OCEANN ENT

Orange County Ear, Allergy, Nose & Neck

Kathy Yu-Syken, MD
John Vincent Enverga, PA-C
Stephanie Cho, PA-C

First Name _____ Middle Initial _____ Last Name_____

Date Of Birth ____/____/____ SSN____-____-_____ Age_____ Gender M / F

Address_____ City_____ State_____ Zip_____

Home: (____) _____ Cell: (____) _____Email: _____

Primary Physician (PCP) _____ Phone Number: (____) _____

Employer _____ Occupation_____ Work (____) _____

How did you hear about us? (*Circle one*)

Google Yelp Internet Referral _____ Other_____

Guarantor/Subscriber

First Name _____ Middle Initial _____ Last Name_____

Date Of Birth ____/____/____ SSN____-____-_____ Age_____ Gender M / F

Address_____ City_____ State_____ Zip_____

Home: (____) _____ Cell: (____) _____ Relationship to Patient: _____

Insurance Information

(Primary)

Subscriber _____

Insurance Company_____

ID # _____

Group # _____

(Secondary)

Subscriber _____

Insurance Company_____

ID #_____

Group # _____

I hereby assign my insurance benefits to be paid directly to Dr. Kathy Yu-Syken. It is understood that in case the patient's insurance company does not make payment, the obligation shall be binding personally upon the patient/ guarantor.

Signature_____ Date_____

Reason for Visit_____

Duration of Symptoms _____

PREFERRED PHARMACY: _____ City _____ Phone (___) _____

MEDICATIONS (*Including Over the Counter*)

Name	**Dosage/Frequency**	**Reason**
***Example*:** *Zyrtec*	*10 mg/ once a day*	*Allergies*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoker: (*Please circle one)* Current Former Never Packs Per Day: _____

Alcohol: Yes No if yes, number of drinks _____ (*Circle one*) DAY WEEK MONTH YEAR

ALLERGIES TO MEDICATIONS? YES NO *(Please circle one) If yes, please list below*

_____**Reaction:** _____ _____**Reaction:** _____

_____**Reaction:** _____ _____**Reaction:** _____

Current Medical History (*Please circle Yes or No*)

Anemia	Yes	No	Glaucoma	Yes	No
Asthma	Yes	No	High Cholesterol	Yes	No
Atrial Fibrillation	Yes	No	Hypertension	Yes	No
Cardiac Issues	Yes	No	Kidney Disease	Yes	No
COPD	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No			

Other: (*Please list*) _____

_____

Past Medical & Surgery History (*Please circle Yes or No, if yes indicate when*)

Adenoidectomy	Yes	No	Hysterectomy	Yes	No
Breast Cancer	Yes	No	Pacemaker	Yes	No
Cholecystectomy	Yes	No	Sinus Surgery	Yes	No
Ear Surgery	Yes	No	Stroke	Yes	No
Ear Tubes	Yes	No	Thyroid Cancer	Yes	No
Heart Attack	Yes	No	Tonsillectomy	Yes	No
Heart Surgery	Yes	No	History of Cancer	Yes	No (*Please indicate below*)

Other: (*Please list*) _____

_____

I.D.:_____ **SINO-NASAL OUTCOME TEST (SNOT-22)** DATE:_____

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.

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

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

Eustachian Tube Dysfunction
Patient Questionnaire (ETDQ-7)[1]

Name:_____ Date: _____

Next to each question, circle the number that best describes how you feel.

During the past 1 month, how much of a problem was each of the following?	**No Problem**			**Moderate Problem**			**Severe Problem**
1. Pressure in the ears?	1	2	3	4	5	6	7
2. Pain in the ears?	1	2	3	4	5	6	7
3. A feeling that your ears are clogged or "under water"?	1	2	3	4	5	6	7
4. Ear problems when you have a cold or sinusitis?	1	2	3	4	5	6	7
5. Crackling or popping sounds in the ears?	1	2	3	4	5	6	7
6. Ringing in the ears?	1	2	3	4	5	6	7
7. A feeling that your hearing is muffled?	1	2	3	4	5	6	7

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

☐ Left ear only ☐ Right ear only ☐ Both ears

Total Score _____ **÷ 7 = Mean item score** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice reserves the right to change the privacy policy as allowed by law.
- The Practice has the right to restrict the use of information, but the Practice does not have to agree to those restrictions.
- The Practice has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: (*PRINT NAME PLEASE*) _____

Signature: _____ Date: _____

Witness: _____ Date: _____