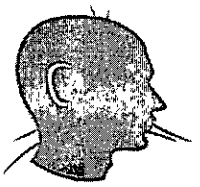


MICHIGAN
# Ear, Nose & Throat
BLOOMFIELD FACIAL PLASTIC & BLOOMFIELD HEARING

Dr. Sam Bahu, M.D. Evan Eschker, PA-C

*** PLEASE PRINT* **

Date: _____

Were you referred by a doctor? (Please circle) No Yes, IF Yes Who? _____

Patient Name: _____ Age: _____ Sex: (Please circle) M F

Birthdate: _____ Patient Soc. Sec. No (Optional): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Name of Spouse/Parent: _____

Primary Insured's Name: _____ Birthdate: _____

Secondary Insured's Name: _____ Birthdate: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Authorized to make medical decisions? Yes No

Where can we contact you at? (Circle all that apply) Home Work Both None Other

You may share my medical information with: (Circle all that apply)

Spouse Ex-Spouse Father Mother Children None Other:_____

Can we mail medical record related information to your home? (Please circle) Yes No

Michigan Ear. Nose. and Throat Associates
Otolaryngology — Head and Neck Surgery Facial Plastic Surgery
Dr. Sam Bahu Evan Eschker, PA-C

Patient Name: _____ Referring/Primary Care Physician: _____

Reason for visit: _____

**History of presents illness**:

- Location (Where is the pain/problem?) :_____
- Quality (ex: normal vs abnormal color, activity, etc.): _____
- Severity (How severe is the pain/ problem scale 1—5, 5 being the worst): _____
- Duration (How long? When did it start?): _____
- Timing (Does the pain/ problem occur at a specific time?): _____
- Context (Where were you at onset of pain/problem?): _____
- Associated Sign/ Symptom's: _____

_____

**Patient Medical History**: Circle one of the following

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Diabetes** | Yes | No | **Hypertension** | Yes | No | **Cancer** | Yes | No |
| **Stoke** | Yes | No | **HIV** | Yes | No | **Arthritis / Gout** | Yes | No |
| **Seizures** | Yes | No | **Bleeding Tendency** | Yes | No | **Thyroid Disease** | Yes | No |
| **Hepatitis** | Yes | No | **Blood Thinner use** | Yes | No | **Sleep Apnea** | Yes | No |

**Heart Trouble** Yes No, If Yes Who is your Cardiologist? _____

Please list any other medical conditions not noted above: _____

_____

Date of Pneumonia Vaccine &/or Influenza Vaccine: _____

Have you fallen in the last year? YES NO If yes, how many times? _____

**Surgical History**:

List all hospitalizations & Surgeries- (Date's, Surgeons/Hospital/Surgery)

_____

_____

_____

_____

_____

**Medications**: _____

_____

_____

_____

_____

_____

**Medication Allergies:**

_____

_____

_____

## Patient Social History: (Please circle what applies)

**Marital Status:** Single Married Separated Divorced Widowed

**Use of Alcohol:** Never Rarely Moderate Daily

**Use of Tobacco:** Never Previously, but quit _____ years ago Currently packs/day: _____

**Use of Illegal Drugs:** Never Rarely Moderate Daily Type/Frequency: _____

**Exposure at home/work to:** Fumes Dust Solvents Airborne Pathogens None

## Family Medical History: (Please answer to the best of your knowledge)

| Family Member | Age | Diseases | If Deceased, please list cause of death |
|---|---|---|---|
| Mother | _____ | _____ | _____ |
| Father | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| | _____ | _____ | _____ |

## Patient Health Questionnaire (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

FOR OFFICE CODING: 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

| Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**Please circle pertaining to you**

## Constitutional Symptoms

Good general health lately ..... No Yes
Recent weight changes ..... No Yes
Fever ..... No Yes
Fatigue ..... No Yes
Headaches ..... No Yes

## Cardiovascular

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

## Respiratory

Chronic or frequent coughs ..... No Yes
Spitting up blood ..... No Yes
Asthmas or wheezing ..... No Yes

## Eyes

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

## Endocrine

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 dryer ..... No Yes

## Allergic/Immunologic

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics ..... No Yes
Morphine/Demerol/other narcotics ..... No Yes
Novocain or other anesthetics ..... No Yes
Aspirin or other pain remedies ..... No Yes
Tetanus antitoxin or other serums ..... No Yes
Iodine, methiolate/other antiseptics ..... No Yes
Latex allergy ..... No Yes
List any other allergies: _____

## Gastrointestinal

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

## Integumentary (skin)

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

## Neurological

Frequent/recurring headaches ..... No Yes
Light headed or dizzy ..... No Yes
Convulsions or seizures ..... No Yes
Numbness/tingling sensation ..... 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 (sleeplessness) ..... No Yes

## Ears/Nose/Mouth/Throat

Hearing loss or ringing ..... No Yes
Earaches or drainage ..... No Yes
Chronic sinus problem ..... No Yes
Nosebleeds ..... No Yes
Mouth sores ..... No Yes
Bleeding gums ..... No Yes
Sore throat or voice change ..... No Yes
Swollen glands in neck ..... No Yes

## Genitourinary

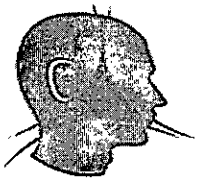
Frequent urination ..... No Yes
Burning or painful urination ..... No Yes
Blood in urine ..... No Yes
Incontinence or dribbling ..... No Yes
Kidney stones ..... No Yes
Sexual Difficulties ..... No Yes

## Hematological/Lymphatic

Slow to heal after cuts ..... No Yes
Bleeding or bruising tendency ..... No Yes
Anemia ..... No Yes
Vein cloths or phlebitis ..... No Yes
Past transfusion ..... No Yes
Enlarged glands ..... No Yes

## Musculoskeletal

Joint pain ..... No Yes
Joint stiffness or swelling ..... No Yes
Weakness of muscles/joints ..... No Yes
Muscle pain or cramps ..... No Yes
Back pain ..... No Yes
Cold extremities (hand/foot) ..... No Yes
Difficulty in walking ..... No Yes



MICHIGAN
# Ear, Nose & Throat
BLOOMFIELD FACIAL PLASTIC & BLOOMFIELD HEARING

Dr. Sam Bahu, M.D. Evan Eschker, PA-C

Patient Name: _____

I hereby authorize the payment of benefits of my insurance policy, if any, to be paid directly to Michigan Ear, Nose, and Throat Associates, Bloomfield Plastic Surgery, and Bloomfield Hearing for medical or surgical services rendered, not to exceed the reasonable and customary charges for these services. I further authorize the release of any medical information required by my insurance carrier. I understand that I am financially responsible for charges not paid by my insurance.

Signature: _____ Date: _____

I hereby authorize the physicians of Michigan Ear, Nose, and Throat Associates, Bloomfield Plastic Surgery, and Bloomfield Hearing to perform upon me or the patient, if not myself, any minor office procedures needed to diagnose and treat my condition, including, but not limited to, flexible or rigid scope, ear cleaning, biopsies, or the need for any other procedures. Risks may include bleeding, infection, wound healing problems, or scar formation. I will have the opportunity to ask any questions prior to a procedure.

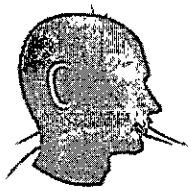
Signature: _____ Date: _____

I have been given the opportunity to review and may choose to take home a copy of the Michigan Ear, Nose, and Throat Associates, Bloomfield Plastic Surgery, and Bloomfield Hearing Notice of Privacy Practices.

Signature: _____ Date: _____

If person signing is not patient, please print your name and relationship to patient below.

Printed Name: _____ Relationship: _____



MICHIGAN
Ear, Nose & Throat
BLOOMFIELD FACIAL PLASTIC & BLOOMFIELD HEARING

Dr. Sam Bahu, M.D. Evan Eschker, PA-C

# PATIENT PROVIDER PARTNERSHIP

For Specialist Care

At Michigan Ear, Nose, and Throat Associates, our goal is to provide you with the highest standard of specialty care. Your care will be coordinated with your Primary Care Physician who acts as the Patient Centered Medical Home (PCMH), as we are part of the Patient Centered Medical Home Neighborhood. Below are some guidelines to our patient and provider commitment.

## Physician Commitment

I, as your physician, am committed to providing the highest quality of patient care. I am committed to ensuring your rights as a patient, including your right:

- To be treated with respect and dignity.
- To schedule your appointments as soon as possible.
- To have open and honest discussions with you regarding your health and plans to managing your care.
- To explain diseases, treatments, and results in an easy to understand way.
- To be available to you by phone in the office to answer questions or concerns.

## Patient Commitment

We ask that you make every effort to commit to:

- Keeping and arriving on time to all scheduled appointments.
- Cancel or reschedule appointments in advance whenever possible.
- Follow through with recommended testing.
- Be honest about your history, symptoms, and other important information about your health.
- Take your medication as directed and follow your doctor's advice.
- Follow up with your Primary Care Physician for your overall healthcare needs.

## Signatures

I have read and understand this agreement.

X_____ X_____

Name of Patient (Print) Signature of Patient