Dear Valued Patient,

On behalf of the physicians, associate practitioners, nurses and staff of USMD Physician Services, I want to welcome you to our organization and thank you for choosing a USMD physician to care for you and/or your loved ones.

At USMD, our physicians put their patients’ needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our physicians are board certified and committed to promoting good health and guiding patients toward a healthy lifestyle.

With nearly 70 locations and more than 250 physicians and associate practitioners in just under 20 different specialties, USMD offers convenient locations all across the Dallas-Fort Worth metroplex to care for everyone in your family at every stage of life.

One of the unique features that USMD offers is NextMD for MCNT patients and Follow My Health for UANT patients. Through NextMD and Follow My Health, patients have communication with their physician’s office through a protected, online portal. NextMD and Follow My Health also give patients the ability to access and review lab results and request appointments and prescription refills. Please talk with a staff member if you have questions or would like more information.

To learn more about USMD, please visit our website at www.usmd.com.

Again, thank you for choosing USMD for your healthcare needs.

Sincerely,

Richard C. Johnston MD, FACP
Chief Executive Officer and Chief Physician Officer
USMD Health System
PATIENT INFORMATION

Patient’s Name (First, Middle, Last): ____________________________________________________________

Address: __________________________________________________________________________________

City: __________________ State: _______ Zip Code: __________ Email: ________________________________

Main Contact#: __________________________ Alternate#: __________________________ Work#: ___________

Date of Birth: ______/_____/______ Sex: ☐ Male ☐ Female SS# (optional): _______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: ____________________________

Patient Referred By: ____________________________________________ Spouse’s Name: _______________________________

Spouse’s Date of Birth: ______/_____/______ Main Contact#: __________________ Alternate#: ___________

Emergency Contact: __________________________________________________________________________

Primary Care Physician: ___________________________________________ Phone#: __________________________

Referring Physician: ____________________________________________ Phone#: __________________________

Which racial category does the patient most closely identify with?

☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic

☐ Native American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other: __________________(Please Specify)

Ethnicity: What is the patient’s ethnicity?

☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is the patient’s language of preference?

☐ English ☐ Spanish ☐ Other: __________________(Please Specify)

Primary Insurance: ____________________________________________ Policy/ID# _______________________

Name of Policy Holder: __________________________ DOB: ______/_____/_____ Group/Acct #: _____________

Employer: __________________________________________________ Employer Address: _______________________

City: __________________ State: _______ Zip Code: __________ Work #: _______________________________

Secondary Insurance: ____________________________________________ Policy/ID# _______________________

Name of Policy Holder: __________________________ DOB: ______/_____/_____ Group/Acct #: _____________

Employer: __________________________________________________ Employer Address: _______________________

City: __________________ State: _______ Zip Code: __________ Work #: _______________________________

Complete – Only if Patient is a Minor

Parent/Guardian Name: __________________________________ Relationship: ____________________________

Parent/Guardian Name: __________________________________ Relationship: ____________________________

Siblings: _______________ DOB: ______/_____/_____ Other Siblings: _______________ DOB: ______/_____/_____
GENERAL CONSENT FORM

Patient Name: ___________________________ Date of Birth: _____ / _____ / _______

Assignment of Benefits. I authorize USMD Physician Services, ("USMD") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that USMD will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: __________

Consent for Treatment. I consent for USMD to administer treatments, tests and/or diagnostic tests to treat my/the patient’s injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient’s blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient’s BBF, USMD may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at USMD’s expense.

Patient Initials: __________

Electronic Prescription. I understand USMD utilizes electronic prescribing technology and participates with SureScripts. SureScripts operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. SureScripts also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Phone Calls. By providing contact information, I authorize USMD, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize USMD to discuss my/the patient’s care and medical needs with the following persons:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth (for identification)</th>
<th>Relationship</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

☐ I DO NOT wish to add an additional contact to discuss my/the patient’s needs. Patient Initials: __________

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #: ___________________________ Secondary Phone #: ___________________________

☐ Leave message with contact number only. ☐ Leave message with contact number only.
☐ Leave message with detailed information. ☐ Leave message with detailed information.
☐ Do not leave message. ☐ Do not leave message.

Patient Financial Policy
I acknowledge receipt of the “Patient Financial Policy.” Patient Initials: __________

Notice of Privacy Practices
I acknowledge receipt of the “Notice of Privacy Practices.” Patient Initials: __________

Minor Patient Photograph (when applicable)
I consent for USMD to photograph the minor patient for identification purposes only. Patient Initials: __________

Print Name of Patient or Personal Representative ___________________________

Signature of Patient or Personal Representative ___________________________ Date _______
USMD Physician Services (“USMD”) recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

• **PAYMENT:** Payment is expected at the time of service. If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, USMD will begin various collection activities including, but not limited to submitting the past due account to a collection agency.

• **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our business office prior to your visit. We require an advance payment for professional services.

• **MANAGED CARE:** All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service. If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as “out of network” or “non covered” treatment, and you will be responsible for a larger amount or all of the charges. The patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

• **MEDICARE:** USMD providers are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

• **AUTOMOBILE ACCIDENT PATIENTS:** We do treat automobile accident patients. However, we are unable to monitor long-term accounts and require payment as a self-paying patient. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.

• **CHILDREN OF DIVORCED PARENTS:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of USMD.
• **SECONDARY INSURANCE:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information. Patient agrees to immediately notify provider of any future additions, changes or deletions in primary or secondary insurance coverage.

• If you have Medicaid coverage of any kind, you must notify us prior to your visit. This is part of your agreement with Medicaid, and **failure to notify us** of Medicaid coverage will result in full financial responsibility for services rendered.

• Before receiving services, you must verify that we are participating providers for your insurance company. It is also necessary that our primary care physician is listed as your primary care provider with your insurance company, if required by your contract with your insurance company. In the event we are not participating providers or our physician is not listed as your primary care provider with your insurance company, we will file the initial claim as a courtesy. Payment, however, is due in full at the time of service.

• We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call **(817) 514-5200**.

• We may charge you a “No Show” fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date.

• **Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

USMD firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please call us at (817) 514-5200.
Today’s Date: _________________

Last Name ___  First Name ___  M.I. ___  D.O.B. ___/___/_______

Whom may we thank for referring you to USMD | UANT?  □ Self  □ Friend  □ Physician: __________________

Primary Care Physician: ____________________________  Previous Urologist: _________________________

What is the main reason for your visit:

□ Elevated PSA  □ History of kidney cancer  □ Blood in urine:  □ Visible  □ Invisible
□ Erectile dysfunction  □ Urinary tract infections  □ BPH or male voiding symptoms or
□ History of bladder cancer  □ Infertility  □ Incontinence or female voiding symptoms
□ Vasectomy  □ History of prostate cancer  □ Other Specify ________________________________
□ Kidney stones  □ Abdominal or flank pain

What is the approximate date when the symptoms started or you first became aware of the problem?
Date: ______/_____/__________  or  ______________ □ days □ weeks □ months □ years ago

Describe any previous treatment (medicines, surgery, etc) prior to this visit for the problem:
___________________________________________________________________________________________________________________________________________________
___________________________________________________________________________________________________________________________________________________

Complete the following section if the reason for today’s visit is for voiding problems (male or female):

How many times during the day do you typically void in the toilet or urinal?  ________________

How many times do you typically get out of bed at night to urinate?  ________________

Do you have difficulty starting your urinary stream?  □ Yes  □ No
Do you have decreased force in your stream?  □ Yes  □ No
Do you have to strain or push to void?  □ Yes  □ No
Do you still feel full when you have finished voiding?  □ Yes  □ No
Does your stream typically stop and start during voiding?  □ Yes  □ No
Do you typically have pain during voiding?  □ Yes  □ No
Have you seen blood in your urine?  □ Yes  □ No

Complete the following section if the reason for today’s visit is for incontinence (male or female):

How many episodes of incontinence do you have in a typical daytime period?  ________________

How many episodes of incontinence do you have in a typical nighttime period?  ________________

Are you incontinent with...

Coughing?  □ Yes  □ No
Sneezing?  □ Yes  □ No
Walking?  □ Yes  □ No
Physical activity?  □ Yes  □ No

Are you bothered by a need to hurry to get to the bathroom?  □ Yes  □ No
Are you incontinent because you cannot get to the bathroom in time?  □ Yes  □ No
Do you wear pads to manage incontinence?  □ Yes  □ No
If yes, type of pad ____________  # pads per day ____________  # pads per night ____________

Last treatment date for a urinary tract infection: _________________________/_____/_______

Do you have...

Diabetes?  □ Yes  □ No
Stroke or head injury?  □ Yes  □ No
Back injury or surgery?  □ Yes  □ No
Past radiation therapy?  □ Yes  □ No
Weak or numb legs?  □ Yes  □ No
Incontinence of stool?  □ Yes  □ No

(WOMEN ONLY) Number of pregnancies/deliveries: ___________/___________
CURRENT MEDICATIONS
(include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or \[\text{NONE}\]

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose (mg)</th>
<th>How often is the medication taken</th>
<th>Reason for taking medication</th>
<th>Physician prescribing</th>
</tr>
</thead>
<tbody>
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<td>1</td>
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</tbody>
</table>

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____________________________________ Phone #: __________________________ Fax #: _____________________
Address:  ______________________________________ City: ___________________________ State/Zip:__________________

ALLERGIES (include medications, foods, x-ray dyes) or \[\text{NONE KNOWN}\]

<table>
<thead>
<tr>
<th>Name of allergen</th>
<th>Type of reaction</th>
<th>Approximate date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<tr>
<td>2</td>
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<td>4</td>
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</tbody>
</table>

PAST SURGERIES (include all surgery in your lifetime. Attach extra sheet if necessary) or \[\text{NONE}\]

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Date (approximate)</th>
<th>Hospital or City if known</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td>2</td>
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<td>8</td>
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</tbody>
</table>

OTHER HOSPITALIZATIONS (include all non surgical hospitalizations) or \[\text{NONE}\]

<table>
<thead>
<tr>
<th>Reasons for Hospital Stay</th>
<th>Date (approximate)</th>
<th>Hospital or City if known</th>
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<tbody>
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<td>1</td>
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<td>7</td>
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</tbody>
</table>
## MEDICAL CONDITIONS
(include past and present medical conditions, check appropriate box)

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>Past (Resolved)</th>
<th>Now Active</th>
<th>Date Onset</th>
<th>Specialist MD if applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood pressure (hypertension)</td>
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<tr>
<td>Elevated cholesterol</td>
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<tr>
<td>Heart attack</td>
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<tr>
<td>Irregular heart beat (cardiac arrhythmia)</td>
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<tr>
<td>Congestive heart failure</td>
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<tr>
<td>Stroke or TIAs</td>
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<tr>
<td>Ulcers of the stomach or intestine</td>
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<tr>
<td>Emphysema, COPD, or lung problems</td>
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<tr>
<td>Asthma</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Bleeding problems</td>
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<tr>
<td>HIV/AIDS</td>
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<tr>
<td>Kidney disease (renal failure)</td>
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<tr>
<td>Liver disease (hepatitis B or C)</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Thyroid disease</td>
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<tr>
<td>Psychological or psychiatric disease</td>
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<tr>
<td>Cancer of any organ (specify)</td>
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<tr>
<td>Kidney stones</td>
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<tr>
<td>Glaucoma</td>
<td></td>
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<tr>
<td>List other conditions</td>
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</tbody>
</table>

## FAMILY HISTORY
Is there a history in your family of:  
<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Affected relative(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
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<tr>
<td>Prostate cancer</td>
<td></td>
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<tr>
<td>Kidney cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney stones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other significant disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## TOBACCO HISTORY
Are you an active cigarette smoker?  
Yes                      No
Have you ever been a cigarette smoker?  
Yes                      No
* If yes, I smoked an average of ________ packs/day for ________ years. I quit in ________ (year)
Do you use other tobacco products?  
Yes                      No
* If yes, please specify ________________________________

## ALCOHOL AND DRUG HISTORY
Have you ever been diagnosed with alcoholism?  
Yes                      No
Do you currently drink alcohol regularly?  
Yes, currently            Never/rarely
If yes, approximately how many drinks per week (beer, wine, or liquor) ________________
Have you ever used intravenous drugs?  
Yes                      No

## OCCUPATION AND MARITAL STATUS
I am currently:  
- single                  
- married                 
- divorced                
- widowed
I am:  
- retired                 
- employed full time      
- employed part time      
- unemployed              
- student
My occupation is/was: ________________________________
## REVIEW OF SYSTEMS

### (Current or Recent Symptoms)

#### Constitutional
- Fever [ ] Yes [ ] No
- Chills [ ] Yes [ ] No
- Headache [ ] Yes [ ] No
- Weight gain over 10 lbs [ ] Yes [ ] No
- Weight loss over 10 lbs [ ] Yes [ ] No

#### Neurological (nervous system)
- Seizures [ ] Yes [ ] No
- Dizziness [ ] Yes [ ] No
- Numbness in extremity [ ] Yes [ ] No
- Weakness in extremity [ ] Yes [ ] No
- Loss of balance [ ] Yes [ ] No
- Frequent falls [ ] Yes [ ] No
- Tremors [ ] Yes [ ] No

#### Endocrine (internal glands)
- Excessive thirst [ ] Yes [ ] No
- Cold or heat intolerance [ ] Yes [ ] No
- Excessive fatigue [ ] Yes [ ] No
- Thyroid disease [ ] Yes [ ] No

#### Gastrointestinal
- Abdominal pain [ ] Yes [ ] No
- Nausea/vomiting [ ] Yes [ ] No
- Indigestion/Heartburn [ ] Yes [ ] No
- Diarrhea [ ] Yes [ ] No
- Constipation [ ] Yes [ ] No
- Blood in stools [ ] Yes [ ] No

#### Cardiovascular
- Chest pain, pressure [ ] Yes [ ] No
- Palpitations [ ] Yes [ ] No
- Calf pain with exercise [ ] Yes [ ] No
- Shortness of breath [ ] Yes [ ] No
- Wake up breathless [ ] Yes [ ] No
- Swelling in legs/ankles [ ] Yes [ ] No

#### Integumentary (skin problems)
- Unexplained rash [ ] Yes [ ] No
- Frequent boils [ ] Yes [ ] No

#### Musculoskeletal
- Joint pain [ ] Yes [ ] No
  - Which joint: _____________________________
- Neck pain [ ] Yes [ ] No
- Back pain [ ] Yes [ ] No
  - Recent or chronic: _____________________________
- Muscle weakness [ ] Yes [ ] No

#### Respiratory (lungs)
- Wheezing [ ] Yes [ ] No
- Frequent coughing [ ] Yes [ ] No
- Shortness of breath [ ] Yes [ ] No
- Coughing up blood [ ] Yes [ ] No

#### Hematologic/Lymphatic
- Swollen lymph glands [ ] Yes [ ] No
- Bleeding tendency [ ] Yes [ ] No

#### Genitourinary (urinary and genital)
- (Complete only if not reason for visit)
  - Painful urination [ ] Yes [ ] No
  - Frequent urination [ ] Yes [ ] No
  - Urgent urination [ ] Yes [ ] No
  - Blood in urine [ ] Yes [ ] No
  - Weak urine stream [ ] Yes [ ] No
  - Straining to urinate [ ] Yes [ ] No
  - Interrupted urine flow [ ] Yes [ ] No
  - Incontinence [ ] Yes [ ] No
  - Incomplete emptying [ ] Yes [ ] No
  - Erectile dysfunction [ ] Yes [ ] No

#### Eyes
- Blurred vision [ ] Yes [ ] No
- Double vision [ ] Yes [ ] No
- Eye pain [ ] Yes [ ] No
- History glaucoma [ ] Yes [ ] No
- Untreated cataracts [ ] Yes [ ] No
- Retinal disease [ ] Yes [ ] No

#### Ear/Nose/Throat/Mouth
- Ear infections [ ] Yes [ ] No
- Sore throat [ ] Yes [ ] No
- Hearing loss [ ] Yes [ ] No
- Sinus allergies [ ] Yes [ ] No
- Difficulty swallowing [ ] Yes [ ] No
- Nose bleeds [ ] Yes [ ] No
- Hoarseness [ ] Yes [ ] No

#### Psychological
- Depression [ ] Yes [ ] No
- Loss of general interest [ ] Yes [ ] No
- Severe anxiety [ ] Yes [ ] No

---

**Patient Name:** _____________________________
**Date of Birth:** _______ /________ /________
  
**Height (inches) _____________________________**
**Weight (lbs) _____________________________**

___________________________________________________________

**Signature**

___________________________________________________________

**Date**