UNIVERSITY OF ILLINOIS AT CHICAGO
DEPARTMENT OF OTOLARYNGOLOGY-HEAD & NECK SURGERY

Location_____ Physician_____ Appt. Date_____

MEDICAL RECORD #: _____

NAME: _____ DATE OF BIRTH: _____
Last First Middle

ADDRESS: _____
City State Zip

HOME TEL. #: _____ SS#:_____ MARITAL STATUS:_____

CELL #: _____ E-MAIL ADDRESS: _____

SEX: Male____ Female____ RACE: White___ Black___ Hispanic___ Other_____

MAIDEN NAME (if applicable): _____ SPOUSE'S NAME: _____

EMPLOYER: _____ TEL. #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

EFFEC. EMPLOYMENT DATE: _____ IF RETIRED, DATE OF RETIREMENT: _____

GUARANTOR INFORMATION (Responsible Party)

GUARANTOR NAME:_____ SS#: _____

ADDRESS: _____
City State Zip

DATE OF BIRTH: _____ REL. TO PATIENT: _____ SEX: ___M ___F RACE: _____

EMPLOYER: _____ TEL. #: _____

ADDRESS: _____
City State Zip

EFFEC. EMPLOYMENT DATE: _____ IF RETIRED, DATE OF RETIREMENT: _____

EMERGENCY CONTACT INFORMATION

NAME: _____ REL. TO PATIENT: _____

HOME TEL. #:_____ WORK #: _____

REFERRING PHYSICIAN INFORMATION

NAME OF PHYSICIAN:_____ TEL. #: _____

IF NOT BY A PHYSICIAN, HOW WERE YOU REFFERED TO US? _____

INSURANCE INFORMATION

Please attach a copy of/ or bring insurance card(s), authorization forms and picture I.D.

MEDICARE NUMBER: _____ EFFECTIVE A only _____ B only_____ A&B_____ DATE: _____

PRIMARY CARE PROVIDER: _____ TPL NUMBER: _____

IDPA CASE #: _____ IDPA RIN ID: _____

PRIMARY INSURANCE: _____ TEL#:_____

CLAIM FILING ADDRESS: _____ CITY, STATE, ZIP: _____

POLICY#: _____ GROUP#: _____ EFF. DATE: _____

HOLDER NAME: _____ SS#:_____ CO-PAY: $_____

EMPLOYER NAME: _____ TEL. #:_____

RELATIONSHIP TO PATIENT _____ NOTATIONS:

SECONDARY INSURANCE: _____ TEL. #:_____

CLAIM FILING ADDRESS: _____ CITY, STATE, ZIP: _____

POLICY#: _____ GROUP#: _____ EFF. DATE: _____

HOLDER NAME: _____ SS#:_____ CO-PAY: $_____

EMPLOYER NAME: _____ TEL. #:_____

RELATIONSHIP TO PATIENT _____ NOTATIONS:

I have read and understand the payment and billing policies given to me. I understand that I am financially responsible for charges not paid by my medical insurance. I authorize any holder of medical information about me to release to any responsible health carrier and/or the Social Security Administration or its intermediaries, any information for this or any related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the Dept. of Oto-HNS for bills or services furnished to me during the period _____ to _____

Print Patient Name/Legal Guardian: _____

Signature of Patient/Legal Guardian:_____

Date: _____

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PATIENT MEDICAL HISTORY & PHYSICAL FORM

Patient Name:_____ Birthdate:_____ Age:_____

Sex:_____ Height:_____ Weight: _____ lbs. Occupation:_____

Chief Complaint:
Reason for Today's Visit:_____

Any recent tests done for above problem(s)? Please List: _____

_____

Past History:
Please list any prior major illnesses and/or injuries: _____

_____

_____

Surgeries/ Hospitalization	Year	Complications:

Have you had previous plastic surgery? _____ What type? _____

Were you satisfied with the results? _____ How long have you considered having plastic surgery? _____

Have you ever had problems with anesthesia? ☐ YES ☐ NO

If yes, what were the complications? _____

Current Medication(s) including Aspirin, Diet Pills, and Herbal Supplements	**Dose**	**Frequency**

ALLERGIES/REACTIONS TO MEDICATIONS, ANESTHETICS OR MATERIALS:

Family History:
Do you have a family history of trouble with anesthesia? ☐ YES ☐ NO

Do you have a family history of easy bleeding? ☐ YES ☐ NO

Social History:
Do you smoke? ☐Yes, I've smoked ____ packs of cigarettes per day for ___ years.
☐No, I have never smoked ☐No, I quit ___ years ago. I smoked __ packs of cigarettes per day for __ years.

Do you chew tobacco? ☐ Yes, I have chewed tobacco for ___ years. How much do you chew? _____
☐No, I have never chewed tobacco. ☐No, I quit ___ years ago. I chewed ___ per day for ___years.

Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to
☐Yes ☐Daily ☐One or more times a week ☐ One or more times a month

Review of Systems

Are you currently, or have you had, problems with:

Constitutional	*Circle One*	
Weight Gain	Yes	No
Weight Loss	Yes	No
Night Sweats	Yes	No
Insomnia	Yes	No

Eyes		
Double Vision	Yes	No
Visual Loss	Yes	No

Ear, Nose, Throat and Mouth		
Hearing loss	Yes	No
Noise/ringing in ears	Yes	No
Drainage from the ear	Yes	No
Right side ___ Left Side ___ Both ____		
Vertigo, Imbalance or dizziness	Yes	No
Fullness or pressure in ear	Yes	No
Right side ___ Left Side ___ Both ____		
Nasal Congestion	Yes	No
Nasal Drainage	Yes	No
Difficulty breathing through the nose	Yes	No
Nose bleeds	Yes	No
Frequent Sinus infections	Yes	No
Frequent sore throat	Yes	No
Trouble swallowing	Yes	No
Hoarseness	Yes	No
Choking or Coughing	Yes	No
Throat clearing or gagging	Yes	No
Frequent cough	Yes	No

Cardiovascular		
Chest pain or angina	Yes	No
Heart trouble	Yes	No
Heart murmur	Yes	No
High blood pressure	Yes	No

Neurological	*Circle one*	
Numbness	Yes	No
Dizziness	Yes	No
Stroke	Yes	No
Headaches	Yes	No

Psychiatric		
Depression	Yes	No

Allergic/Immunologic		
Sneezing	Yes	No
Itchy eyes/nose	Yes	No
Itchy throat	Yes	No
Skin rash	Yes	No
HIV/AIDS	Yes	No

Respiratory		
Asthma	Yes	No
Cough up blood	Yes	No
TB	Yes	No
Pneumonia	Yes	No
Trouble breathing at night	Yes	No
Snoring	Yes	No

Gastrointestinal		
Bladder trouble	Yes	No
Kidney disease	Yes	No
	Yes	No
Musculoskeletal	Yes	No
Arthritis	Yes	No

Endocrine		
Diabetes	Yes	No
Thyroid disease	Yes	No
Hematologic		
Bleeding disorders	Yes	No
Easy bleeding	Yes	No

The above information is as accurate to the best of my knowledge

_____ _____

Patient Signature *Date*

I have reviewed the above information with the patient.

_____ _____

Physician Signature *Date*

Revised 8/4/06