Texas Tech Physicians of LUBBOCK SURGERY

Health Questionnaire: Otolaryngology

MR# _____

Patient Name _____ **Date of Birth** _____
Last First MI

Address _____ SS# _____

City _____ State _____ Zip Code _____ M ___ F ___

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Primary Care Physician _____ Referring Physician _____

A. PERSONAL HISTORY

❑ Married ❑ Widow ❑ Divorced ❑ Single

Currently Employed ❑ Yes ❑ No

Occupation _____ How long? _____

Current Living Arrangements ❑ Apartment ❑ House ❑ Other

Do you live ❑ with spouse/family ❑ alone ❑ with others

Do you have a living will or advance directive? ❑ Yes ❑ No

Do you need assistance with your home care needs? ❑ Yes ❑ No

B. ILLNESSES

Have you ever had the following illnesses?

	Yes	No	Year		Yes	No	Year
German Measles	❑	❑	_____	Pleurisy/Pneumonia	❑	❑	_____
Mumps	❑	❑	_____	Tuberculosis	❑	❑	_____
Diabetes	❑	❑	_____	Typhoid Fever	❑	❑	_____
Tonsillitis	❑	❑	_____	High Blood Pressure	❑	❑	_____
Rheumatic Fever	❑	❑	_____	Heart Disease	❑	❑	_____
Thyroid Problems	❑	❑	_____	Excessive Bleeding or Bruising	❑	❑	_____
Lung Problems	❑	❑	_____	Stomach or Colon Problems	❑	❑	_____
Any Type of Cancer Including Skin Cancer	❑	❑	_____	Bone or Joint Problems	❑	❑	_____
Bladder or Kidney Problems	❑	❑	_____	Other	❑	❑	_____

Vaccinations ❑ Up to Date _____

C. HOSPITALIZATIONS

Have you ever been hospitalized? ❑ Yes ❑ No

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

PLEASE CHECK ALL PREVIOUS SURGERIES YOU HAVE HAD: NO SURGERIES ❑

❑ Ear Surgery	❑ Neck Surgery	❑ Stomach or Colon Surgery	❑ Bladder or Kidney Surgery
❑ Nose or Sinus Surgery	❑ Heart Surgery	❑ Eye Surgery	❑ Blood Vessel Surgery
❑ Tonsil Surgery	❑ Appendix Surgery	❑ Broken Bone Repaired	❑ Lung Surgery
❑ Cosmetic Surgery	❑ Gallbladder Surgery	❑ Female Surgery	❑ Thyroid Surgery
❑ Cancer Surgery	❑ Hernia Surgery	❑ Prostate Surgery	❑ Other _____

Please list all medications you are allergic to or are unable to take and why: _____

_____

_____

Please list all medications you are presently taking, both prescription or over the counter.

Name of Medication	Strength	How often do you take it

D. NUTRITION

Do you have special dietary needs? ❑ Yes ❑ No

If so, explain: _____

What is your appetite like? ❑ Good ❑ Poor

Your present weight? _____ lbs. Your usual weight? _____ lbs. Your weight 1 year ago? _____ lbs.

SYSTEM REVIEW

Please circle the appropriate answer:

CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

EYES

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

CARDIOVASCULAR

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath while walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Asthma or wheezing	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes

GENITOURINARY

Frequent Urination	No	Yes
Burning or painful urination	No	Yes
Blood in Urine	No	Yes
Kidney stones	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

INTEGUMENTARY (SKIN, BREAST)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes

NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

ENDOCRINE

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming drier	No	Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

This is to certify that the above information is correct, accurate, and complete and that there are no other medical conditions, diagnosis, medications or treatments that I have or had other than those listed on this form. I understand that the doctor is relying on this information.

Signature _____ Date _____

E. TOBACCO, CAFFEINE, ALCOHOL, DRUG USE

			How many years? _____
Do you currently smoke cigarettes:	❑ Yes	❑ No	# of packs per day _____
Have you used tobacco products like			How many years? _____
cigars, pipes, smokeless tobacco, marijuana?	❑ Yes	❑ No	# per day _____
Do you currently consume alcohol?	❑ Yes	❑ No	How many years? _____
What type? _____	Amount per day _____		
Have you used drugs?	❑ Yes	❑ No	How many years? _____
What type? _____	Amount per day _____		
Have you received treatment for substance abuse:	❑ Yes	❑ No	
How many cups of coffee/caffeine drinks do you drink daily?	_____		

F. MENTAL HEALTH

Have you ever seen a psychiatrist or mental health professional?	❑ Yes	❑ No
Do you have any emotional problems that concern you at present?	❑ Yes	❑ No
Have you or family members ever experienced depression or anxiety?	❑ Yes	❑ No
Have you been physically, sexually or emotionally abused?	❑ Yes	❑ No

G. LEARNING NEEDS

How do you learn best about something new?

❑ Seeing and doing ❑ Reading about it ❑ Watching a movie ❑ Listening to a tape

FAMILY HISTORY	Age	Living	Dead	Cause of Death	Current Health Status
Father					
Mother					
Brother					
Sister					
Children					

MEDICAL USE ONLY

REVIEWED BY: _____ M.D. _____ RN _____ Date

_____ M.D. _____ RN _____ Date

Texas Tech University Health Sciences Center
Ambulatory Clinics

Consent to Treatment/Health Care Agreement

Patient Label (Name, DOB, MRN)

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Texas Tech University Health Sciences Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as "TTUHSC"), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only. I understand that TTUHSC is a teaching institution. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I acknowledge that TTUHSC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the TTUHSC Ambulatory Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

RELEASE OF MEDICAL INFORMATION: I acknowledge that "protected health information" pertains to my diagnosis and/or treatment at TTUHSC including, but not limited to, information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs, or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, prescriptions, medical history, prescription history, treatment progress or any other such related information.

I acknowledge that the "Notice of Privacy Practices" provides information about how TTUHSC and its workforce may use and/or disclose protected health information about me for treatment, payment, health care operations, and as otherwise allowed by law. I understand TTUHSC cannot be responsible for use or re-disclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign to TTUHSC physicians and providers and/or the TTUHSC Medical Practice Income Plan my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by, or which exceed, the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer, and agree to make payment as requested by TTUHSC.

ADVANCE DIRECTIVE:

Has an Advance Directive been signed?	___ YES	___ NO
If yes, is it still in effect?	___ YES	___ NO
Has a signed copy been provided to TTUHSC?	___ YES	___ NO

NOTICE OF PRIVACY PRACTICES:
I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____ (Patient's Initials)

I certify that I have read this form or it has been read to me*.

Date _____ Print Name _____ Patient/Other legally authorized person _____

Time _____ Witness/Translator* _____ Relationship to Patient _____

Revised May 2012
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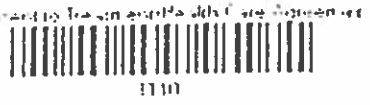

Texas Tech University Health Sciences Center

Confidential Communication Request
And
Identity Theft Protection Questions

Patient Name: _____

MRN: _____

DOB: _____

TTUHSC values the privacy of its patients and is committed to operating our practice in a manner that promotes patient confidentiality while providing high quality patient care. TTUHSC will accommodate reasonable requests.

If you need copies of medical records, you will need to complete a different authorization form. Please ask a staff member for the required form.

☐ Permission to give verbal protected health information or leave messages with the following person(s): **Example: family members, friends, personal caregivers, etc. You do not need to list any medical providers who are involved in your care.**

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

☐ Permission to call the following numbers to leave messages (without disclosing protected health information): **Please note that TTUHSC cannot leave specific test results or details of treatment plan on answering machines or voice mail due to our concern for your privacy.**

Phone #: _____ Phone #: _____

☐ Permission to use e-mail address for the purpose of providing information about on-line patient portal and general information about TTUHSC.

E-mail address: _____

Security and Identity Theft Protection Questions: Please provide a minimum of two answers.

1. What was the name of the elementary school you attended? _____
2. What is your mother's maiden name? _____
3. What model was your first car? _____
4. What town were you born in? _____

Date	Print Name	Signature (Patient or Other Legally Authorized Person)
Time	Witness/Translator	Relationship to Patient

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

NOTICE OF PRIVACY PRACTICES

EFFECTIVE: APRIL 14, 2003
REVISED: SEPTEMBER 23, 2013

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ABOUT THIS NOTICE:

Texas Tech University Health Sciences Center (TTUHSC) is dedicated to maintaining the privacy of your Protected Health Information (PHI). TTUHSC provides health care services and items through its Schools of Medicine, Nursing, Pharmacy and Allied Health Sciences. TTUHSC provides services at its main community hospitals, ambulatory care clinics, ambulatory surgical centers, pharmacies, research units and several community service outreach centers throughout West Texas. TTUHSC is required by law to maintain the privacy of your PHI and provide you with notice of its legal duties and privacy practices. This notice of privacy practices describes how TTUHSC may use or disclose your PHI. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (3) the past, present, or future payment for your health care. For TTUHSC at Lubbock, University Medical Center (UMC), and UMC Physicians Network Services (PNS) participate in a clinically integrated health care setting which is considered an organized health care arrangement under HIPAA. This arrangement involves participation of three legally separate entities in the delivery of health care services in which no entity will be responsible for the medical judgment or patient care provided by the other entities in the arrangement. Each entity within this arrangement (TTUHSC, UMC, and PNS) will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to TTUHSC's privacy practices until it is changed by TTUHSC.

YOUR PRIVACY RIGHTS:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 14 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You may file a complaint in one of the following ways:
  - Contact the TTUHSC privacy official at the address indicated below
  - Use our confidential website at www.Ethicspoint.com
  - Contact The Office for Civil Rights:
    United States Department of Health and Human Services
    1301 Young Street, Suite 1169, Dallas, Texas 75202
    www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate or take action against you for filing a complaint.

YOUR CHOICES:

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care.
  - Share information in a disaster relief situation.
  - Include your information in a hospital directory
  - Contact you for fundraising efforts, but you can tell us not to contact you again.
  - If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **In these cases we never share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most sharing of psychotherapy notes

TTUHSC USES AND DISCLOSURES:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- **Treat you.** We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **How else can we use or share your health information?** We are allowed or required to share you information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
  - **Help with public health and safety issues.**
    - We can share health information about you for certain situations such as:
      - Preventing disease
      - Helping with product recalls
      - Reporting adverse reactions to medications
      - Reporting suspected abuse, neglect, or domestic violence
      - Preventing or reducing a serious threat to anyone's health or safety
  - **Conducting Research.** We can use or share your information for health research.
  - **Comply with the law.** We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
  - **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.
  - **Work with a medical examiner or funeral director.** We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
  - **Address workers' compensation, law enforcement, and other government request.**
    - We can use or share health information about you:
      - For workers' compensation claims
      - For law enforcement purposes or with a law enforcement official
      - With health oversight agencies for activities authorized by law
      - For special government functions such as military, national security, and presidential protective services
  - **Respond to lawsuits and legal actions.** We can use or share health information about you in response to a court or administrative order, or in response to a subpoena.

TTUHSC RESPONSIBILITIES:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGE IN NOTICE OF PRIVACY PRACTICES:

TTUHSC reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

QUESTIONS:

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.ttuhsc.edu/hipaa

PRIVACY OFFICIAL CONTACT INFORMATION

SONYA CASTRO
INSTITUTIONAL PRIVACY OFFICER
3601 4TH STREET, STOP 8165
LUBBOCK, TX 79430
(806) 743-3949

ALICIA KRIZAN
REGIONAL PRIVACY OFFICER
AMARILLO
1400 COULTER RD, ROOM B903
AMARILLO, TX 79106
(806) 354-5588

YVETTE QUINTANA-CHAVEZ
REGIONAL PRIVACY OFFICER
EL PASO
4800 ALBERTA AVENUE
EL PASO, TX 79905
(915) 215-4456

MELISSA CASTRACANE
REGIONAL PRIVACY OFFICER
AT THE PERMIAN BASIN
800 WEST 4TH STREET
ODESSA, TX 79763
(432) 703-5160

www.Ethicspoint.com

TTUHSC Provides For Program Accessibility To Members Of The Public. Those Who Need Materials In Braille, Large Print, Tape Format, Or Who Need An Interpreter Or Telecommunications Device For The Deaf Are Asked To Contact The Clinic Manager.