

Provider Signature: I have personally reviewed the below history.



**CEDARS-SINAI**  
MEDICAL GROUP

Pediatric & Adult Ear, Nose & Throat  
Otolaryngology, Head and Neck Surgery

INSTRUCTIONS: Please check if you currently have any of the following symptoms.

**CONSTITUTIONAL:**

Recent unexplained weight loss

**EYES:**

Double vision

**HEART:**

Chest pain

**LUNGS:**

Coughing up blood

**GI:**

Vomiting

**GU:**

Blood in urine

**NEUROLOGICAL:**

Loss of consciousness

**PSYCHIATRIC:**

Hallucinations

**HEMATOLOGY:**

Easy bleeding

**SKIN:**

Rash

**None of the above**

Thank you for completing this questionnaire. If you have any questions about any of the above items, please ask your physician at the time of your appointment.

Signature (Patient or Legal Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

# Voice Related Quality of Life Measure

Anca M. Barbu, M.D. FACS

Laryngeal Surgery/Care of Professional Voice

Office (310) 423-1220

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

We are trying to learn more about how a voice problem can interfere with your day-to-day activities. On this paper, you will find a list of possible voice-related problems. Please answer all questions based on what your voice has been like over the past two weeks. There are no “right” or “wrong” answers.

Considering both how severe the problem is when you get it, and how frequently it happens, please rate each item below on how “bad” it is (that is, the amount of each problem that you have). Using the following scale for rating the amount of the problem.

- 1 = None, not a problem
- 2 = A small amount
- 3 = A moderate (medium) amount
- 4 = A lot
- 5 = Problem is as “bad as it can be”

**Because of my voice.....**

	None	A small amount	A moderate amount	A lot	“Bad as it can be”
1. I have trouble speaking loudly or being heard in noisy situations.	1	2	3	4	5
2. I run out of air and need to take frequent breaths when talking.	1	2	3	4	5
3. I sometimes do not know what will come out when I begin speaking.	1	2	3	4	5
4. I am sometimes anxious or frustrated (because of my voice).	1	2	3	4	5
5. I sometimes get depressed (because of my voice).	1	2	3	4	5
6. I have trouble using the telephone (because of my voice).	1	2	3	4	5
7. I have trouble doing my job or practicing my professions (because of my voice)	1	2	3	4	5
8. I avoid going out socially (because of my voice).	1	2	3	4	5
9. I have to repeat myself to be understood.	1	2	3	4	5
10. I have become less outgoing (because of my voice).	1	2	3	4	5



**New Patient Information (Age 13 & Older)**

Name \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Primary Care Physician (PCP) \_\_\_\_\_

Referring Physician \_\_\_\_\_

Reason for Visit \_\_\_\_\_

**Past and Current Medical History** (check all that apply)

- Acid Reflux (GERD)       Cancer (type, year) \_\_\_\_\_       Hepatitis       Migraines
- Asthma       COPD/Emphysema       High blood pressure       Osteoporosis
- Blood Clot       Diabetes       HIV       Sleep Apnea
- Bleeding Disorder       Heart/Lung Disorder: \_\_\_\_\_       Stroke
- Other \_\_\_\_\_

**Past Surgeries (type and approximate year)** \_\_\_\_\_

**Allergies (Environmental, Food, Medications)** \_\_\_\_\_

**Routine Medications And Dosages** \_\_\_\_\_

**Please check the boxes below if you have any family history of the following diseases. Please fill in who in your family was affected.**

- Allergies \_\_\_\_\_       Bleeding Disorder \_\_\_\_\_       Cancer \_\_\_\_\_ Type of Cancer \_\_\_\_\_
- Early Hearing Loss \_\_\_\_\_       Heart Disease \_\_\_\_\_       Migraines \_\_\_\_\_       Thyroid \_\_\_\_\_
- Other \_\_\_\_\_

**Social History**

- Have you ever smoked tobacco?       yes       no      if yes, \_\_\_\_\_ packs/day for \_\_\_\_\_ years
- Have you quit?       yes       no      if yes, how long ago? \_\_\_\_\_
- Have you ever used chewing tobacco?       yes       no
- Do you drink alcohol?       yes       no      if yes, \_\_\_\_\_ drinks per day / week / month
- Other substance use? \_\_\_\_\_

Upcoming Travel or Major Family Events \_\_\_\_\_



Today's Date: \_\_\_\_\_

# AUTHORIZATION FOR ELECTRONIC TRANSMISSION OF PROTECTED HEALTH INFORMATION AND USE OF ELECTRONIC COMMUNICATIONS

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Medical Record Number: \_\_\_\_\_

Protected health information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment. For other than test results, a valid HIPAA compliant release must be completed. You may further authorize us to release your PHI to answering machines, faxes, or electronic mail. To ensure your privacy, we will not leave messages containing PHI on answering devices without your permission. You may also authorize us to provide your confidential PHI to another person or persons. Test results related HIV, Hepatitis, substance abuse, or malignancy/cancer require your prior authorization be transmitted via electronic means (voicemail, FAX, e-mail, MyCSLink).

When you provide us with your contact information, you authorize us and our agents to use any mailing address, e-mail address, telephone number (landline, wireless, residential or business) for the purpose of communicating with you regarding appointment information, test results, discharge instructions or other clinical information, as well as regarding account information or other information pertinent to medical services. You also are agreeing to accept live or autodialed calls and other messages to these numbers or addresses where we may leave recorded messages.

### I authorize physicians and/or staff to contact me via the following:

FAX Number: \_\_\_\_\_

Telephone Voicemail: \_\_\_\_\_

E-mail Address: \_\_\_\_\_  
(E-mail is not an option available from all medical offices)

\_\_\_\_\_  
Name of Alternative Person I Elect to Receive My PHI:

\_\_\_\_\_  
Phone Number:

\_\_\_\_\_  
Address:

\_\_\_\_\_  
Signature: (Patient or individual legally authorized to consent to release)

\_\_\_\_\_  
Date:

**This authorization shall remain in effect until you are notified by me in writing of any changes.**

The Health Information Manager will review your request and respond in writing if your request cannot be honored. If you have any questions or concerns, you may contact the Health Information Manager at 310-248-7058.



**CEDARS-SINAI<sup>®</sup>**  
**MEDICAL GROUP**

### **A Notice to Our Valued Patients**

During your visit in our ENT department, your physician may find it necessary to use endoscopes (special lighted instruments) as part of his evaluation. This will enable your physician to provide you with the most thorough examination of your sinuses and throat when needed. Although, this is fairly routine for our specialty, most insurance companies consider this a “Surgery” or “In- office Procedure” and it may be reflected as such on your billing statement or explanation of benefits. In addition, your physician may also require you to have an Audiogram, also known as a hearing test. Each of these services will result in an additional charge and therefore an additional financial responsibility for you. We want you to be informed of these services so there are no surprises or concerns after you leave our office.

Please sign below to acknowledge that you received the office notification regarding office Endoscopies/Audiograms and are aware that it may be performed during your visit.

\_\_\_\_\_  
Patient/Guardian

\_\_\_\_\_  
Date

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