AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

(PATIENT OR IF MINOR, PARENT/LEGAL GUARDIAN)

I, _____,
First Name Middle Initial Last Name

DOB _____, Social Security# _____, Phone# _____

Address_____ City_____ State _____ Zip _____,

Email: _____

Hereby Authorize,
(Primary Care Dr) _____ Phone # _____

(Cardiologist) _____ Phone# _____

(Allergist) _____ Phone# _____

(Other) _____ Phone# _____

to release to American Sinus Institute Phone# _____ Fax# _____,
and vice versa, the following medical information within my medical records regarding my medical care and/or treatment. I understand federal regulations prohibit and further disclosure of my medical records without my specific written authorization of as other permitted by such regulations. This authorization shall remain in effect from the date signed and shall remain in effect until such notice is given in writing to revoke such authorization. A copy of this written authorization shall be considered as effective and as valid as the original.

Please list any person(s) you authorize to obtain information or communicate regarding services provided to you while under our care:

Name	**Relation**
_____	_____
_____	_____

INFORMATION HEREBY AUTHORIZATION TO BE RELEASED

_____ Complete Medical Records (All)
_____ Laboratory Report(s)
_____ Xray/Imaging Report(s)
_____ Audio, Rast, ENG, &/or ABR Report(s)
_____ Surgical Report(s)
_____ Other (Specify) _____

Personal Use: 1-20 pages $25.00 charge _____ $0.30/page thereafter _____
Initials ***Initials***

Physician Request: NO Charge Insurance Request: NO Charge

_____ _____
Printed Name Signature

_____
Date

9150 Huebner Road, Ste 280
San Antonio, Texas 78240
Phone: (210) 225-5666
Fax: (210) 561-8893

SCORE: (office use only)

PATIENT HISTORY FORM

Date: _____/_____/_____ **How did you hear about us?** _____

NAME: _____ **Birth date:**____/_____/_____

Describe briefly your present symptoms: _____

Please list the names and phone numbers or location of other practitioners you have seen for these problems: _____

_____

Drug allergies: ☐ No ☐ Yes **To what?** _____

CURRENT MEDICATIONS:

Please list any medications that you are now taking including prescription, non-prescription, AND vitamins or supplements:

Name of drug & Dose (strength & number of pills per day)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

SEMAGLUTIDES/TIRZEPATIDE:

Please indicate below if you are on any of the following due to anesthesia restrictions: Ozempic, Wegovy, Rybelsus, or Mounjaro, etc.

_____

PAST MEDICAL HISTORY:

Do you now or have you ever had:

- ☐Diabetes
- ☐High blood pressure
- ☐High cholesterol
- ☐Hypothyroidism
- ☐Goiter
- ☐Cancer (type and location)

_____
_____
_____

- ☐Leukemia
- ☐Psoriasis
- ☐Angina
- ☐Heart problems
- ☐Heart murmur
- ☐Pneumonia
- ☐Pulmonary embolism
- ☐Asthma
- ☐Emphysema
- ☐Stroke

- ☐Epilepsy (seizures)
- ☐Cataracts
- ☐Kidney disease
- ☐Kidney stones
- ☐Jaundice
- ☐Crohn's disease
- ☐Colitis
- ☐Anemia
- ☐Hepatitis

- ☐Stomach or peptic ulcer
- ☐Rheumatic fever
- ☐Tuberculosis
- ☐HIV/AIDS
- ☐Other_____

_____
_____
_____

PAST SURGICAL HISTORY:

Please include the month and year of the surgeries.

_____
_____
_____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

AMERICAN SINUS INSTITUTE

RM #:_____ **SNOT SCORE:**_____

Patient Name: _____ **Date:**_____

DOB: _____

Staff Use Only:	HR:_____
Ht:_____	O2:_____
Wt:_____	B/P:_____
Allergies:	

Circle The Answers That Apply:

Do you suffer from Allergy Symptoms?

Sneezing/Coughing Sore Throat Post Nasal Drip(*Drainage to Throat*)

Itchy/Watery Eye Burning/Dryness of the Eye

Do you experience Headaches? YES NO

Do you experience: Sinus Pressure/Pain? YES NO

(*Pressure or Pain to the Face*)

Thick Nasal Discharge? YES NO

Runny Nose? YES NO

Nasal Congestion? (*Stuffy Nose*) YES NO

Are you a Mouth Breather? YES NO

Do You Snore? YES NO

Do you feel you sleep well at night? YES NO

Are you tired when you wake up? YES NO

Diagnosed with Sleep Apnea? YES NO

Do you have trouble with smell? YES NO

Do you have trouble with taste? YES NO

Do you suffer chronic bad breath? YES NO

Do you have Ear Complaints?

Ear Pain Ear Popping Ear Fullness Muffled Sound Ear Ringing

Ear Pressure Ear Drainage Decreased Hearing Dizziness

Have you had Sinus Surgery in the Past? YES NO

If So, What Year? _____

How many years have you suffered with Sinus Problems? _____

How many times a year do you suffer w/ sinus symptoms?_____

What Medications are you currently on or taken in the past?

Allegra Zyrtec Claritin Nasonex Flonase Dymista Nasacort

Steroid Injections Oral Steroids Singulair Sinus Rinses Afrin

Which Antibiotics (if any) have you been on for Sinus Infections?

Augmentin Levaquin Amoxicillin Azithromycin(Z-pak) Cefdinir

Doxycycline Bactrim

Medical Problems: Heart Lungs Kidneys Liver Diabetes

HIV None of the Above

Do You See A Specialist? Cardiologist Endocrinologist Pulmonologist Hematologist Oncologist

Pharmacy: _____ Address:_____ Phone:_____

AMERICAN SINUS INSTITUTE

SCORE: *(office use only)*

Want to know if Balloon Sinuplasty IS RIGHT FOR YOU?

- The following questionnaire is intended to help define your symptoms and provide valuable information and insights for your doctor. **Answer the questions; rating to the best of your ability, the problems you experience on your WORST day of symptoms.**

Patient Name: _____

Date: _____

Sino-Nasal Outcome Test (SNOT-22)

1. Consider how severe the problem is when you experience it and how frequently it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel. 2. Please mark the most important items affecting your health (maximum of 5 items).	No problem	Very mild problem	Mild or slight problem	Moderate problem	Severe problem	Problem is as bad as it can be		5 Most important items
1. Need to blow nose	0	1	2	3	4	5		O
2. Nasal obstruction (blockage)	0	1	2	3	4	5		O
3. Sneezing	0	1	2	3	4	5		O
4. Runny nose	0	1	2	3	4	5		O
5. Cough	0	1	2	3	4	5		O
6. Post-nasal drip	0	1	2	3	4	5		O
7. Thick nasal discharge	0	1	2	3	4	5		O
8. Ear fullness	0	1	2	3	4	5		O
9. Dizziness	0	1	2	3	4	5		O
10. Ear pain	0	1	2	3	4	5		O
11. Facial pain/pressure	0	1	2	3	4	5		O
12. Decreased sense of smell or taste	0	1	2	3	4	5		O
13. Difficulty falling asleep	0	1	2	3	4	5		O
14. Wake up at night	0	1	2	3	4	5		O
15. Lack of sleep	0	1	2	3	4	5		O
16. Wake up tired	0	1	2	3	4	5		O
17. Fatigue	0	1	2	3	4	5		O
18. Reduced productivity	0	1	2	3	4	5		O
19. Reduced concentration	0	1	2	3	4	5		O
20. Frustrated/ restless/ irritable	0	1	2	3	4	5		O
21. Sad	0	1	2	3	4	5		O
22. Embarrassed	0	1	2	3	4	5		O