

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: \_\_\_\_\_



**New Patient Information (Age 12 & Under)**

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

Your Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

	Parent(s)/Legal Guardian(s)	Relationship to Patient	Custody?
(1)	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
(2)	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

Pediatrician \_\_\_\_\_

Allergies to Medications \_\_\_\_\_

Environmental or Food Allergies \_\_\_\_\_

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

Other Medications Taken In Last Month \_\_\_\_\_

List All Past Surgeries (type and approximate year) \_\_\_\_\_

Birth History Born at \_\_\_\_\_ weeks weight \_\_\_\_\_  c section  vaginal delivery

Complications during pregnancy or delivery? \_\_\_\_\_

Newborn Hearing Screen Performed?  yes  no If yes, result was:  pass  refer

Past and Current Medical History (check all that apply)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> autism         | <input type="checkbox"/> hearing loss    | <input type="checkbox"/> speech delay        | <input type="checkbox"/> cleft lip or palate |
| <input type="checkbox"/> NICU stay      | <input type="checkbox"/> diabetes        | <input type="checkbox"/> thyroid problems    | <input type="checkbox"/> bleeding problems   |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> asthma          | <input type="checkbox"/> other lung problems | <input type="checkbox"/> sickle cell         |
| <input type="checkbox"/> GERD/reflux    | <input type="checkbox"/> kidney problems | <input type="checkbox"/> migraines           | <input type="checkbox"/> cancer              |
| <input type="checkbox"/> other _____    |  |  |  |

Immunizations  had all recommended immunizations  had some  had none

Family History (check all that apply)

- |                                       |                                      |  |  |                                 |
|---------------------------------------|--------------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> hearing loss | <input type="checkbox"/> allergies   | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> cancer |
| <input type="checkbox"/> migraines    | <input type="checkbox"/> other _____ |  |  |                                 |

Social History

In daycare or school?  yes  no Secondhand smoke exposure?  yes  no

Household members/siblings (ages) \_\_\_\_\_

**After the information above has been transferred to your electronic medical record, this worksheet is securely destroyed**

**SINO-NASAL OUTCOME TEST**

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.

DATE: _____ NAME: _____ DATE OF BIRTH: _____	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. 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: →								
<b>1. Need to blow nose</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>2. Nasal Blockage</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>3. Sneezing</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>4. Runny nose</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>5. Cough</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>6. Post-nasal discharge</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>7. Thick nasal discharge</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>8. Ear fullness</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>9. Dizziness</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>10. Ear pain</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>11. Facial pain/pressure</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>12. Decreased Sense of Smell/Taste</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>13. Difficulty falling asleep</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>14. Wake up at night</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>15. Lack of a good night's sleep</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>16. Wake up tired</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>17. Fatigue</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>18. Reduced productivity</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>19. Reduced concentration</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>20. Frustrated/restless/irritable</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>21. Sad</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>
<b>22. Embarrassed</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>		<input type="radio"/>

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



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

8635 W. Third Street, Suite 590W  
Los Angeles, CA 90048