Mark box in
[ ] each section
when "None Applies"

CASE HISTORY

Updated_____
Updated_____
Updated_____

Name_____**Date**_____

Reason for visit_____

When it was first noticed_____**Patients Current Weight**_____
Photo's of patient may be necessary for patient care,these photo's will be protected by HIPAA_____.
(INITIAL)

ANY hospitalizations or surgeries you have EVER had:
☐ Attached list ☐ I have **NEVER** had surgery or been hospitalized.

Year	Illness or Operation	Year	Illness or Operation
_____/	_____/	_____/	_____/
_____/	_____/	_____/	_____/
_____/	_____/	_____/	_____/
_____/	_____/	_____/	_____/

Medications-List ALL that you are taking including ones you buy without prescription (vitamins, herbs, aspirin, etc.)
☐ Attached list ☐ I take **NONE** of the Above

_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

Allergies - Please list any reactions you have to prescription or OTC drugs, latex, foods, etc.

_____
_____

Medical History - Please circle the ones that you have **EVER** had: ☐ **None apply to me**

Head Injury	Hay Fever/Allergies	Diabetes
Headaches-Migraine	Sinus Pain	Thyroid Disease
Dizzy or Fainting Spells	Sore Throat	Heart Disease
Glaucoma/Eye Disease	Sleep Apnea	High Blood Pressure
Decreased Hearing	Hoarseness-Chronic Cough	Contact with Blood
Ringing in Ears-high or low pitch	Emphysema/COPD	Easy Bleeding or Bruising
Exposure to Loud Noise	Difficulty Swallowing	Blood Transfusion
Ear Infection-frequent	Indigestion or Heartburn	Are you pregnant_____
Nose Bleeds-frequent	Nausea/Vomiting	How far along_____
Were you ever exposed to: T.B.____	Hepatitis____ Aids____	Malignant Hyperthermia

Other Active Illness_____

Family History - *Circle* if a blood family member has suffered any of the following: **(Excluding Patient)** ☐ **None Apply**

1) Epilepsy (seizures)	2) Migraine Headaches	3) Diabetes
4) High Blood Pressure	5) Heart Disease	6) Alcoholism
7) Stroke	8) Cancer (type)_____	9) Bleed Easily
10) Hearing Loss	11) Reaction to Anesthetic	12) Malignant Hyperthermia

13) Other (please list)_____

Habits ☐ **None**
Smoke____ Pkg/day_____ yrs_____ **Alcohol**_____ Drinks/week_____ **Coffee**_____ Cups/day_____

Regular Exercise ____yes ____no **Street Drugs**_____ When_____ What_____

Test Done (Head & Neck Area) When and Where ☐ **I have NEVER had a CT, MRI OR Xray**

CT_____

MRI_____

X-Rays_____

REVIEW OF SYSTEMS

Patient Name:_____ **Date:**_____

Have you had **ANY** of the following symptoms in the past 2-3 weeks? If so, **please circle** those that you have experienced.
(If you have had any of these symptoms prior to that time, please add that information to the Medical History section of the Case History form.)

Head: eye strain/pain; sensitivity to light; excessive tearing/drainage; change in vision; pain in mouth, teeth, or gums; sores or bleeding of gums/mouth; sore throat

Respiratory: shortness of breath; pain; phlegm; cough; hoarseness; sneezing; wheezing; upper respiratory infection; pneumonia; asthma; emphysema; allergies

Cardiovascular: shortness of breath that wakes you at night; chest pain; heart murmur; palpitations; fainting; swelling; cold hands/feet; hypertension; inflammation of a vein; anemia; blood clot in leg; arrhythmia; edema

Gastrointestinal: change of appetite/diet or weight; nausea; vomiting; change in bowel movements; diarrhea; constipation;
black, tarry stools; vomiting blood; excessive gas/heartburn/indigestion; difficulty swallowing; abdominal pain; hemorrhoids

Genitourinary: change in urine color; odor or voiding habits; unusual discharge; painful urination; excessive urination at night;
increased urine volume; incontinence; pain in lower abdomen; urinary tract infection; sexual problems or impotence

Menses: change in interval; regularity/volume; discharge/flow or cramps

Musculoskeletal: joint stiffness; muscle pain; back pain; deformity; limitation of movement; redness, swelling, or weakness;
broken bone; gout; arthritis; herniated disc

Neurologic: headache; weakness; change in balance/coordination; change in speech or smell; fainting; tremors; loss of memory/concentration or consciousness; head injury

Endocrine: bulging eyes; fatigue; weight change; heat/cold intolerances; excessive sweating; increased thirst/hunger; diabetes

Skin: itch; irritation; non-healing lesions or sores; changes in or bleeding from skin lesions or moles

Other: please describe any other symptoms you have experienced in the past 2-3 weeks that were not covered above:

_____

_____

☐ **Nothing Above Applies to Me in the Past 2-3 weeks**

I acknowledge the above information is correct
And hereby do sign:

_____
Patient's Signature Date

_____

_____

Salina Regional Health Center

Salina Regional Health Center
Authorization to Verbally Release Protected Health Information and Emergency Contact List:

I authorize Salina Regional Health Center, and all affiliates, health care providers to provide verbal information concerning my health care to those that I have listed below while I am a patient. Verbal requests for information from other friends, family, caretakers, concerning my health care will not be disclosed without an additional authorization from me. (Exception: Health Information may be disclosed without authorization in an emergency situation or if SRHC determines that the disclosure is in my best interest and the information disclosed is limited to those persons involved in my care).

Emergency Contact

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages (circle one)* Y N
Address	*City*	*State*	*Zip*

Additional Contacts

Include Emergency Contact listed above? (*circle one*) Y N

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages (circle one)* Y N
Address	*City*	*State*	*Zip*

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages (circle one)* Y N
Address	*City*	*State*	*Zip*

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages (circle one)* Y N
Address	*City*	*State*	*Zip*

Contact Name	*Relationship to Patient*	*Phone Number*	*Allow Messages (circle one)* Y N
Address	*City*	*State*	*Zip*

I may revoke this authorization at any time by notifying my nurse. I have read the above and authorize verbal disclosure of my medical condition. I understand that treatment is not conditioned upon the execution of this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations.

X______________________ X____

Date *Signature of Patient or Authorized Agent/Representative*

____ ____________________________

Printed name of authorized agent/representative *Relationship to patient*

(Note: Any requests for restriction/communication accommodation should be forwarded to the Privacy Office for approval on the "Request for Disclosure Restriction/Communication Accommodation Form")

SINUS QUESTIONNAIRE

How long have your sinuses been a problem? _____ weeks_____ months_____ years

Is there a history of sinus problems in your family? Yes No

What originally brought on your condition? _____

Do you have difficulty breathing? Yes No How _____

Is there a lot of drainage in front _____ or down your throat_____

Does it have odor _____ or color _____

Do you have headaches? Yes No Where _____

Do you have pain in your face? Yes No Where _____

Do you have nasal obstruction? Yes No Right side Left side Both

How is your sense of smell? _____

Do you have bad breath or a bad taste in your mouth? _____

Do you have asthma? _____ Polyps _____ Aspirin sensitivity _____

Have you ever been exposed to any toxic chemicals or fumes? _____

Are you a smoker? Yes No How much per day? _____ How many years _____

Is there anything that makes it better or worse? _____

Have you had any previous sinus or nose surgeries? _____

Have you had any previous nasal injuries? _____

Did it cause deformity? Yes No What? _____

Have you ever had x-rays taken of your sinuses? Yes No When _____

Where? _____

Are you on any medications, nasal sprays (over-the-counter or RX), nose drops? Yes No

What _____

Do you have allergies? Yes No If so, what are treatments _____

Do you have seasonal changes? _____ Sneezing _____ Watery eyes _____

Do you have ear pain, pressure, etc.? Yes No

Do you snore, have sleep disturbance, nighttime mouth breathing? _____

Any dental abnormalities of upper jaw or recent dental problems? _____

TINNITUS HANDICAP INVENTORY

Patient Name:_____ Date:_____

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every questions. Please do not skip any questions.

1. Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3. Does your tinnitus make you angry?	Yes	Sometimes	No
4. Does your tinnitus make you feel confused?	Yes	Sometimes	No
5. Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6. Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7. Because of your tinnitus, do you have trouble falling asleep at night?	Yes	Sometimes	No
8. Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9. Does your tinnitus interfere with your ability to enjoy your social activities (Such as going out to dinner, to the movies)?	Yes	Sometimes	No
10. Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11. Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13. Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14. Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15. Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16. Does your tinnitus make you upset?	Yes	Sometimes	No
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19. Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20. Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21. Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22. Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23. Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24. Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25. Does your tinnitus make you feel insecure?	Yes	Sometimes	No

FOR CLINICIAN USE ONLY

Total Per Column				
	x4	**x2**	**x0**	
Total Score	**+**	**+**		**=**

Dizziness Questionnaire

A. When you are "dizzy", do you experience any of the following sensations? Please read the entire list first. Circle yes or no to describe your feelings most accurately and fill in any blanks.

Answer all the questions.

1. Lightheadedness or swimming sensation in the head? YES NO
2. Blacking out or loss of consciousness? YES NO
3. Tendency to fall: To the right? To the left? Forward? Backward? YES NO
4. Object spinning or turning around you? YES NO
5. Sensation that you are turning or spinning inside, with outside objects remaining stationary? YES NO
6. Loss of balance when walking: Veering to the right? Veering to the left? YES NO
7. Headache? YES NO
8. Nausea or vomiting? YES NO
9. Pressure in the head? YES NO
10. My dizziness is constant or in attacks (circle one)

    If in attacks: How often?_____

    How long do they last?_____

    When was a less attack?_____

    Do you have any warning that the tach is about to start? YES NO
    Do they occur at any particular time of the day or night? YES NO
    Already completely free of dizziness between attacks? YES NO

11. When did the dizziness first occur?_____
12. This change of position make you dizzy? YES NO
13. Do you have trouble walking in the dark? YES NO
14. When you are dizzy, must you support yourself when standing? YES NO
15. Do you know of any possible causes of your dizziness? YES NO
    What?_____
16. Do you know anything that will:
    Stop your dizziness or make it better?_____
    Make her dizziness worse?_____
    Precipitate an attack?_____
    (Fatigue, exertion, hunger, menstrual period, Stress, Etc.)
17. Were you exposed to any irritating fumes, paints, Etc., At the onset of dizziness? YES NO
18. If you ever injured her head, where you unconscious? YES NO

B. Do you have any of the following symptoms?

19. Difficulty in hearing? YES NO Both Ears RIGHT LEFT
20. Noise in your ears? YES NO Both Ears RIGHT LEFT

    Describe the noise_____

    Does the noise change with dizziness? YES NO If so, how?_____

21. Fullness or stuffiness in your ears? YES NO Both Ears RIGHT LEFT
22. Pain in your ears? YES NO
23. Discharge from your ears? YES NO
24. Double vision, blurred vision, or blindness? YES NO Constant In Episodes
25. Numbness of face? YES NO Constant In Episodes
26. Numbness of arms or legs? YES NO Constant In Episodes
27. Weakness in arms or legs? YES NO Constant In Episodes
28. Clumsiness of arms or legs? YES NO Constant In Episodes
29. Confusion or loss of consciousness? YES NO Constant In Episodes
30. Difficulty with speech? YES NO Constant In Episodes
31. Difficulty with Swallowing? YES NO Constant In Episodes
32. Pain in the neck or shoulder? YES NO Constant In Episodes

Sino-Nasal Outcome Test (SNOT-22) Questionnaire

Name: _____ **DOB:** _____

Date: _____

Below you will find a list of symptoms and social/emotional consequences of your nasal disorder. 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.

A. Considering 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	Very Mild Problem	Mild or Slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be	Most important items
1. Need to blow nose	0	1	2	3	4	5	[ ]
2. Sneezing	0	1	2	3	4	5	[ ]
3. Runny nose	0	1	2	3	4	5	[ ]
4. Nasal obstruction	0	1	2	3	4	5	[ ]
5. Loss of smell or taste	0	1	2	3	4	5	[ ]
6. Cough	0	1	2	3	4	5	[ ]
7. Post-nasal discharge	0	1	2	3	4	5	[ ]
8. Thick nasal discharge	0	1	2	3	4	5	[ ]
9. Ear fullness	0	1	2	3	4	5	[ ]
10. Dizziness	0	1	2	3	4	5	[ ]
11. Ear pain	0	1	2	3	4	5	[ ]
12. Facial pain/pressure	0	1	2	3	4	5	[ ]
13. Difficulty falling asleep	0	1	2	3	4	5	[ ]
14. Waking up at night	0	1	2	3	4	5	[ ]
15. Lack of a good night's sleep	0	1	2	3	4	5	[ ]
16. Waking 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	[ ]
TOTALS (each column):							

GRAND TOTAL SCORE (all columns together):

B. Please check off the most important items affecting your health in the last column (max of five items)