Patient name:_____

MASS EYE AND EAR ASSOCIATES
PATIENT INFORMATION

PATIENT'S NAME:_____MRN#_____

ADDRESS:_____

CITY:_____

STATE:_____ZIP:_____

HOME PH:_____CELL PH._____

WORK PH:_____ E-mail: _____

PRIMARY CARE PHYSICIAN:_____

LOCATION (Town):_____

DATE OF BIRTH:_____AGE:_____

GENDER: _____M _____F

*******IF PATIENT IS A CHILD OR DEPENDENT********
PLEASE FILL IN NAME & CONTACT INFO FOR RESPONSIBLE PARTY

PARENT/GUARDIAN NAME:_____

PHONE #: SAME or _____

RELATIONSHIP:_____ DOB:_____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:_____

INSURANCE CARD #:_____GROUP #:_____

SUBSCRIBER'S NAME (CARRIES INS): SELF or _____

D.O.B._____AGE:_____ RELATIONSHIP TO PATIENT:_____

SUBSCRIBER'S ADDRESS (if different):_____

SUBSCRIBER'S EMPLOYER:_____

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY:_____

INSURANCE CARD #:_____GROUP #:_____

Patient name:_____

MASSACHUSETTS EYE AND EAR SOUTH PATIENT INFORMATION SHEET

Please fill in appropriate circles completely ⇒ O
Please leave BLANK any non-applicable questions

Social History

What is patient's marital status? (leave blank if child) O Married O Other

Number of people in household: O 1 O 2 O 3 O 4 or more

Legal guardian (leave blank if patient is adult): O Parent O Other

Does the patient CURRENTLY use tobacco products (if no, skip next 4 questions)?
O Yes O No

What form of tobacco, if ever, does/did the patient use? O Cigarettes O Cigars
O Chewing Tobacco O Other

How many packs per day? O Less than 1 O 1-2 O 2-3 O greater than 3

When, if ever, did the patient quit tobacco use? O Did not quit O Less than 5 yrs O 5-10 yrs ago O 10-20 yrs ago O Greater than 20 yrs ago

Does the patient want to quit tobacco use in future? O Yes O No

Does the patient consume alcohol? (if no, skip next question) O Yes O No

How many alcoholic drinks does the patient consume per WEEK? O 5 or less
O 5-10 O 10-20 O greater than 20

Does the patient consume caffeine (coffee, tea, soda, etc)? O Yes O No

If yes, how many caffeine servings does the patient drink per day?
O 2 or less O 2-4 O greater than 4

Past Medical History ***PLEASE FILL IN ANY THE PATIENT HAS EVER SUFFERED FROM:***

Heart and blood vessel disease: O high blood pressure O chest pain
O previous heart attack O peripheral vascular disease O irregular heart beat O valvular disease O other cardiac disease _____

Cholesterol disease: O high cholesterol, or on medications for cholesterol

Lung disease: O asthma O emphysema O chronic bronchitis O pneumonia
O obstructive sleep apnea O other pulmonary disease _____

Cancer history: O breast O lung O skin O lymphoma O ovarian
O uterine O cervical O prostate O other _____

If you have had cancer, how were you treated? O surgery O radiation
O chemotherapy O other _____

Diabetes or endocrine/hormonal disease: O diabetes--insulin dependent
O diabetes--noninsulin dependent O overactive thyroid O underactive thyroid
O other endocrine disease _____

Hepatitis or liver disease: O Hepatitis A O Hepatitis B O Hepatitis C
O cirrhosis O other liver disease _____

Bleeding or clotting problems: O Coumadin use O aspirin use O hemophilia
O other bleeding disorder _____

Patient name:_____

Gastric or intestinal problems: O heartburn/acid reflux O peptic ulcer disease O esophagitis O colitis O diverticulitis O irritable bowel syndrome O other GI disease _____

Arthritis or bone disease O osteoperosis/osteopenia O osteoarthritis O rheumatoid arthritis O other arthritis _____

Autoimmune disease: O rheumatoid arthritis O lupus O sarcoidosis O Wegener's disease O other autoimmune disease _____

Kidney/bladder/prostate disease: O bladder infections O kidney infections O kidney stones O kidney insufficiency/failure O dialysis O prostate disease O other kidney disease _____

Neurological disease: O migraine O other chronic headache O ADHD O dementia O stroke O multiple sclerosis O spine disease O neuropathy O other neurological disease _____

Psychiatric disease: O depression O bipolar disease O anxiety/panic attacks O other psychiatric disease _____

Hereditary or congenital disease: O Down's syndrome O developmental delay O hypotonia O cerebral palsy O other congenital disease _____

Surgical history: O tonsillectomy O ear tubes O appendectomy O gallbladder removal O cardiac bypass/stent O bowel surgery O joint replacement O cancer surgery O problems with general anesthesia O other surgery _____
_____

Family History

Please check off any diseases that apply to the patient's family **MOTHER'S** side:
O thyroid disease O hearing loss O autoimmune disease O hereditary diseases O endocrine diseases O bleeding disorders O problems with general anesthesia O other _____

Please check off any diseases that apply to the patient's family **FATHER'S** side:
O thyroid disease O hearing loss O autoimmune disease O hereditary diseases O endocrine diseases O bleeding disorders O problems with general anesthesia O other _____

Review of Systems

Besides the patient's known past medical problems, are there any new psychiatric issues today, such as depression or anxiety? O Yes O No

Besides the patient's known past medical problems, are there any new cardiac issues today, such as chest pain or heart palpitations? O Yes O No

Besides the patient's known past medical problems, are there any new gastric or bowel issues today, such as heartburn, indigestion or diarrhea? O Yes O No

Besides the patient's known past medical problems, are there any new skin issues today, such as rash or itching? O Yes O No

Besides the patient's known past medical problems, are there any new hormonal issues today, such as heat intolerance, unexplained weight change or blood sugar problems? O Yes O No

Besides the patient's known past medical problems, are there any new neurological issues today, such as new headache or unsteadiness? O Yes O No

Patient name:_____

Besides the patient's known past medical problems, are there any new eye issues today, such as new vision change or tearing problems? O Yes O No

Besides the patient's known past medical problems, are there any new lung issues today, such as difficulty breathing or cough? O Yes O No

Besides the patient's known past medical problems, are there any new blood disease issues today, such as unexplained bruising or bleeding? O Yes O No

Besides the patient's known past medical problems, are there any new bladder/kidney issues today, such as difficulty urinating or pain? O Yes O No

Besides the patient's known past medical problems, are there any new joint or muscle issues today, such as joint stiffness or swelling? O Yes O No

Besides the patient's known past medical problems, are there any new problems with fatigue or malaise today? O Yes O No

Patient's height and weight

Height_____ Weight_____

Allergies

Is the patient allergic to any medications? O Yes O No
If yes, please list:

_____

Medications

Is the patient taking any medications? O Yes O No
If yes, please list all current medications (including nose sprays, eye drops, etc):

_____

_____

_____

_____

What pharmacy does the patient use?

Pharmacy name_____

Pharmacy's street_____town_____

What is the reason for today's visit? _____

_____

_____

Has any testing, such as bloodwork, x-rays or scans, been ordered by another physician/provider for the above problem? If so, what?

_____

Patient name:_____

MEEI, Massachusetts Eye and Ear Associates
DISEASES OF EAR, NOSE AND THROAT
MAXILLOFACIAL, HEAD & NECK SURGERY

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Monica S. Lee, M.D.

ALTERNATE COMMUNICATION CONSENT

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I give my permission to be contacted in the following manner (check all that apply):

[ ] **Home telephone:** _____
- [ ] Ok to leave message with detailed information
- [ ] Leave message with call back number only

[ ] **Work telephone**: _____
- [ ] OK to leave message with detailed information
- [ ] Leave message with call back number only

[ ] **Cell Phone**:_____
- [ ] Ok to leave message with detailed information
- [ ] Leave message with call back number only

[ ] **Written Communication**
- [ ] OK to mail to my home address
- [ ] OK to mail to my work/office address
- [ ] Ok to fax to this number _____

[ ] **E-mail**: _____
- [ ] Ok to send message with detailed information

I agree to inform the office if my phone number or e-mail changes.

I, _____, give permission for physicians and staff at Mass Eye and Ear to speak to _____regarding my medical care, information and test results. (If you don't want us to speak to anyone else, please write "no one".

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
PATIENT NAME **PATIENT DOB**

FOR OFFICE USE: PHYSICIAN - AKD CDC MSL HZI DSK