CEDARS-SINAI®
MEDICAL GROUP

Pediatric & Adult Ear, Nose & Throat
Otolaryngology, Head & Neck Surgery

INSTRUCTIONS: Please check if you currently have any of the following symptoms.

CONSTITUTIONAL:

☐ Recent unexplained weight loss

EYES:

☐ Double vision

HEART:

☐ Chest pain

LUNGS:

☐ Coughing up blood

GI:

☐ Vomiting

GU:

☐ Blood in urine

NEUROLOGICAL:

☐ Loss of consciousness

PSYCHIATRIC:

☐ Hallucinations

HEMATOLOGY:

☐ Easy bleeding

ALLERGIC:

☐ Anaphylaxis

☐ None of the above

Thank you for completing this questionnaire. If you have any questions about any of the above items, please ask your physician at the time of your appointment.

Signature (Patient or Legal Guardian): ____________________________ Date: ________________

STAFF USE ONLY:

*Provider Signature:*____
I have personally reviewed the above history.

Voice Related Quality of Life Measure

Anca M. Barbu, M.D. FACS
Laryngeal Surgery/Care of Professional Voice
Office (310) 423-1220

Patient Name: ___________________________ Date: _____________

We are trying to learn more about how a voice problem can interfere with your day-to-day activities. On this paper, you will find a list of possible voice-related problems. Please answer all questions based on what your voice has been like over the past two weeks. There are no “right” or “wrong” answers.

Considering both how severe the problem is when you get it, and how frequently it happens, please rate each item below on how “bad” it is (that is, the amount of each problem that you have). Using the following scale for rating the amount of the problem.

- 1 = None, not a problem
- 2 = A small amount
- 3 = A moderate (medium) amount
- 4 = A lot
- 5 = Problem is as “bad as it can be”

Because of my voice…..

	None	A small amount	A moderate amount	A lot	“Bad as it can be”
1. I have trouble speaking loudly or being heard in noisy situations.	1	2	3	4	5
2. I run out of air and need to take frequent breaths when talking.	1	2	3	4	5
3. I sometimes do not know what will come out when I begin speaking.	1	2	3	4	5
4. I am sometimes anxious or frustrated (because of my voice).	1	2	3	4	5
5. I sometimes get depressed (because of my voice).	1	2	3	4	5
6. I have trouble using the telephone (because of my voice).	1	2	3	4	5
7. I have trouble doing my job or practicing my professions (because of my voice)	1	2	3	4	5
8. I avoid going out socially (because of my voice).	1	2	3	4	5
9. I have to repeat myself to be understood.	1	2	3	4	5
10. I have become less outgoing (because of my voice).	1	2	3	4	5

Hogikyan ND and Rosen CA. A review of outcome measurements for voice disorders. Otolaryngology-Head and Neck Surgery 2002; 126(5) 562-72.

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New Patient Information (Age 12 & Under)

Name______________________________ **Date** ______________________________

Your Name ______________________________ **Relationship to Patient** ______________________________

Parent(s)/Legal Guardian(s)	**Relationship to Patient**	**Custody?**
(1) ______________________	______________________	☐ yes ☐ no
(2) ______________________	______________________	☐ yes ☐ no

Pediatrician ______________________________

Allergies to Medications ______________________________

Environmental or Food Allergies______________________________

Routine Medications And Dosages______________________________

____

Other Medications Taken In Last Month ______________________________

____

List All Past **Surgeries** (type and approximate year) ______________________________

____

Birth History Born at _____ weeks weight ______ ☐ c section ☐ vaginal delivery

Complications during pregnancy or delivery? ______________________________

Newborn Hearing Screen Performed? ☐ yes ☐ no **If yes, result was:** ☐ pass ☐ refer

Past and Current Medical History (check all that apply)

☐ autism	☐ hearing loss	☐ speech delay	☐ cleft lip or palate
☐ NICU stay	☐ diabetes	☐ thyroid problems	☐ bleeding problems
☐ heart problems	☐ asthma	☐ other lung problems	☐ sickle cell
☐ GERD/reflux	☐ kidney problems	☐ migraines	☐ cancer

☐ other ______________________________

Immunizations ☐ had all recommended immunizations ☐ had some ☐ had none

Family History (check all that apply)

☐ hearing loss ☐ allergies ☐ thyroid disease ☐ bleeding disorder ☐ cancer
☐ migraines ☐ other______________________________

Social History

In daycare or school? ☐ yes ☐ no Secondhand smoke exposure? ☐ yes ☐ no

Household members/siblings (ages) ______________________________

After the information above has been transferred to your electronic medical record, this worksheet is securely destroyed

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CEDARS-SINAI®

Today's Date: ____________________

AUTHORIZATION FOR ELECTRONIC TRANSMISSION OF PROTECTED HEALTH INFORMATION AND USE OF ELECTRONIC COMMUNICATIONS

Name: ____________________

Date of Birth: ____________________

Medical Record Number: ____________________

Protected health information (PHI) is any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment. For other than test results, a valid HIPAA compliant release must be completed. You may further authorize us to release your PHI to answering machines, faxes, or electronic mail. To ensure your privacy, we will not leave messages containing PHI on answering devices without your permission. You may also authorize us to provide your confidential PHI to another person or persons. Test results related HIV, Hepatitis, substance abuse, or malignancy/cancer require your prior authorization be transmitted via electronic means (voicemail, FAX, e-mail, MyCSLink).

When you provide us with your contact information, you authorize us and our agents to use any mailing address, e-mail address, telephone number (landline, wireless, residential or business) for the purpose of communicating with you regarding appointment information, test results, discharge instructions or other clinical information, as well as regarding account information or other information pertinent to medical services. You also are agreeing to accept live or autodialed calls and other messages to these numbers or addresses where we may leave recorded messages.

I authorize physicians and/or staff to contact me via the following:

- ☐ FAX Number: ____________________
- ☐ Telephone Voicemail: ____________________
- ☐ E-mail Address: ____________________
  (E-mail is not an option available from all medical offices)

Name of Alternative Person I Elect to Receive My PHI: ____________________

Phone Number: ____________________

Address: ____________________

Signature: (Patient or individual legally authorized to consent to release) ____________________

Date: ____________________

This authorization shall remain in effect until you are notified by me in writing of any changes.
The Health Information Manager will review your request and respond in writing if your request cannot be honored. If you have any questions or concerns, you may contact the Health Information Manager at 310-248-7058.

A Notice to Our Valued Patients

During your visit in our ENT department, your physician may find it necessary to use endoscopes (special lighted instruments) as part of his evaluation. This will enable your physician to provide you with the most thorough examination of your sinuses and throat when needed. Although, this is fairly routine for our specialty, most insurance companies consider this a "Surgery" or "In- office Procedure" and it may be reflected as such on your billing statement or explanation of benefits. In addition, your physician may also require you to have an Audiogram, also known as a hearing test. Each of these services will result in an additional charge and therefore an additional financial responsibility for you. We want you to be informed of these services so there are no surprises or concerns after you leave our office.

Please sign below to acknowledge that you received the office notification regarding office Endoscopies/Audiograms and are aware that it may be performed during your visit.

______________________________ ____________________

Patient/Guardian Date

8635 W. Third Street, Suite 590W
Los Angeles, CA 90048