MidWest Sinus Center - **University Head and Neck Associates**

William R. Panje, M.D. ~ Robert M. Bumsted, M.D. ~ Neal M. Lofchy, M.D.
Joseph P. Allegretti, M.D. ~ Jay M. Dutton, M.D.

Dear Patient:

Thank you for scheduling an appointment with our group. We have enclosed some pre-appointment paperwork for you to complete. It is important that you bring this completed paperwork with you to your visit.

Please note: All co-pays are collected at the time of your visit before you see the physician. For your convenience, we accept cash, check, MasterCard and Visa.

Also, please bring the following items with you to your visit:
Insurance Card(s)
Drivers License
Referral Form, if needed
List of all Medications presently being taken
Copies of recent CT/MRI scans

Your appointment is with Dr. ______________________ on ____
day of the week / month / date
at _____________________in our ____________________________ office.
time / am or pm Rush / Oak Brook / Tinley Park.

Thank you and we look forward to seeing you soon.

URL: http://www.midwestsinuscenter.com

Rush-Presbyterian-St. Lukes Medical Center
Professional Building
1725 West Harrison Street - Suite 340
Chicago, IL 60612
VOICE: (312) 664-6715
FAX: (312) 563-0165

Ingalls Family Care Center
Professional Building
6703 W. 159th Street - Suite 100
Tinley Park, IL 60477
VOICE: (708) 444-1530
FAX: (708) 444-1533

Oak Brook Center
Professional Building
120 Oak Brook Center - Suite 508
Oak Brook, IL 60523
VOICE: (630) 574-8222
FAX: (630) 574-8225

MIDWEST SINUS CENTER - UNIVERSITY HEAD & NECK ASSOCIATES
PATIENT INFORMATION [ ]NEW [ ]UPDATE

LAST NAME: ____________________________ FIRST NAME: __________________________ M. I.: _____________
SOCIAL SECURITY #: __________________________ DATE OF BIRTH: _________________ GENDER: ______________
STREET ADDRESS____________________________ CITY ______________________ STATE _____ ZIP _____________
HOME PHONE _________________________ MARITAL STATUS __________ BUSINESS PHONE # ________________________________
EMPLOYER _________________________ OCCUPATION ______________ ALTERNATE PHONE # _____________________
SPOUSE'S NAME _________________________ SPOUSE'S EMPLOYER _________________ BUSINESS PHONE # _______________________

INSURANCE HOLDERS INFORMATION

PRIMARY INSURANCE

INSURED'S NAME ____
INSURANCE __________________________________
I.D. OR POLICY # ____________________________________
GROUP # ____________________________________
PHONE # TO VERIFY ___________________________________

SECONDARY INSURANCE

INSURED'S NAME _________________________________
INSURANCE ____________________________
I.D. OR POLICY #_______________________________
GROUP # ______________________________
PHONE # TO VERIFY ____________________________

EMERGENCY INFORMATION (IN THE EVENT OF AN EMERGENCY PLEASE NOTIFY)

NAME ____ RELATIONSHIP ______________________________
ADDRESS ____ HOME PHONE ______________________________
BUSINESS PHONE # _________________________________ ALTERNATE PHONE # ___________________________

HOW WERE YOU REFERRED OR HOW DID YOU FIND OUR PRACTICE?

[ ] HMO/PPO [ ] YELLOW PAGES [ ]INTERNET [ ] TV/RADIO [ ] FRIEND/RELATIVE (NAME) _______________

[ ] PHYSICIAN/HOSPITAL (NAME) ______________________ [ ]NEWSPAPER/MAGAZINE (NAME)_________________

[ ] OTHER ______________________________

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO THE TREATING PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY PORTION OF MY BILL NOT COVERED BY MY INSURANCE INCLUDING BUT NOT LIMITED TO ANY APPLICABLE CO-PAYS AND OR DEDUCTIBLES.

X____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE TREATING PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE COURSE OF MY TREATMENT TO MY INSURANCE COMPANY

X____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS OFFICE'S "NOTICE OF PRIVACY PRACTICES" & "AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION."

x____
PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

MIDWEST SINUS CENTER -
UNIVERSITY HEAD AND NECK ASSOCIATES

We would like to be able to correspond with your primary care physician and any other referring physicians who might be instrumental in your professional health care. Please supply us with the names and addresses of your medical doctors:

PATIENT NAME: ____

PRIMARY CARE PHYSICIAN:

NAME: ____

ADDRESS: ____

CITY: ________________________ STATE: ______ ZIP CODE: _________

PHONE: __________________________ FAX: ________________________

CONTACT PERSON: ____

REFERRING PHYSICIAN:

NAME: ____

ADDRESS: ____

CITY: ________________________ STATE: ______ ZIP CODE: _________

PHONE: __________________________ FAX: ________________________

CONTACT PERSON: ____

OTHER PHYSICIANS SEEN IN THE PAST YEAR:

NAME: ________________________ PHONE/CITY: ____________________

NAME: ________________________ PHONE/CITY: ____________________

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

Page 1

PATIENT NAME: ______________________________ DATE: ________________

CHIEF COMPLAINT

WHAT ARE YOU BEING SEEN FOR TODAY? ______________________________

HOW LONG HAVE YOU HAD THIS PROBLEM? ______________________________

WHO IS YOUR REFERRING DOCTOR? ______________________________

PAST MEDICAL HISTORY

- DO YOU HAVE ANY SENSITIVITY OR ALLERGIC REACTIONS TO ANY MEDICATIONS OR FOODS?

☐ YES ☐ NO

- IF YES, PLEASE LIST THE NAME OF EACH AND YOUR TYPE OF REACTION:

1.________________ 4. ________________ 7. ________________

2.________________ 5. ________________ 8. ________________

3.________________ 6. ________________ 9. ________________

- DO YOU HAVE AN ALLERGY TO LATEX? ☐ YES ☐ NO

- DO YOU HAVE ANY IMPLANTS SUCH AS AN ARTIFICIAL HEART VALVE OR HIP PROSTHESIS?

  ☐ YES ☐ NO IF YES, WHAT TYPE? ______________________________

- PLEASE LIST ANY SURGERIES OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY / REASON FOR HOSPITALIZATION	DATE	COMPLICATIONS

- PLEASE LIST ANY OTHER MAJOR ILLNESSES AND/OR INJURIES: ______________________________

____

____

MEDICATIONS

- PLEASE LIST YOUR CURRENT MEDICATIONS. INCLUDE ANY BIRTH CONTROL PILLS, STEROIDS, ANY OVER-THE-COUNTER MEDICATIONS OR ANY RECREATIONAL DRUGS

CURRENT MEDICATIONS	DOSE	FREQUENCY

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: ____ **DATE:** _______________________

FAMILY HISTORY

PLEASE CIRCLE ANY MEDICAL PROBLEMS THT RUN IN YOUR FAMILY (GRANDPARENTS, PARENTS, SIBLINGS, OR CHILDREN)

DIABETES	ARTHRITIS	PROBLEMS WITH ANESTHESIA	TUBERCULOSIS
HEART DISEASE/HEART ATTACKS	KIDNEY DISEASE	BLEEDING PROBLEMS	IMMUNE DISORDER
HYPERTENSION	THYROID DISEASE (GOITER, ETC.)	CANCER-TYPE:__________	HEARING LOSS
MIGRAINES	ASTHMA	HAY FEVER	SEIZURES
STROKES/TIA'S	BIRTH DEFECTS	OTHER-EXPLAIN:	

SOCIAL HISTORY

- WHAT TYPE OF WORK DO YOU DO? ____
- DO YOU CURRENTLY DRINK OR HAVE YOU EVER USED ALCOHOLIC BEVERAGES IN THE PAST?
  □ YES □ NO IF YES, WHAT? _______________ AMOUNT? __________HOW OFTEN? __________ LAST TIME USED? _________
- DO YOU USE / OR HAVE YOU USED TOBACCO IN ANY FORM? □ YES □ NO
  IF YES, WHAT? ___________ AMOUNT? ________HOW OFTEN? __________ LAST TIME USED? _________
  DO YOU WANT HELP TO STOP? □ YES □ NO
- FOR PEDIATRIC PATIENTS:
  ARE ALL IMMUNIZATIONS UP TO DATE? □ YES □ NO
  IS THE CHILD EXPOSED TO TOBACCO SMOKE IN THE HOME OR DAYCARE? □ YES □ NO
  IS THE CHILD IN DAYCARE? □ YES □ NO

REVIEW OF SYSTEMS

ARE YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH:

	YES	NO
CONSTITUTIONAL		
NIGHT SWEATS	□	□
RECURRENT FEVERS	□	□
WEIGHT LOSS IN THE LAST SIX MONTHS	□	□
WAS THE WEIGHT LOSS INTENTIOAL?	□	□
WHAT IS YOUR USUAL WEIGHT? _____LBS.		
EYES		
DOUBLE VISION	□	□
INJURIES	□	□
GLAUCOMA	□	□
WEARING GLASSES/CONTACTS - DATE OF LAST EXAM: __________	□	□
EARS, NOSE, THROAT		
WEARING HEARING AIDS - DATE OF LAST EXAM: __________	□	□
HEARING LOSS	□	□
EAR PAIN	□	□
EAR INFECTIONS	□	□
RINGING IN EARS CIRCLE: LEFT RIGHT BOTH	□	□
DRAINAGE FROM EARS CIRCLE: LEFT RIGHT BOTH	□	□
BALANCE PROBLEMS (VERTIGO OR SPINNING)	□	□
NOSE BLEEDS	□	□
NASAL CONGESTION	□	□

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: ____________________ **DATE:** ____________________

EARS, NOSE, THROAT (CONT'D)	**YES**	**NO**
NASAL DRAINAGE……	☐	☐
INABILITY TO SMELL……	☐	☐
SINUS PROBLEMS……	☐	☐
SORE THROATS……	☐	☐
MOUTH SORES……	☐	☐
HOARSENESS……	☐	☐
DIFFICULTY SWALLOWING……	☐	☐
SEASONAL ALLERGIES (HAYFEVER) ……	☐	☐
CARDIOVASCULAR		
CHEST PAIN OR ANGINA - DATE OF LAST EKG: __________ ……	☐	☐
HIGH BLOOD PRESSURE……	☐	☐
IRREGULAR PULSE……	☐	☐
HEART MURMUR……	☐	☐
ABNORMAL HEART ANATOMY……	☐	☐
HAS A PHYSICIAN EVER RECOMMENDED ANTIBIOTICS PRIOR TO SURGICAL PROCEDURES (DENTAL WORK) OR BECAUSE OF A HEART MURMUR OR IMPLANT? …	☐	☐
RESPIRATORY		
ASTHMA……	☐	☐
CHRONIC COUGH……	☐	☐
EMPHYSEMA……	☐	☐
SHORTNESS OF BREATH……	☐	☐
BRONCHITIS/PNEUMONIA……	☐	☐
LUNG CANCER……	☐	☐
BLOODY SPUTUM……	☐	☐
TUBERCULOSIS……	☐	☐
DATE OF LAST CHEST X-RAY: __________		
GASTROINTESTINAL		
INDIGESTION OR PAIN WITH EATING……	☐	☐
CHRONIC NAUSEA/VOMITING……	☐	☐
LIVER DISEASE (HEPATITIS) ……	☐	☐
JAUNDICE……	☐	☐
ULCERS OR GASTRITIS……	☐	☐
COLON OR STOMACH CANCER……	☐	☐
GENITOURINARY		
RECURRENT URINARY TRACT INFECTIONS……	☐	☐
BLOOD IN YOUR URINE……	☐	☐
PROSTATE CANCER (MALES) ……	☐	☐
UTERINE OR CERVICAL CANCER (FEMALES) ……	☐	☐
MUSCULOSKELETAL		
BROKEN BONES - LIST: ____________________ ……	☐	☐
CHRONIC ARM OR LEG WEAKNESS……	☐	☐
ARTHRITIS……	☐	☐
INTEGUMENTARY		
SKIN CANCER……	☐	☐
SKIN DISEASE……	☐	☐

MIDWEST SINUS CENTER - UNIVERSITY HEAD AND NECK ASSOCIATES

MEDICAL HISTORY QUESTIONNAIRE
Page 4

PATIENT NAME: ______________________________ **DATE:** ________________

	YES	NO
NEUROLOGICAL		
FAINTING SPELLS OR "BLACKING OUT"…	◻	◻
SEIZURES…	◻	◻
DIFFICULTY WITH YOUR SPEECH…	◻	◻
FREQUENT HEADACHES OR MIGRAINES…	◻	◻
STROKES…	◻	◻
PSYCHIATRIC		
ANXIETY…	◻	◻
DEPRESSION…	◻	◻
OTHER PSYCHIATRIC DISORDER/TREATMENT: ____________ …	◻	◻
ENDOCRINE		
DIABETES…	◻	◻
THYROID DISEASE…	◻	◻
EXCESSIVE THIRST OR URINATION…	◻	◻
HORMONE PROBLEMS…	◻	◻
ARE YOU PREGNANT OR BREASTFEEDING? (FEMALES) …	◻	◻
HEMATOLOGIC/LYMPHATIC		
ANEMIA…	◻	◻
HEMOPHILIA/EASY BLEEDING TENDENCIES…	◻	◻
PERSISTENT SWOLLEN GLAND OR LYMPH NODES…	◻	◻
BLOOD TRANSFUSIONS - IF YES, WHEN? __________ …	◻	◻
IMMUNOLOGIC		
IMMUNOLOGICAL DISORDERS (IMMUNE DEFICIENCY) …	◻	◻

HAVE YOU EVER HAD ANY RADIATION TREATMENT?
IF YES, PLEASE EXPLAIN: ______________________________

SIGNATURE ______________________________ DATE: ______________________
(PATIENT/PERSON COMPLETING FORM)

RELATIONSHIP TO PATIENT: ______________________________

REVIEWING STAFF SIGNATURE	DATE	NO CHANGES	CHANGES AS NOTED
		◻	◻
		◻	◻
		◻	◻
		◻	◻
		◻	◻

COMMENTS:

NAME: ____________________________________ DATE: _______________________

SINO-NASAL OUTCOME TEST-16

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. Consider how severe the problem is when you experience it and how frequently 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	MILD OR SLIGHT PROBLEM	MODERATE PROBLEM	SEVERE PROBLEM		5 MOST IMPORTANT ITEMS
1. NEED TO BLOW NOSE	**0**	**1**	**2**	**3**		O
2. SNEEZING	**0**	**1**	**2**	**3**		O
3. RUNNY NOSE	**0**	**1**	**2**	**3**		O
4. COUGH	**0**	**1**	**2**	**3**		O
5. POST NASAL DISCHARGE	**0**	**1**	**2**	**3**		O
6. THICK NASAL DISCHARGE	**0**	**1**	**2**	**3**		O
7. EAR FULLNESS	**0**	**1**	**2**	**3**		O
8. HEADACHE	**0**	**1**	**2**	**3**		O
9. FACIAL PAIN / PRESSURE	**0**	**1**	**2**	**3**		O
10. WAKE UP AT NIGHT	**0**	**1**	**2**	**3**		O
11. LACK OF A GOOD NIGHT'S SLEEP	**0**	**1**	**2**	**3**		O
12. WAKE UP TIRED	**0**	**1**	**2**	**3**		O
13. FATIGUE	**0**	**1**	**2**	**3**		O
14. REDUCED PRODUCTIVITY	**0**	**1**	**2**	**3**		O
15. REDUCED CONCENTRATION	**0**	**1**	**2**	**3**		O
16. FRUSTRATED / RESTLESS/ IRRITABLE	**0**	**1**	**2**	**3**		O

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

NAME: ___________________________________ DATE: ______________________

1. OVERALL, HOW WOULD YOU RATE YOUR HEALTH?

2. _____EXCELLENT
3. _____VERY GOOD
4. _____FAIR
5. _____POOR

2. PLEASE INDICATE THE OVERALL AMOUNT OF DISTURBANCE OR "BOTHER" THAT YOU EXPERIENCE IN YOUR LIFE AS A RESULT OF YOUR RHIOSINUSITIS PROBLEMS:

1. _____NOT BOTHERED
2. _____BOTHERED A LITTLE, BUT NOT A LOT
3. _____BOTHERED MORE THAN A LITTLE, BUT NOT A LOT
4. _____BOTHERED A LOT
5. _____EXTREMELY BOTHERED

3. HOW LONG HAVE YOU BEEN EXPERIENCING YOUR CURRENT SYMPTOMS?

1. _____I AM NOT EXPERIENCING ANY SYMPTOMS NOW.
2. _____2-4 WEEKS.
3. _____GREATER THAN 4 WEEKS BUT LESS THAN 6 WEEKS
4. _____6 WEEKS TO 3 MONTHS
5. _____GREATER THAN 3 MONTHS
6. _____UNSURE

4. WHAT RHINOSINUSITIS MEDICATIONS OR TREATMENTS ARE YOU USING NOW OR HAVE USED SINCE DEVELOPING YOUR PRESENT SYMPTOMS? (PLEASE CHECK ALL THAT APPLY)

0. _____NONE
1. _____NON-DRUG METHODS (EXAMPLES: STEAM INHALATIONS, WARM PACKS)
2. _____SALINE NASAL SPRAYS, DROPS, OR NASAL EMOLLIENTS.
3. _____"OVER THE COUNTER" DECONGESTANT NASAL SPRAYS OR DROPS (EXAMPLES: NEOSYNEPHRINE, AFRIN)
4. _____DECONGESTANTS (EXAMPLES: SUDAFED)
5. _____ANTIHISTAMINES (EXAMPLES: BENADRYL, CLARITIN, CLARINEX, ALLEGRA, ZYRTEX)
6. _____BOTH ANTIHISTAMINE AND DECONGESTANT (EXAMPLES: CLARITIN –D, ALLEGRA-D)
7. _____ANTIBIOTICS (EXAMPLES: AMOXICILLIN, ERYTHROMYCIN, CEFTIN, LEVAQUIN, Z-PACK, BIAXIN)
8. _____ORAL STEROIDS (EXAMPLES: PREDNISONE, MEDROL)
9. _____NASAL CROMOLYN SPRAYS (EXAMPLE: NASALCROM)
10. _____NASAL STEROID SPRAYS (EXAMPLES: FLONASE, NASONEX, RHINOCORT)
11. _____ALLERGY SHOTS

5. HAVE YOU EVER HAD SINUS OR NOSE SURGERY? IF SO, PLEASE DESCRIBE:

DATE	TYPE
______________	____
______________	____
______________	____

THANK YOU FOR YOUR PARTCIPATON!

UPDATE: 3/16/05