If yes, were any tests positive? Yes ☐ No ☐

Medications: please list current medications including doses ______________________________