Welcome to Keck Hospital of USC Department of Otolaryngology – Head & Neck Surgery. Our goal is to provide a comprehensive evaluation of your problem. In order to update our records, we are asking for your help in providing the following information, some of which you may have provided in another format. We apologize if you have already submitted this information.

During your visit, we will review your medical history, undergo a physical exam and review any labs and x-rays as appropriate.

To prepare for your visit, please do the following:

- **complete all documentation below**
- **include accurate information on all current medications you are taking**
- **obtain copies of all reports relevant to your surgical problem and bring them with you (examples include: previous CT and MRI scans and images on discs, culture and biopsy results).**

TODAY'S VISIT

What specifically is the reason for your visit today? _____

_____

_____

How long have you been experiencing the conditions/symptoms? _____

Please describe past treatments for the symptoms/condition: _____

_____

_____

_____

_____

TREATING PHYSICIANS

Please list all Doctors/Providers who referred you here, including your primary care doctor, and any other doctor(s) from whom you are receiving care?

<u>This information is required, including the FAX numbers:</u>

Referring Doctor/Provider: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ FAX: (_____) _____

Primary Care Doctor/Provider: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ FAX: (_____) _____

Additional doctors to send my visit report to: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ FAX: (_____) _____

Additional doctors to send my visit report to: _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ FAX: (_____) _____

PATIENT INFORMATION: Please complete all fields

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home (_____) _____ Cell (_____) _____ Work (_____) _____

FAX: (_____) _____ Email Address: _____

Is English your primary language? ☐ Yes ☐ No

If "No," what is your primary language? _____

How well do you speak English? (check one) ☐ Very well ☐ Well ☐ Not well ☐ Not at all

What language would you prefer to receive healthcare information? _____

Do you have an advanced directive? ☐ Yes ☐ No

If medical necessary, would you consent to a blood transfusion? ☐ Yes ☐ No

Do you have a preferred relative or friend we should contact if we cannot reach you? ☐ Yes ☐ No

Preferred contact person(s) and relationship to you: _____

Phone: Home (_____) _____ Cell (_____) _____ Work (_____) _____

Other suggestions: _____

Who else can we speak to about your healthcare?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PHARMACY INFORMATION

Pharmacy Name: ____________________

Address: ____________________ City: ____________________ State: __________

Phone: (________) ____________________ Fax: (________) ____________________

ALLERGIES

Have you ever had a reaction to any of the following:

☐	Eggs	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
☐	Latex	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
☐	Iodine (including shellfish)	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
☐	Bee stings	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
☐	Intravenous contrast agent (used in CT and MRI scans)	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):

Are you allergic to any medications? If yes, please list the medication and the reaction that you had to them:

MEDICATION NAME	REACTION (check all that apply)
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):
	☐ anaphylaxis/shock ☐ rash ☐ itching ☐ nausea/vomiting ☐ short-of breath ☐ other (describe):

PATIENT ID

MEDICATIONS

Please list all medications you are **currently taking**. Please also include over-the-counter and herbal medications.

Name of Medication	Dosage or Strength Examples: 500 mg/mL, 250 mg	Route Examples: by mouth, patch, injection, etc.	Frequency (how often do you take this medication?) Examples: twice a day, every 2 hours, etc.	Start Date

PATIENT ID

PAST MEDICAL HISTORY

Please complete the section below for any illnesses/conditions you currently have or have had in the past.

Condition	Yes (x)	Condition	Yes (x)	Condition	Yes (x)
Anemia		Allergies		Chronic Bronchitis	
Arthritis		Bleeding Disorder		Cancer (list types)	
Depression		Diabetes		Seizures	
Heart Disease		Hepatitis		Psychiatric Treatment	
High Blood Pressure		HIV/AIDS		Kidney Disease	
Liver Disease		Pneumonia		Heart Attack	
Stroke		Thyroid Disorders		Tuberculosis	
Stomach ulcers		Lung Disease		Ear Infection	
Sinus Disorder		Sleep Apnea		Hearing Loss	
Urinary Tract Infection (UTI)		Salivary Duct Stone		Hearing Aid	
Benign Prostatic Hyperplasia (BPH)		GERD (reflux)		Other:	
Other:		Other:		Other:	

PAST SURGICAL HISTORY

Please complete the section below for any surgeries/procedures you have had in the past.

Surgery	Yes (x)	Surgery	Yes (x)	Surgery	Yes (x)
Adenoidectomy		Colonoscopy		Tonsillectomy	
Appendectomy		Esophagus surgery		Ear tubes	
Bronchoscopy		Cholecystectomy (gall bladder removal)		Sinus Surgery	
Eye Surgery				Nose Surgery (Rhinoplasty)	
Nasal Septum Surgery		Nasal Surgery		Inner ear Surgery	
Middle Ear Surgery		External Ear Surgery		Salivary gland Surgery	
Throat Surgery		Neck Surgery		Uvulopalatopharyngoplasty (Sleep Apnea Surgery)	
Cardiac Surgery		Facial Cosmetic Surgery			
Other:		Snoring Procedure		Other:	
Other:		Other:		Other:	
Other:		Other:		Other:	

Have you ever been hospitalized? ☐ Yes ☐ No

If YES, please list the date(s) and reasons.

Date	**Reason**

FAMILY HISTORY

Please indicate any family history:

Relationship to You	Anesthesia Problem	Asthma	Autoimmune Disease	Bleeding Disorder	Breast Cancer	Colon Cancer	Diabetes	Hearing Loss	Heart Disease	High Cholesterol	Hyperlipidemia	Hypertension	Kidney Failure	Lung Cancer	Melanoma	Migraines	Nose Bleeds (Severe)	Osteoarthritis	Seizures	Sleep Apnea	Snoring	Stroke	Thyroid Disease
Mother																							
Father																							
Sister																							
Brother																							
Daughter																							
Son																							
Other:																							
Other:																							
Other:																							

HEALTH HABITS

Do you drink alcohol? ☐ Yes ☐ No

If yes, what is the average number of drinks per week:

	glasses of wine per week
	cans of beer per week
	shots of liquor per week
	Drinks containing 0.5 oz of alcohol

Do you currently use drugs recreationally? ☐ Yes ☐ No

If YES, check the drugs you use:

☐ amphetamines	☐ amyl nitrate	☐ anabolic steroids	☐ barbiturates	☐ Benzodiazepines (such as Xanax, Ativan, Valium)	☐ "crack" cocaine
☐ cocaine	☐ codeine	☐ Fentanyl	☐ GHB	☐ heroin	☐ hydrocodone
☐ hydromorphone	☐ ketamine	☐ LSD	☐ marijuana	☐ MDMA ecstasy	☐ methamphetamine
☐ methaqualone	☐ methylphenidate	☐ morphine	☐ nitrous oxide	☐ opium	☐ oxycontin
☐ PCP	☐ Psilocybin	☐ solvent inhalants	☐ IV drugs	☐ Other:	

Are you a (check one):

☐ Current everyday smoker	☐ Current some day smoker	☐ Former smoker	☐ Never Smoked	☐ Passive (2nd Hand Smoke) Smoke Exposure

How many **packs of cigarettes per day** do you (or did you) smoke, on average? _____ packs

How many years have you smoked? _____ years

If you are a former smoker, what date did you quit? _____

Do you smoke (check all that apply) ☐ Cigarettes ☐ Cigars ☐ Pipe Tobacco

Do you chew tobacco (check one): ☐ Current User ☐ Former User ☐ Never Used

If you formerly chewed tobacco, what date did you quit? _____

Do you use nicotine gum or nicotine patches? ☐ Yes ☐ No

If you use tobacco products, are you ready to quit? ☐ Yes ☐ No

PATIENT ASSESSMENT

Nutrition Screen:

Have you experienced unplanned weight loss or weight gain in the last three (3) months: ☐ Yes ☐ No

Have you experienced poor oral intake for four (4) or more days prior to your visit: ☐ Yes ☐ No

If YES, please explain: _____

Are you experiencing difficulty chewing or swallowing: ☐ Yes ☐ No

If YES, please explain: _____

Activities of Daily Living (ADL) Screen:

Hearing – RIGHT EAR

- ☐ My hearing is normal
- ☐ I have poor hearing
- ☐ I have difficulty with noise
- ☐ I am deaf
- ☐ Unknown

Hearing – LEFT EAR

- ☐ My hearing is normal
- ☐ I have poor hearing
- ☐ I have difficulty with noise
- ☐ I am deaf
- ☐ Unknown

Assistive Devices:

- ☐ None
- ☐ Sensory Aids (ex: hearing aid)
- ☐ Other (please explain): _____

Falls:

Have you fallen more than once in the past one (1) month? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please check if you have any of the following:

Yes	Constitutional
	Activity Change
	Appetite Change
	Chills
	Diaphoresis (Sweating)
	Fatigue
	Fever
	Unexpected Weight Change

Yes	HENT
	Facial Swelling
	Neck Pain
	Neck Stiffness
	Ear Discharge
	Hearing Loss
	Ear Pain
	Tinnitus (Ringing in Ear)
	Nosebleeds
	Congestion
	Rhinorrhea (Runny Nose)
	Postnasal Drip
	Sneezing
	Sinus Pressure
	Dental Problem
	Drooling
	Mouth Sores
	Sore Throat
	Trouble Swallowing
	Voice Change

Yes	Eyes
	Eye Discharge
	Eye Itching
	Eye Pain
	Eye Redness
	Photophobia
	Visual Disturbance

Yes	Respiratory
	Apnea
	Chest Tightness
	Choking
	Cough
	Shortness of Breath
	Stridor
	Wheezing

Yes	Cardiovascular
	Chest Pain
	Leg Swelling
	Palpitations

Yes	GI
	Abdominal Distension
	Abdominal Pain
	Anal Bleeding
	Blood in Stool
	Constipation
	Diarrhea
	Nausea
	Rectal Pain
	Vomiting

Yes	GU
	Difficulty Urinating
	Dysuria (painful urination)
	Enuresis (bed wetting)
	Frequency
	Hematuria (blood in urine)
	Urgency
	Urine Decreased

Yes	Musculoskeletal
	Arthralgias (Joint Pain)
	Back Pain
	Gait Problem
	Joint Swelling
	Myalgias (Muscle Aches/Pain)

Yes	Skin
	Color change
	Pallor
	Rash
	Wound

Yes	Neurological
	Dizziness
	Facial Asymmetry
	Headaches
	Light-Headedness
	Numbness
	Seizures
	Speech Difficulty
	Syncope (Fainting)
	Tremors
	Weakness

Yes	Hematologic
	Adenopathy
	Bruises/Bleeds Easily

Yes	Psychiatric
	Agitation
	Behavior Problem
	Confusion
	Decreased Concentration
	Hyperactive
	Nervous/Anxious
	Sleep Disturbance

What specifically is the reason for your visit today? _____

Height: _____ Weight: _____ Neck size (collar size): _____

What was your weight 1 year ago? _____ 2 years ago? _____ At age 18? _____

Do you snore? ☐ Yes ☐ No How often? _____ (days/week)

How loudly (scale 0–10)? _____ How long have you been a snorer? _____

Has it worsened recently? ☐ Yes ☐ No Over how long a period of time? _____

Do you hold your breath or gasp for air while asleep? _____

Anything make your snoring or breathing patterns at night better or worse (e.g, sleeping on back vs. side or stomach, alcohol intake, nasal blockage, being tired)? _____

_____

Weekday bedtime and wake up time: _____ Weekend: _____

Do you nap? ☐ Yes ☐ No How often, and for how long? _____

How long does it take you to fall asleep at night? _____

How many times do you wake up at night? _____ How long to fall back asleep? _____

In what position do you sleep (back, right or left side, stomach)? _____

Do you feel refreshed when you wake up in the morning? _____

Do you frequently awaken with (check all that apply): ☐ dry mouth ☐ headaches ☐ excessive sweating ☐ choking or gasping ☐ nasal blockage ☐ chest pain ☐ heartburn or sour taste

Does fatigue limit your daily activities? ☐ No ☐ Mild ☐ Moderate ☐ Severe

Caffeinated beverages per day (coffee, tea or soda)? _____

What led you to obtain a sleep study, if you have had one? _____

Have you used positive airway pressure therapy (CPAP, BiPAP, or AutoPAP)? ☐ Yes ☐ No

Describe your experience with CPAP / BiPAP / AutoPAP, including the reasons for not wearing it if you are not able to? _____

On average, how many nights a week are or were you able to wear it? _____

For how many hours per night (range and average)? _____

Still using CPAP / BiPAP / AutoPAP? ☐ Yes ☐ No Still own equipment? ☐ Yes ☐ No

If not using CPAP / BiPAP / AutoPAP, how long has it been? _____

What type of masks do you use or have you used?
☐ Nasal mask (over nose) ☐ Nasal pillows (inside nostrils) ☐ Full face (over nose and mouth)

Have you ever used an oral appliance? ☐ Yes ☐ No

If yes, what is/was your experience? _____

_____

DEPARTMENT OF OTOLARYNGOLOGY – HEAD & NECK SURGERY
NEW SLEEP PATIENT QUESTIONNAIRE (VERSION K)

PATIENT ID

WHITE - MEDICAL RECORD

Do you feel a restless sensation in your legs while lying awake in bed? _____

Do you make kicking or twitching movements while asleep? _____

Do you ever awaken feeling paralyzed? _____

Experience sudden loss of strength in your arms or legs during the day? _____

If yes, is this brought on by sudden right or laughter? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep (in contrast to feeling tired) in the following situations? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Choose the following scale to choose the most appropriate number for each situation.

0 would never doze
1 slight chance of dozing
2 moderate chance of dozing
3 high chance of dozing

SITUATION	CHANCE OF DOZING			
	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place (for example, a movie theater or meeting)	☐	☐	☐	☐
As a passenger in a car for an hour, without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

NASAL BREATHING

Do you have difficulty breathing through your nose? _____

Is this a problem during the day? _____ During the night? _____

Is your nose blocked on one side, both sides, or does it alternate between side? _____

Does your nasal blockage change with the time of year (seasons)? _____

Do you have symptoms of allergies, such as itchy or watery eyes or hay fever? _____

What medications or devices have you tried to treat nasal obstruction, and what has been the result?

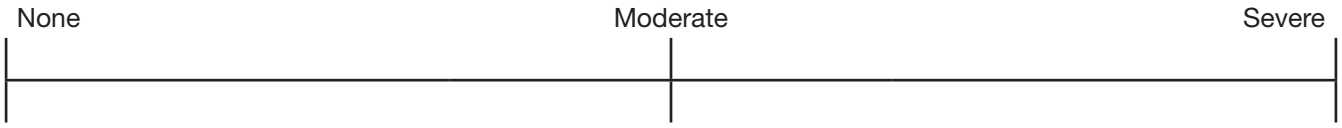
_____

Over the past ONE month, how much of a problem were the following conditions for you?

Please check the most correct response.

	(0) Not a Problem	(1) Very Mild Problem	(2) Moderate Problem	(3) Fairly Bad Problem	(4) Severe Problem
1. Nasal congestion or stuffiness.	☐	☐	☐	☐	☐
2. Nasal blockage or obstruction.	☐	☐	☐	☐	☐
3. Trouble breathing through my nose.	☐	☐	☐	☐	☐
4. Trouble sleeping.	☐	☐	☐	☐	☐
5. Unable to get enough air through my nose during exercise or exertion.	☐	☐	☐	☐	☐

Please mark on this line how troublesome your difficulty in breathing through your nose is:



FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off," or that you feel the urge to take a nap. These words do **not** refer to the tired or fatigued feeling you may have after you have exercised.

DIRECTIONS: Please put an X in the box for your answer to each question. Select only **one** answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) I don't do this activity for other reasons	**(4)** No difficulty	**(3)** Yes, a little difficulty	**(2)** Yes, Moderate difficulty	**(1)** Yes, Extreme difficulty
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	☐	☐	☐	☐	☐
2. Do you generally have difficulty remembering things because you are sleepy or tired?	☐	☐	☐	☐	☐
3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐

PATIENT ID

	(0) I don't do this activity for other reasons	(4) No difficulty	(3) Yes, a little difficulty	(2) Yes, Moderate difficulty	(1) Yes, Extreme difficulty
4. Do you have difficulty operating a motor vehicle for longer distances (greater than 100 miles) because you become sleepy or tired?	☐	☐	☐	☐	☐
5. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?	☐	☐	☐	☐	☐
	(4) No	**(3)** Yes, A Little	**(2)** Yes, Moderately	**(1)** Yes, Extremely	
6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?	☐	☐	☐	☐	
	(0) I don't do this activity for other reasons	**(4)** No difficulty	**(3)** Yes, a little difficulty	**(2)** Yes, Moderate difficulty	**(1)** Yes, Extreme difficulty
7. Do you have difficulty watching a movie or video because you become sleepy or tired?	☐	☐	☐	☐	☐
8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?	☐	☐	☐	☐	☐
9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?		☐	☐	☐	☐
10. Has your desire for intimacy or sex been affected because you are sleepy or tired?	☐	☐	☐	☐	☐

Thank you for completing this questionnaire.