

**Becker Nose and Sinus Center, LLC**  
Medical and Surgical Treatment of the Sinus

**New Patient Health Survey**

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

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: ( )M ( )F

Referring /Family Doctor: \_\_\_\_\_ Tel #: \_\_\_\_\_

Please complete this form so we can facilitate your care or provide resource information regarding available services. If you are offended by the personal nature of the question content, you do not have to answer.

**Chief Complaints:**

Please list all reason(s) you are here: \_\_\_\_\_

**History of Present Illness:**

How long have you had this/these problem(s), & when did they start? \_\_\_\_\_

Rate your problem's severity on a scale of 1 to 10 \_\_\_\_\_

What type of activities aggravate this/these problem(s)? \_\_\_\_\_

What makes these symptoms better? \_\_\_\_\_

Describe any pain (ie throbbing, dull, sharp, etc) its location, & its severity on a scale of 1 to 10.  
\_\_\_\_\_

What type of treatments/medications have you received for this/these problems? Have they helped?  
\_\_\_\_\_

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**Medications:**

Are you taking other medication, drugs or pills ( ) No ( ) Yes. If yes, please list name and dosage.  
\_\_\_\_\_  
\_\_\_\_\_

Do you take aspirin or any products with aspirin in it? \_\_\_Yes \_\_\_No. If so how much and how often?  
\_\_\_\_\_

**Allergies:**

Do you have any allergic or adverse reactions to any medication or substance? ( ) No ( ) Yes  
If yes please list: \_\_\_\_\_

## New Patient Health Survey (page 2)

**Patients Name:** \_\_\_\_\_

### HPI: Associated Signs & symptoms

Do you have environmental allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, have you had allergy shots? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, did they help? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please circle which allergy symptoms you have:

**Sneezing**

**Runny Nose**

**Itchy Throat**

**Itchy Nose**

**Itchy/runny/watery eyes**

**Itchy Ears**

Do you have asthma? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have migraine Headaches? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you have any of the following nose and sinus symptoms?

If yes, please rate on a scale of 1 (mild) to 5 (severe).

|                              |   |   |   |   |   |
|------------------------------|---|---|---|---|---|
| Nasal blockage or stuffiness | 1 | 2 | 3 | 4 | 5 |
| Postnasal drip               | 1 | 2 | 3 | 4 | 5 |
| Discolored nasal drainage    | 1 | 2 | 3 | 4 | 5 |
| Nasal bleeding               | 1 | 2 | 3 | 4 | 5 |
| Ear fullness/hearing loss    | 1 | 2 | 3 | 4 | 5 |
| Ringing in the ears          | 1 | 2 | 3 | 4 | 5 |
| Sinus infections             | 1 | 2 | 3 | 4 | 5 |
| Headache or facial pain      | 1 | 2 | 3 | 4 | 5 |
| Halitosis (bad breath)       | 1 | 2 | 3 | 4 | 5 |
| Snoring                      | 1 | 2 | 3 | 4 | 5 |
| Cough                        | 1 | 2 | 3 | 4 | 5 |
| Tooth Pain                   | 1 | 2 | 3 | 4 | 5 |

**New Patient Health Survey (page 3)**

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

**Hospitalizations:**

Have you been admitted in the hospital during the past five years? ( ) No ( ) Yes

If yes, please list name of hospital and year of admission: \_\_\_\_\_

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**Past medical history:**

Please check if you suffer from, or have been treated for any of the following medical conditions:

- Hypertension             Diabetes             Arthritis  
 Stroke                     Asthma             Congestive Heart Failure(Heart Problems)  
 Bleeding tendencies     HIV/Aids            Other: \_\_\_\_\_

**Past Surgical History:**

Please list any major surgeries you have had and the year: \_\_\_\_\_

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**Family History:**

Please check if any of the following diseases run in your family, and indicate which relative(s):  
(father, mother, brother, sister)

- Hypertension             Diabetes             Arthritis  
 Stroke                     Asthma             Heart problem  
 Bleeding tendencies     Other: \_\_\_\_\_

**Social History:**

Do you smoke?  No  Yes If yes, # of packs \_\_\_\_\_ per day/week.

Do you drink alcohol?  No  only socially  Yes If yes, # of glasses \_\_\_\_\_per day/week

Do you use any street drugs?  No  Yes If yes, what type? \_\_\_\_\_

**New Patient Health Survey (page 4)**

**Patient's Name:** \_\_\_\_\_

**Review of Systems: Please check if you recently have had any of the following:**

|   |   |  |
|---|---|--|
| <p><b>Constitutional:</b><br/> <input type="checkbox"/> Weight Gain/Loss<br/> <input type="checkbox"/> Fatigue<br/> <input type="checkbox"/> Fever</p> <p><b>Eyes:</b><br/> <input type="checkbox"/> Blurred Vision<br/> <input type="checkbox"/> Visual changes<br/> <input type="checkbox"/> Double vision<br/> <input type="checkbox"/> Corrective lens</p> <p><b>Ears/nose/mouth/throat:</b><br/> <input type="checkbox"/> Ear pain<br/> <input type="checkbox"/> Difficulty in hearing<br/> <input type="checkbox"/> Ringing in the ears<br/> <input type="checkbox"/> Sinus pain<br/> <input type="checkbox"/> Mouth sore/ulcer<br/> <input type="checkbox"/> Gum bleeding<br/> <input type="checkbox"/> Pain on swallowing<br/> <input type="checkbox"/> Hoarseness</p> <p><b>Breast:</b><br/> <input type="checkbox"/> Pain<br/> <input type="checkbox"/> Lump/masses<br/> <input type="checkbox"/> Nipple discharge</p> <p><b>Respiratory:</b><br/> <input type="checkbox"/> Difficulty breathing<br/> <input type="checkbox"/> Wheezing<br/> <input type="checkbox"/> Coughing up blood</p> | <p><b>Cardiovascular:</b><br/> <input type="checkbox"/> Chest pain/tightness<br/> <input type="checkbox"/> Palpitation<br/> <input type="checkbox"/> Shortness of breath<br/> <input type="checkbox"/> Heart attack<br/> <input type="checkbox"/> Leg pain when walking<br/> <input type="checkbox"/> Leg swelling</p> <p><b>Gastrointestinal:</b><br/> <input type="checkbox"/> Loss of appetite<br/> <input type="checkbox"/> Constipation<br/> <input type="checkbox"/> Bloating/belching<br/> <input type="checkbox"/> Abdominal pain<br/> <input type="checkbox"/> Nausea and vomiting<br/> <input type="checkbox"/> Diarrhea<br/> <input type="checkbox"/> Change in bowel habits<br/> <input type="checkbox"/> Bloody stool<br/> <input type="checkbox"/> Hemorrhoids</p> <p><b>Genitourinary:</b><br/> <input type="checkbox"/> Frequent urination<br/> <input type="checkbox"/> Pain on urination<br/> <input type="checkbox"/> Hesitancy<br/> <input type="checkbox"/> Incontinence<br/> <input type="checkbox"/> Blood in urine<br/> <input type="checkbox"/> Impotence<br/> <input type="checkbox"/> Prostate problems<br/> <input type="checkbox"/> Menstrual problems</p> | <p><b>Musculoskeletal:</b><br/> <input type="checkbox"/> Joint pain<br/> <input type="checkbox"/> Muscle/bone pain</p> <p><b>Integumentary/Skin:</b><br/> <input type="checkbox"/> Skin color/texture changes<br/> <input type="checkbox"/> Itching<br/> <input type="checkbox"/> Rashes<br/> <input type="checkbox"/> Ulcers</p> <p><b>Neurologic:</b><br/> <input type="checkbox"/> Frequent headaches<br/> <input type="checkbox"/> Numbness<br/> <input type="checkbox"/> Tremors<br/> <input type="checkbox"/> Twitching</p> <p><b>Psychiatric:</b><br/> <input type="checkbox"/> Anxiety<br/> <input type="checkbox"/> Feeling depressed</p> <p><b>Endocrine:</b><br/> <input type="checkbox"/> Thyroid problems<br/> <input type="checkbox"/> Frequent thirst<br/> <input type="checkbox"/> Excessive sweating</p> <p><b>Hematologic/Lymphatic:</b><br/> <input type="checkbox"/> Easy Bruising<br/> <input type="checkbox"/> Bleeding tendencies<br/> <input type="checkbox"/> Swollen lymph nodes</p> |
|---|---|--|

(For women only) Are you pregnant  No  Yes \_\_\_\_\_Months. Nursing?  No  Yes  
 Are you taking birth control pills?  No  Yes

**Review of Systems negative except as noted above. Reviewed and discussed with patient.**  
**Doctor Initial/Date** \_\_\_\_\_

**Physical Examination and Endoscopy Procedures, as well as Letters to Referring Physician(s), Lab Results, Radiographic Results, and other related office notes, please also see Electronic Medical Record.** **Doctor Initial/Date** \_\_\_\_\_

*I understand the above information is necessary to provide me with surgical/medical care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you/ I will notify the doctor of any change in my health or medications.*

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*I have reviewed all information in the health survey and discussed it with the patient/guardian.*

**Attending Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_