MEDICAL WEST
OTOLARYNGOLOGY
an affiliate of the UK HEALTH SYSTEM

Patient Registration Form

Patient's Name _____ maiden/Other Name _____

Birthdate _____ Sex _____ Social Security # _____ _____ _____ Race _____

Street Address _____ City/State/Zip _____

Home Phone _____ Other Phone _____ Marital Status _____

Religion _____ Notify by Email ☐ Yes ☐ No Notify by Mail ☐ Yes ☐ No

Email _____

Patient's Employer _____ Employer Phone _____

Employer's Address _____ City/State/Zip _____

Patient Occupation _____

Next of Kin _____ Relationship to patient _____

Street Address _____ City/state/zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Person to notify in care of Emergency _____ Relationship to Patient _____
(This should be someone other than Next of Kin)

Street Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Is Patient an organ donor? **Is visit due to accident/injury?**

Name of Guarantor _____ Guarantor's Phone _____
(Person responsible for bill) Relationship to patient _____

Guarantor's Address _____ City/State/Zip _____

Guarantor's Home Phone _____ Guarantor's DOB _____

Social Security # _____ _____ _____ Guarantor's Employer _____

Guarantor's Employer Address _____ City/State/Zip _____

Welcome to Medical West! We look forward to getting to know you better. Please help us to provide you with the best medical care possible by answering or updating the following questions as completely and accurately as you can.

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Name:		☐ M ☐ F	**DOB:**
Marital status	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Employment	☐ Full Time ☐ Part Time ☐ Homemaker ☐ Retired ☐ Disabled ☐ Student ☐ Other		
	Current Occupation:		
	Past Occupation:		
Personal Safety	Do you live alone? ☐ Yes ☐ No If no? ☐ With Family ☐ With Spouse ☐ Other		
	Do you have frequent falls?		☐ Yes ☐ No
	Do you have vision or hearing loss?		☐ Yes ☐ No
	Do you have an Advance Directive and/or Living Will?		☐ Yes ☐ No
	Would you like information on Advance Directives?		☐ Yes ☐ No

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire will be kept strictly confidential.

Exercise	☐ No exercise			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less that 4 x week for 30 minutes)			
	☐ Regular vigorous exercise (i.e., work or recreation 4 x week for 30 minutes)			
Diet	Eating Problems			☐ Yes ☐ No
	Comments			
Alcohol	Do you drink Alcohol?			☐ Yes ☐ No
	How many drinks per day?			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes pks./day	☐ Chew - # / day	☐ Pipe - # / day	☐ Cigars - # / day
	☐ # of years	☐ Previous User	☐ # of years quit	
Drugs	Do you currently use recreational or street drugs?			☐ Yes ☐ No
	What kind?			

PAST MEDICAL HISTORY

Family History	Dementia ✓	Cancer ✓ (Type)	Diabetes ✓	Heart Disease ✓	High Blood Pressure (Hypertension) ✓	Living ✓	Deceased ✓
Adopted ☐ Yes ☐ No							
Mother							
Father							
Sister							
Brother							
Maternal Grandmother (mother)							
Maternal Grandfather (mother)							
Paternal Grandmother (father)							
Paternal Grandfather (father)							
Other							
Other							

List any significant health problems that are not listed

Please turn to next page

Patient Name: _____ DOB: _____ / _____ / _____ Date: _____ / _____ / _____

Medical Problems				
	☐ Acid Reflux	☐ Emphysema	☐ Menopausal	☐ Rheumatic Fever
	☐ ADD	☐ ETOH (alcohol abuse)	☐ Metabolic Syndrome	☐ Schizophrenia
	☐ ADHD	☐ Fatigue	☐ Mononucleosis	☐ Sciatica
	☐ Seasonal Allergies	☐ Fibrocystic Breast	☐ Morbid Obesity	☐ Seizure Disorder
	☐ Anemia	☐ Fibromyalgia	☐ Multiple Sclerosis	☐ Sexually Trans. Disease
	☐ Aneurysm	☐ Gallstones	☐ MVP	☐ Sleep Apnea
	☐ Anxiety Disorder	☐ Gastritis	☐ Myocardial Infarction	☐ Spinal Stenosis
	☐ Asthma	☐ Gastrointestinal Bleed	☐ Nausea	☐ Stomach Ulcers
	☐ Atrial Fibrillation	☐ Glaucoma	☐ Nephritis	☐ Strep Throat
	☐ Arthritis	☐ Goiter	☐ Nephrolithiasis	☐ Structural Disease Heart
	☐ Autoimmune Ds.	☐ Gout	☐ Neuropathy	☐ Squamous Cell Carcinoma
	☐ B12 Deficiency	☐ Head Trauma	☐ Obstructive Sleep Apnea	☐ TIA
	☐ Back Pain	☐ Headaches	☐ Osteoarthritis	☐ Tuberculosis
	☐ Bipolar Disorder	☐ Headaches - Migraines	☐ Osteopenia	☐ Ulcerative Colitis
	☐ BPH	☐ Heart Valve Disorder	☐ Osteoporosis	☐ Upper Respiratory Infect.
	☐ Blood Clots	☐ Hepatitis	☐ Pancreatitis	☐ Chronic UTI
	☐ Blood Disorders	☐ Herpes	☐ Pain Disorder	☐ Urinary Tract Infection
	☐ Bronchitis	☐ Human Papillomavirus	☐ Paralysis	☐ Valvular Heart Disease
	☐ Cancer	☐ Huntington's Disease	☐ Parkinson Disease	☐ Vertigo
	☐ Cardiomyopathy	☐ High Cholesterol	☐ Pelvic Inflammatory Disease	☐ Vomiting
	☐ Carotid Stenosis	☐ High Blood Pressure	☐ Peripheral Artery Disease	☐ Vision Problems
	☐ Chronic Back Pain	☐ Hyperthyroidism	☐ Phlebitis	☐ Vitamin D Deficiency
	☐ Chronic Pain	☐ Inner Ear Trouble	☐ Pneumonia	☐ Weight Gain
	☐ Cirrhosis	☐ Insomnia (not sleeping)	☐ Polymyopathy	☐ Weight Loss
	☐ Colon Polyps	☐ Interstitial Cystitis	☐ Postmenopausal	
	☐ Diabetes	☐ Irritable Bowel Syndrome	☐ Prostate Cancer	
	☐ Diarrhea	☐ Kidney Stones	☐ Prostatitis	
	☐ Diverticulitis	☐ Low Blood Pressure	☐ Psoriasis	
	☐ Diverticulosis	☐ Low Testosterone	☐ Pyelonephritis	
	☐ Drug Abuse	☐ Lupus	☐ Restless Leg Syndrome	
	☐ DVT	☐ Memory Loss	☐ Retinopathy	
	☐ Eczema			

List any medical problems that other doctors have diagnosed

SURGICAL HISTORY

Year	Hospital / City / State	Type of surgery / complications if any

ALLERGIES TO MEDICATIONS

Name of Drug		Type of reaction	Comments
Penicillin	☐ Yes ☐ No		
Sulfa	☐ Yes ☐ No		
Codeine	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		
Other:	☐ Yes ☐ No		

Please turn to next page

Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Current Medications		
Medication Name	Strength	Frequency Taken

PERSONAL HEALTH HISTORY		
Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and Dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ Measles, Mumps, Rubella
	☐ Other	
Previous Performed Tests	☐ Mammogram	Date Performed:
	☐ Pap Smear	Date Performed:
	☐ Bone Density Study	Date Performed:
	☐ Colonoscopy	Date Performed:
	☐ PSA	Date Performed:
	☐ TB Skin Test	Date Performed:
	☐ Dilated Eye Exam	Date Performed:
	☐ Other:	Date Performed:

PHARMACY INFORMATION		
Pharmacy Name:	Pharmacy Location:	Pharmacy Phone #:

MEDICAL WEST
OTOLARYNGOLOGY / ENT
REVIEW OF SYSTEMS

Patient Name: _____ DOB: _____ / _____ / _____ Date _____ / _____ / _____

In each area, if you are not having any difficulties, please put a check mark beside **"No Problems"**. If you are experiencing any of the symptoms listed, **PLEASE CIRCLE ONLY THOSE THAT APPLY**, or *give an explanation* for any that may not be listed.

General Health _____No Problems Appetite change, excessive sweating, fatigue, fever, chills, night sweats, unexpected weight change, weight gain, weight loss.
Other _____

Eyes _____ No Problems Blurred vision, corrective lenses [contacts or glasses], decreased vision, Double vision, vision loss.
Other: _____

Ears, Nose, Mouth & Throat _____ No Problems Ear pain hearing loss, tinnitus [ringing in ears], vertigo, facial pain, nasal discharge, nasal congestion, epistaxis [nose bleed], postnasal drainage, mouth lesions, hoarseness, sore throat.
Other _____

Cardiovascular (Heart & Blood Vessels) _____No Problems Chest pain, decreased exercise tolerance, dizziness, dyspnea [difficult or labored breathing], palpitations, syncope [fainting].
Other _____

Respiratory (Lungs & Breathing) _____No Problems Cough [nocturnal, productive, non-productive], hemoptysis [coughing up blood], shortness of breath, wheezing, snoring, apneas.
Other _____

Gastrointestinal (Stomach & Intestines) _____No Problems Abdominal pain, food intolerance, nausea, vomiting, hematemesis [vomiting up blood], dysphagia [difficult swallowing], reflux, heartburn, altered bowel habits.
Other _____

Genitourinary (Kidney & Bladder) _____No Problems Change in urinary stream – If Female: Postmenopausal, last menstrual period _____ / _____ / _____.
Other _____

Orthopedic (Muscles, Bones, Joints) _____No Problems Back pain, joint pain, joint swelling, limited range of motion, muscle aches, muscle weakness, stiffness.
Other _____

Integumentary (Skin and Hair) _____No Problems Hair changes, lesions, changes in moles, pigment changes, rash.
Other _____

Neurologic (Brain & Nerves) _____ No Problems Abnormal gait, dizziness, focal weakness, headache, incoordination, memory problems, numbness, seizures.
Other _____

Psychiatric (Mood & Thinking _____ No Problems Anxiety, depression, irritability, panic attacks, sleep disturbances, sadness/tearfulness.
Other _____

Endocrinological (Glands) _____ No Problems High blood sugar, low blood sugar, polyuria [frequent urination], cold intolerance, heat intolerance.
Other _____

Hematologic (Blood/Lymph) _____ No Problems Bruising, bleeding tendencies, lymphadenopathy [enlarged lymphnode9s0], recurrent infections.
Other _____

Allergic/Immunologic _____ No Problems Eczema, seasonal allergies, urticaria [hives].
Other_____

If you have any questions about this, please ask one of the nurses or speak with your doctor.

No Show/Cancellation Acknowledgment

I acknowledge the following:

- It is important to my health that I show up on time for my doctor's appointment.
- If I do not show up for a scheduled appointment, it may affect my health and it creates an unused appointment slot that could have been used for another patient.
- It is important that I notify my doctor's office at least 24 hours in advance when I need to cancel an appointment.
- My doctor may choose to terminate me from this practice if I have more than two no-show occurrences at any given time.

Signature: _____ Date: _____
(Patient or Family Member)

Relationship: _____

Receipt for HIPAA Privacy Notice and Authorization to Obtain or Release Information (MR119)

NAME _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that **I may revoke this authorization at any time by notifying Medical West** in writing, but if I do it will not have an effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise.

I hereby authorize Medical West to disclose health information to the following:

Release to _____ Relationship to patient _____
NAME

Phone ( ) _____ Cell ( ) _____

Release to _____ Relationship to patient _____
NAME

Phone ( ) _____ Cell ( ) _____

PLEASE NOTE THAT NOT ANSWERING THE QUESTIONS BELOW MAY RESULT IN THE STAFF OF MEDICAL WEST LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE.

YES NO The physicians and staff of Medical West may confirm my appointment to my answering machine at the number provided on my patient information sheet.

YES NO The physicians and staff of Medical West may leave lab results or results of other diagnostic studies (e.g., MRI, CT, Bone Scan, etc.) on my answering machine.

YES NO The physicians and staff may release information to my pharmacy without prior authorization in order to allow call in of a prescription.

Special Instructions: _____

My Signature below is acknowledgement that I have received a copy of the Medical West Privacy Notice (MR119) and that I agree to the conditions stated in this notice.

Patient Signature _____ Date _____