Aspire ALLERGY & SINUS

DISCLOSURE AND CONSENT

You have the right, as a patient to be informed about your recommended treatment so that you may make the decision whether or not to undergo treatment under the care of Aspire Allergy & Sinus. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to treatment.

____(initial) **CONSENT TO TREATMENT**

I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider at Aspire Allergy & Sinus and their designated medical office staff as is deemed necessary in the medical provider's judgment. I agree to be financially responsible for the costs of such diagnostic procedures. I authorize and consent to the disposal of materials/substances that would normally be removed in the course of such diagnostic procedures and medical treatment. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as a result of treatments or examination. The opportunity has been provided for me to ask questions regarding the proposed allergy treatment and these questions have been answered to my satisfaction. ***I understand that I have the right to refuse any medical or surgical treatment that I do not want.***

____(initial) **RECEIPT OF *NOTICE OF PRIVACY PRACTICES***

I have been given access to Aspire Allergy & Sinus's Notice ***of Privacy Practices,*** which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____(initial) **CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION**

HIPAA allows individuals to designate a family member or other individual with whom my Protected Health Information be disclosed for purposes of communication results, findings, and/or care decisions. Uses and disclosures for treatment records, payment information and healthcare operations may be permitted without prior consent in an emergency. I authorize Aspire Allergy & Sinus to share my Protected Health Information with the following:

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization at any time, must be in writing.

I have read and understand the information above.

PATIENT NAME (PRINTED)_____

PATIENT SIGNATURE _____ DATE_____

PARENT/LEGAL GUARDIAN SIGNATURE_____ DATE_____

*As a parent/legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.

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SYMPTOM QUESTIONNAIRE

The following questionnaire is used to help your provider gain valuable information about the symptoms you're currently experiencing. Answer the questions rating the symptoms you've experienced over the past two weeks. **For patients under the age of 14, only rate the symptoms that apply to you.**

Patient Name: _____

Patient Phone: _____

Date: _____

Things to consider:

- How severe is the problem when you experience it and how often does it occur? Circle the number that corresponds with how you feel.
- Identify the most significant areas affecting your health at this time in the last column (up to five).

	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem as bad as it can be	Total Score	Up to five 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. Cough	0	1	2	3	4	5		☐
5. Post-nasal discharge	0	1	2	3	4	5		☐
6. Thick nasal discharge	0	1	2	3	4	5		☐
7. Ear fullness	0	1	2	3	4	5		☐
8. Dizziness	0	1	2	3	4	5		☐
9. Ear pain	0	1	2	3	4	5		☐
10. Facial pain / pressure	0	1	2	3	4	5		☐
11. Difficulty falling asleep	0	1	2	3	4	5		☐
12. Waking up at night	0	1	2	3	4	5		☐
13. Lack of sleep	0	1	2	3	4	5		☐
14. Wake up tired	0	1	2	3	4	5		☐
15. Fatigue	0	1	2	3	4	5		☐
16. Reduced productivity	0	1	2	3	4	5		☐
17. Reduced concentration	0	1	2	3	4	5		☐
18. Frustrated / restless / irritable	0	1	2	3	4	5		☐
19. Sad	0	1	2	3	4	5		☐
20. Embarrassed	0	1	2	3	4	5		☐
TOTAL								

FOR OFFICE USE ONLY

Sinus headaches / facial pressure? _____ Constant Congestion? _____

Frequent sinus infections / colds? _____ Score greater than 20? _____

Has the patient had sinus surgery? _____ Refer for sinus consult? Y / N

Aspire Allergy & Sinus Health History Form

Patient Account #_____ Scope:_____ ENT:_____ CT:_____

Vial Prep (Per Unit): _____ Injection: _____ First Vial Prep Bill Est.: _____ Rel Qty: _____ SNOT Score: _____

Height: _____ **Weight:** _____ **BP:** _____ **HR:** _____ **Temp:** _____ **O_2:** _____ **RR:** _____

Last Name: _____ First Name: _____

Date of Birth: _____ Today's Date: _____ Pharmacy: _____

CC: Reason for Today's visit (please specify how long you have had these symptoms):

_____

1. How long have you suffered with allergies?

_____

2. What are your main symptoms?

☐ Sneezing ☐ Coughing ☐ Wheezing
☐ Ear pain/congestion ☐ Headaches ☐ Watery/itchy eyes
☐ Sinus pain/pressure ☐ Congestion ☐ Hives
☐ Sleep Problems ☐ Runny Nose ☐ Nasal Drainage
☐ Loss of smell/taste ☐ Other _____

3. Are you currently on an Antihistamine? YES / NO

if yes, which one? _____

4. Do you use a Nasal Spray? YES / NO

if yes, which one? _____

5. Do you have symptoms year-round? YES / NO

worst season? ☐Spring ☐Summer ☐Fall ☐Winter

6. Have you had previous allergy testing? YES / NO

If yes, when and what type of known seasonal allergies?_____

_____

Any known food allergies? YES / NO

If yes, what food? _____

If yes, what type of reaction? _____

7. Have you had immunotherapy? YES / NO

If yes, which method; ☐Drops ☐ Shots

If yes, when was your last drop/injection? _____

If yes, how long was treatment?_____

If yes, why did you stop? _____

8. Ever had an anaphylactic reaction? YES / NO

If yes, when? _____

Did you to use/receive Epinephrine? YES / NO

Did you go to the hospital? YES / NO

9. Do you have pets (circle)? YES / NO

If so, what kind? _____

10. Have you ever had sinus/ENT surgery? YES / NO

If yes, what surgery? _____

If yes, when was the surgery? _____

Have you had a Sinus infection? YES / NO

If yes? ☐< 2 per year ☐≤ 4 per year ☐> 5 per year

Ever suffer from prolonged loss of smell? YES / NO

Ever have Pain/Pressure in face/sinuses? YES / NO

Have you taken Antibiotics this past year? YES / NO

If yes, which type? _____

Have you taken steroids this past year? YES / NO

If yes, which type? _____

11. Have you ever had Asthma? YES / NO

List any inhalers you use and how often?_____

_____

_____

Have you had to go to ER in the last year for asthma/SOB/wheezing? YES / NO

If yes, when? _____

12. Do you have any Drug Allergies? YES / NO

If so, to which drugs? _____

13. Any significant health conditions? YES / NO

If Yes, explain: _____

_____

_____

14. Are you currently pregnant or is there a chance of pregnancy? YES / NO

15. Please list any medications you are currently taking:

_____

_____

_____

_____