TOTUM HEALTH

LEXINGTON E.N.T · New York SLEEP · City AESTHETICS

Patient Information

Lisa Liberatore, MD FACS — Dara R. Litotta, MD

Name: DOB: Age: Date:

Address:

City/State/Zip:

Home Phone: Cell Phone: Marital Status:

Email: SS#: Sex: Male Female

Business Address:

Business Phone: Employed By: Occupation:

Emergency Contact: Mobile Phone:

Pharmacy Name: Pharmacy Phone:

Insurance Information

Primary Insurance: ID #:

Secondary Insurance: ID #:

Guarantor Information

Person responsible for account: Birthdate:

Relation to Patient: SS#:

Address (if different from patient):

City/State: Zip Code: Home Phone:

Who Referred You? *(please mark and provide name)*

Physician: Medical Facility: Other:

☐ Lecture ☐ Online Search ☐ Advertisement/Newspaper

Assignment & Release

I, the undersigned, hereby certify that I (or my dependent) has insurance coverage with the below noted insurance company and assign directly to Lisa Liberatore MD, all insurance benefits. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature ______________________________ Date ______________

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Health Questionaire

Name: DOB: Age: Date:

Reason for Visit:

Medications:

Please list the name and strength of the medications you are currently taking. (For example, Digoxin 0.125 rrg.)

Name	Strength (e.g. 10mg)	Name	Strength

Drug Allergies:

Please list any drug allergies, including reactions. Please state NONE if no allergies.

Name	Strength (e.g. 10mg)	Name	Strength

Non-Drug Allergies:

Please list any food or nondrug allergies, including reactions. State NONE ir no allergies. (For example, Latex, mold, milk, nuts, etc.)

Name	Strength (e.g. 10mg)	Name	Strength

Past Illness *(please mark Y or N if you have had any illnesses in the past.)*

Anemia	☐yes ☐no	Chronic fatigue	☐yes ☐no	Hepatitis	☐yes ☐no	Stroke	☐yes ☐no
Arthritis	☐yes ☐no	Hay Fever/Allergies	☐yes ☐no	Psoriasis	☐yes ☐no	Eczema	☐yes ☐no
Anxiety	☐yes ☐no	Pneumonia	☐yes ☐no	Diabetes I	☐yes ☐no	Memory Loss	☐yes ☐no
Asthma	☐yes ☐no	Coronary heart dieseae	☐yes ☐no	Hypertension	☐yes ☐no	TB	☐yes ☐no
Bone	☐yes ☐no	Heart murmur	☐yes ☐no	Seizures	☐yes ☐no	Glaucoma	☐yes ☐no
Bronchitis	☐yes ☐no	Peptic ulcer	☐yes ☐no	Diabetes II	☐yes ☐no	Osteoporosis	☐yes ☐no
Cataract	☐yes ☐no	Depression	☐yes ☐no	Kidney stones	☐yes ☐no	Thyroid	☐yes ☐no

Cancer ☐yes ☐no ______________________________

Please describe type of cancer and treatment you have received. (For example, radiation, chemotherapy, surgery)

Chicken Pox ☐yes ☐no Measels ☐yes ☐no Mumps ☐yes ☐no

Previous Surgeries *(please list name and date of any past surgeries.)*

Surgery	Year

Height: ______________

Weight: ______________

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Family History *(Please mark if any blood relative has suffered any of the following)*

☐ Alcoholism ☐ Anemia ☐ Anesthesia complications ☐ Arthritis ☐ Asthma ☐ Bleeding easily
☐ Blindnes ☐ Cancer ☐ Crib death ☐ Diabetes ☐ Hay fever ☐ Hearing Loss ☐ Heart disease
☐ High cholesterol ☐ Hypertension ☐ Migraines ☐ Renal (kidney) disease ☐ Stroke ☐ Thyroid disease

Social History *(Please mark appropriate resppnses)*

Use of alcohol: ☐ Never ☐ Occasional/ Social ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Previously but quite in:_________ ☐ Pack/Day__________

Is there a history of exposure to second hand smoke? ☐ Yes ☐ No

Use of recreational drugs: ☐ Never ☐ Previously but quite in:_________ ☐ Active Use__________

Is there a history of exposure to excessive noise? ☐ Yes ☐ No ☐ Military ☐ Work ☐ Hobbies

Review of Symptoms *(Please mark Yes or No if you have had any of these symptoms)*

Constitution
Appetite Loss ☐ yes ☐ no
Bad breath/taste ☐ yes ☐ no
Chills ☐ yes ☐ no
Fatigue ☐ yes ☐ no
Fever ☐ yes ☐ no
Difficulty sleeping ☐ yes ☐ no
Daytime sleepiness ☐ yes ☐ no
Weight Loss-recent ☐ yes ☐ no

Other
Night sweats ☐ yes ☐ no
Travel out of U.S. ☐ yes ☐ no
Head banging ☐ yes ☐ no
Fussy/Irritable ☐ yes ☐ no
Speech/Language ☐ yes ☐ no
Difficulty ☐ yes ☐ no

Eyes
Blurred vision ☐ yes ☐ no
Double vision ☐ yes ☐ no
Failing vision ☐ yes ☐ no
Eye pain ☐ yes ☐ no

Musculoskeletal
Muscle Weakenss ☐ yes ☐ no

Cardiovascular
Chest pain ☐ yes ☐ no
SWelling of ankles ☐ yes ☐ no
Heart palpitations ☐ yes ☐ no

ENT
Ear ache/pain ☐ yes ☐ no
Ear drainage ☐ yes ☐ no
Ear infection ☐ yes ☐ no
Ringing in ears ☐ yes ☐ no
Nose bleeds ☐ yes ☐ no
Sinus problems ☐ yes ☐ no
Sore throats ☐ yes ☐ no
Snoring ☐ yes ☐ no
Diffculty swallowing ☐ yes ☐ no
Prolonged hoarseness ☐ yes ☐ no
Decreased hearing ☐ yes ☐ no
Decreased smell ☐ yes ☐ no
Ear pulling ☐ yes ☐ no

Respiratory
Cough,chronic ☐ yes ☐ no
Shortness of breath ☐ yes ☐ no
On exertion ☐ yes ☐ no
Lying flat ☐ yes ☐ no
Coughing Blood ☐ yes ☐ no

Neurology
Dizzy spells ☐ yes ☐ no
Headaches ☐ yes ☐ no
Numbness/ tingling ☐ yes ☐ no
Fainting spells ☐ yes ☐ no

Skin
Rash ☐ yes ☐ no

Snoring Assesment
Do you snore ☐ yes ☐ no
Has your snoring bothered other people ☐ yes ☐ no
Have you ever nodded off or fallen asleep while driving a vehicle ☐ yes ☐ no
Have you ever dozed off while sitting, inactive in a public place or while sitting and talking ☐ yes ☐ no

Psychiatric
Depression ☐ yes ☐ no
Anxiety ☐ yes ☐ no
Memory Loss ☐ yes ☐ no

Gastroenterology
Abdominal pain ☐ yes ☐ no
Bloody stools ☐ yes ☐ no
Constipation ☐ yes ☐ no
Diarrhea ☐ yes ☐ no
Heartburn ☐ yes ☐ no
Persistant Nausea ☐ yes ☐ no
Persistant vomiting ☐ yes ☐ no

Hematology
Easy bruising ☐ yes ☐ no
Transfusion history ☐ yes ☐ no

Genitourinary
Blood in urine ☐ yes ☐ no
Frequent urinary infections ☐ yes ☐ no

Patient Signature: ______________________________ Doctor Signature: ______________________________

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