

Pacific Eye and Ear ° Pacific Head and Neck Pacific Cosmetic Surgeons ° Pacific Hearing and Balance SPECIALISTS

Alyssa Ba MD, PhD

Ear, Nose & Throat
Head and Neck Surgery
Nasal and Sinus Surgery
Adults and Children

Cadvan O. Griffiths MD, LLB

Cosmetic & Reconstructive Surgery
Medical Legal Consultant

Chester F. Griffiths MD, FACS

Ear, Nose & Throat
Head and Neck Surgery
Nasal and Sinus Surgery
Cosmetic & Reconstructive Surgery
Adults and Children

Howard R. Krauss, MD

Ophthalmology
Neuro-Ophthalmology
Orbital Surgery
Adult Strabismus
Oculoplastic Surgery
Laser Vision Correction

William W. Lee, MD FACS

Ear, Nose & Throat
Head and Neck Surgery
In Consultation

Jeremy E. Levenson, MD

Ophthalmology
Cornea/External Disease of Eye
Cataract Surgery

Dorothy Wang, MD

Ear, Nose & Throat
Head and Neck Surgery
Nasal and Sinus Surgery
Adults and Children

Gregory J. Frazer AuD, PhD Marni L. Novick, AuD, CCC-A

Audiology
Balance Testing/Therapy
Hearing Aids
Children and Adults

Welcome To Our Practice

We are very happy to welcome you to our multi-subspecialty office and surgical center. We appreciate the chance to take care of you and your family. Our office is focused on providing you with high quality care with a friendly and welcoming staff to assist you.

Enclosed you will find a health history form, a patient registration form, our financial policy and directions to our office location. Please complete the enclosed forms and bring them with you on your first appointment. Please also be sure to bring you insurance card.

Please note: we are out of network for all insurance companies and you will be responsible for a portion of your visit. The amount will depend on your insurance company, but we will bill them as a courtesy to you. We DO NOT accept any form of HMO's.

We have two locations to help serve you: Brentwood and Marina del Rey. We also would like you to be aware of the other services we are able to offer to our patients:

Laser Services

- Hair Removal
- Photofacial
- Vein Removal
- Micro Laser Peel
- Skin Resurfacing
- Photodynamic Acne/Rocacea Therapy

Hearing & Balance

- Hearing Tests
- Vestibular/Balance Testing
- State of the Art Hearing Aids
- *Featuring the world's FIRST invisible Hearing Aid, The Lyric!*

Cosmetic Procedures

- Blepharoplasty (Eyelid)
- Rhinoplasty
- Otoplasty (Ear revision)
- Brow Lift
- Chin, Cheek and Facial Implants
- Breast Augmentation/Reduction
- Abdominalplasty (Tummy Tuck)
- Liposuction
- BOTOX
- Restylane Injections
- Radiesse Injections
- Juvaderm Injections
- Physician ONLY Skin Care Products

Ear, Nose & Throat

- Pillar (Snoring Procedure)
- Sinus Surgery
- Tonsillectomy w/ Coblation
- Skin Cancers

Ophthalmology

- LASIK
- Implantable Contact Lenses
- Refractive & Cataract Surgery
- Thyroid Eye Disease
- Orbital Surgery
- Contact lenses

Please visit our websites for directions and more information: www.PacificSpecialists.com and www.PacificCosmeticSurgeons.com.

Thank you for choosing our office, we look forward to meeting you.

Sincerely,

The Doctors and Staff of Pacific Specialists

11645 Wilshire Boulevard - Suite 600 - Los Angeles, CA 90025 - Tel 310.477.5558 - Fax 310.477.7281
4644 Lincoln Boulevard - Suite 400 - Marina del Rey - CA 90292 - Tel 310.574.1116 - Fax 310.574.1126

www.PacificSpecialists.com

www.PacificCosmeticSurgeons.com

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Dorothy Wang, MD • Gregory J. Frazer AuD, PhD • Marni L. Novick AuD CCC-A

Date: _____

ACCT.#: _____

Please print and complete ALL sections below

PATIENTS PERSONAL INFORMATION

Marital status Single Married Divorced Widowed Age (edad) _____ Sex F M
(estado civil)

Name: _____
Last Name (apellido) First Name (primer nombre) Middle Initial

Street address: _____ (Apt # _____) City: _____ State: _____ Zip: _____
(domicilio) (ciudad) (estado) (zona postal)

Home phone: (_____) _____ Work phone: (_____) _____ Mobile phone: (_____) _____
(teléfono de casa) (teléfono de trabajo) (teléfono de celular)

Date of Birth: ____/____/____ Driver's license (State): _____ Social Security#: _____
(fecha de nacimiento) (licencia de conducir) (numero de seguro social))

Spouse or parent's name (if minor): _____

How do you wish to be addressed? _____

PATIENT/RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Self Spouse Other

Responsible party's home phone: (_____) _____ Work phone: (_____) _____

Address: _____ (Apt # _____) City: _____ State: _____ Zip: _____
(domicilio) (ciudad) (estado) (zona postal)

Employer's name: _____ Phone number: (_____) _____
(nombre de trabajo/compañía) (teléfono de trabajo)

Your occupation: _____ Email: _____
(nombre de empleo) (correo electrónico)

PATIENT'S INSURANCE INFORMATION

PRIMARY insurance company's name: _____

Name of insured: _____ Date of birth: _____

Relationship to insured: Self Spouse Child Other

Insurance ID number: _____ Group number: _____

SECONDARY insurance company's name: _____

Name of insured: _____ Date of birth: _____

Relationship to insured: Self Spouse Child Other

Insurance ID number: _____ Group number: _____

PATIENTS REFERRAL INFORMATION

Referred by: _____ Phone: _____
(referencia, médico quien lo/la recomendó?) (teléfono de doctor)

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____
(NAME ONLY, contacto de emergencia)

Address: _____ City: _____ State: _____ Zip: _____

Phone number (home): (_____) _____

Signature (firma) _____

Print Name (en letra de molde) _____

Date (fecha) _____

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ADULT SHEET

PATIENT NAME _____ AGE _____ DATE _____

What is the reason for your visit today? _____

• Please list all medications you currently take with the dose and times per day: * This includes herbal, vitamins and all non-prescription products and supplements. _____

• Do you take Aspirin/Advil on a regular basis? YES NO Diet Pills? YES NO How Long? _____

MEDICATION ALLERGIES: 1. _____ 2. _____ 3. _____

OTHER ALLERGIES: 1. _____ 2. _____ 3. _____

*Please write additional information on the back

• Are you currently pregnant? YES NO Are you currently on a Contraceptive medication program? YES NO

PAST MEDICAL HISTORY (type and date): *Please write additional information on the back

Hospitalizations: 1. _____ 2. _____ 3. _____

Operations: 1. _____ 2. _____ 3. _____

Illnesses: 1. _____ 2. _____ 3. _____

Injuries/Fractures 1. _____ 2. _____ 3. _____

SOCIAL HISTORY:

• Smoke: YES NO _____ packs per day • Drugs: YES NO _____ type/amount • Caffeine: YES NO _____ cups per day

• Alcohol: YES NO _____ type/amount • Diet: _____ type

FAMILY HISTORY (check any that apply):

- | | | | | |
|--|-----------------------------------|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Dizziness (vertigo) | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye Problems |

HAS ANYONE IN THE FAMILY HAD AN UNFAVORABLE REACTION TO ANESTHESIA? YES NO

Please Explain _____

REVIEW OF SYSTEMS (check any that apply):

EARS:	<input type="checkbox"/> Hearing Aids	<input type="checkbox"/> Pain	<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Hearing Aids
	<input type="checkbox"/> Exposure to Loud Noise	<input type="checkbox"/> Tinnitus (noise in ears)	<input type="checkbox"/> Discharge	<input type="checkbox"/> Surgery: _____
NOSE:	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Stuffiness	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Change in Smell <input type="checkbox"/> Post Nasal Drip
	<input type="checkbox"/> Snoring	<input type="checkbox"/> Nasal Sprays	<input type="checkbox"/> Injuries	<input type="checkbox"/> Surgery: _____
THROAT:	<input type="checkbox"/> Soreness	<input type="checkbox"/> Pain or Difficulty Swallowing	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Cough
	<input type="checkbox"/> Bad Taste	<input type="checkbox"/> Recent Dental Work	<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Reflux
	<input type="checkbox"/> Throat Clearing	<input type="checkbox"/> Voice Change/Hoarseness	<input type="checkbox"/> Lump	<input type="checkbox"/> Surgery: _____
NECK:	<input type="checkbox"/> Lumps	<input type="checkbox"/> Thyroid Nodules	<input type="checkbox"/> Injuries	
	<input type="checkbox"/> Pain	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Surgery: _____	
EYES:	<input type="checkbox"/> Loss/Blurred Vision	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Injuries	<input type="checkbox"/> Excess Tearing
	<input type="checkbox"/> Crossed Eyes	<input type="checkbox"/> Itching, Burning, Irritation	<input type="checkbox"/> Eye Pain/Soreness	<input type="checkbox"/> Redness/Inflammation
	<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Floating Objects in Vision	<input type="checkbox"/> Dryness of Eyes	<input type="checkbox"/> Glaucoma
	<input type="checkbox"/> Eye Disease	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Surgery: _____

PERSONAL HISTORY:

- | | | | | | |
|--|---|---|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis or | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Shortness Of Breath |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Headaches | Jaundice | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Failure/Attack | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rashes | <input type="checkbox"/> Vaginitis |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Weight Loss or Gain |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pain w/ Urination | | <input type="checkbox"/> Sexual Dysfunction | |

Is there anything else about your medical history that might be helpful for the doctor to know? _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

PATIENT SIGNATURE: _____ DATE: _____

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SUPPLEMENTAL REGISTRATION INFORMATION

Full name and address of referring physician: _____

Telephone number: _____

Full name and address of general physician/internist: _____

Full names and addressed of other physicians you wish to receive reports: _____

Telephone number: _____

DATE

PATIENTS SIGNATURE

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Financial and Payment Policy For Medical Services

Insurance

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

You will be asked to update your demographic and insurance information periodically, including providing our office with copies of your insurance card(s). We are required to obtain your signature for permission to release information to your insurance carrier annually. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements. We will, however, assist you to insure all plan requirements are met.

_____initial

Cancelled Appointments

Charges may be made for broken, confirmed appointments and appointments cancelled without 24 hours advance notice. Your cooperation in canceling your scheduled appointment well in advance of the appointment allows us the opportunity to offer your appointment to another person who needs medical care. Failure to show up for a scheduled confirmed appointment may result in a \$50 cancellation fee.

_____initial

General

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. It is important to understand however, that: **WE ARE NOT PREFERRED PROVIDERS FOR ANY INSURANCE PLANS. AS A COURTESY, WE WILL BILL YOUR INSURANCE BUT YOU ARE RESPONSIBLE FOR THE PORTION OF THE BILL THAT IS UNPAID.** Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We are very sensitive to keeping health care costs affordable to our patients. As a result, we take great care to insure that our fees are consistent with the charges in the geographic region. Your insurance company may not use "reasonable charge information" specific to this region and specialties in this office. In fact, many carriers purchase non-specific data and/or do not update their information on an annual basis. Some reputable insurance companies consider our fees usual, customary, and reasonable. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is the patient's responsibility and duty to have an understanding of the benefits and eligibility, stipulated under their individual insurance policy. We will contact your insurance carrier to verify coverage information prior to rendering Surgical Services ONLY.

We must emphasize that as medical care providers, our relationship is with YOU, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

_____initial

Payment for Services

Payment for services is due at the time services are rendered if: you do not have insurance, are a Blue Shield or Blue Cross Individual Provider member, or are receiving cosmetic treatments. We accept cash, personal checks, cashier's checks, money orders, Visa and Mastercard. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

_____initial

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Thank you.

My Signature below constitutes acknowledgement and acceptance of this policy.

Signed Patient or Guarantor

Print

Date

Witness

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11645 Wilshire Blvd., Suite 600
Los Angeles, CA 90025
310-477-5558 310-477-7281 (fax)

Hearing and Dizziness/Balance Patient Questionnaire

Patient Name: _____ **Date:** _____

Date of birth: _____

HEARING SECTION

Check all of the following that apply to you:

I think I have a hearing loss, but this is not confirmed by testing

I have a documented hearing loss

In both ears

Only the right ear

Only the left ear

My hearing changes from day to day

I have a ringing or noise (tinnitus) that I hear

In both ears

Only in the right ear

Only in the left ear

Constant

Intermittent

I have a feeling of fullness or pressure in my ear(s)

In both ears

Only in the right ear

Only in the left ear

Constant

Intermittent

I have pain in my ear(s)

- In both ears
- Only in the right ear
- Only in the left ear
- Constant
- Intermittent

I have frequent ear infections/drainage from my ear(s)

- In both ears
- Only in the right ear
- Only in the left ear
- Constant
- Intermittent

Do you have dizziness? Yes No

If yes, when did your dizziness first occur? _____

Are your symptoms with you 24 hours per day (never stopping)?

Yes No

If yes, check all symptoms that are present 24 hours per day never stopping:

- Off balance when standing or walking
- Off balance when sitting or lying
- Lightheaded or fainting sensation
- Tumbling or spinning sensation

Do you have symptoms that occur in spells? Yes No

If yes, check all symptoms that occur in spells (no matter how long the spell):

- Off balance when standing or walking
- Off balance when sitting or lying
- Lightheaded or fainting sensation
- Tumbling or spinning sensation

Check the one that, on average, describes the length a typical, single spell:

- Measured in seconds
- Measured in minutes to hours, but less than 24 hours
- Measured in hours to days, but less than 7 days

Measured in days, can last continuously for weeks

Check the one that, on average, describes how frequently your spells are occurring:

Daily or Multiple times per day

Multiple times per week

Multiple times per month

Several times in a 2-month interval

Several times in a 6-month interval

Several times in a 12-month interval

Do you ever have symptoms occur when you are sitting, standing, lying completely still, NOT having just moved and NOT watching anything that is moving?

Yes No

If yes, check all symptoms that occur in this spontaneous manner:

Off balance

Lightheadedness or fainting sensation

Tumbling or spinning sensation

Do you ever have symptoms that are provoked by you making a movement or change in position? Yes No

If yes check all symptoms that occur with your movement & position changes:

Off balance

Lightheadedness or fainting sensation

Tumbling or spinning sensation

Are your symptoms made worse by any of the following? Check all that apply:

Lying down/rolling in bed Sitting up/Standing up

Walking in the dark Walking on uneven surfaces

Hot baths or showers Coughing/sneezing/nose blowing

Menstrual cycle Supermarket aisles/malls/tunnels

Automobile rides Windshield wipers

Loud sounds Restaurants or movie theaters

Reading Turning your head when walking

Exercise Overexertion

Lifting things

Escalators

ASSOCIATED SYMPTOMS AND PROBLEMS

Check all the following symptoms that you have experienced:

<u>Symptom</u>	<u>In the past</u>	<u>With dizziness/imbalance</u>
Unexplained falls	<input type="checkbox"/>	<input type="checkbox"/>
Sensation of being pulled or pushed down	<input type="checkbox"/>	<input type="checkbox"/>
Sensation of swaying or rocking	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness (blacked out)	<input type="checkbox"/>	<input type="checkbox"/>
Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Double vision (side by side or up down)	<input type="checkbox"/>	<input type="checkbox"/>
Vision "jumps" when walking/ riding	<input type="checkbox"/>	<input type="checkbox"/>
Cloudiness or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>
Heart racing/palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Panic feeling/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Numbness of face or extremities	<input type="checkbox"/>	<input type="checkbox"/>
Weakness or clumsiness in arms/legs	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with speech	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with swallowing	<input type="checkbox"/>	<input type="checkbox"/>

HEADACHES

1) Have you had a total of 5 or more headaches (does not matter how severe) in your lifetime? Yes No

2) Have you ever had a headache that was severe enough to make you stop your activity and sit or lie down? Yes No

3) Have you ever experienced a temporary change in your vision, such as jagged lines, color spots or lightening bolts in your vision; loss of vision with recovery?
 Yes No

If you answered YES to 1, 2 or 3 above, then please complete this section. If you have answered NO to all (1, 2 and 3) above, then go to the section on HEARING.

Please check all of the following that you have experienced:

- Headaches where the discomfort localizes to a region(s) of the head
- Increased sensitivity to light during a headache
- Increased sensitivity to sound during a headache
- Increased sensitivity to odors during a headache
- A headache provoked by sudden bright light, such as sunlight
- Increased chance of headache around your menses (N/A)
- Change in headache behavior with pregnancy or after (N/A)
- Certain foods or beverages increase the chances of a headache
- Motion sickness as a young child prior to puberty
- Nausea and/or vomiting with a headache
- Headache that lasted longer than 24 hours
- Headaches associated with your problems of dizziness/imbalance
- Headaches where the pain throbs or pulses

If having headaches, at what age do you first remember having a headache?

- Under age 12
- In your teens
- In your twenties or thirties
- In your forties or fifties
- In your sixties or seventies
- In your eighties

OTHER DISORDERS

Do you currently have or have you been diagnosed in the past with any of the following? Please check all that apply.

- | | | | |
|--------------------|--------------------------|-------------------------------|--------------------------|
| Stroke | <input type="checkbox"/> | Brain or Spinal cord disorder | <input type="checkbox"/> |
| Heart Problems | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Anxiety/depression/panic | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | Ongoing breathing problems | <input type="checkbox"/> |
| Joint disease | <input type="checkbox"/> | Blood disease | <input type="checkbox"/> |
| Sexual dysfunction | <input type="checkbox"/> | Memory problems | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | Ongoing numbness or tingling | <input type="checkbox"/> |
| Loss of taste | <input type="checkbox"/> | Ongoing stomach problems | <input type="checkbox"/> |
| Loss of smell | <input type="checkbox"/> | Significant weight changes | <input type="checkbox"/> |
-

HOSPITALIZATIONS AND INJURIES

Have you been in the hospital for any of the following or had any of the following injuries? Please check all that apply.

- | | | | |
|--|--------------------------|---------------------------------|--------------------------|
| Hospitalized for treatment of an infection with antibiotic therapy | <input type="checkbox"/> | | <input type="checkbox"/> |
| Surgery on either ear | <input type="checkbox"/> | Surgery on brain or spinal cord | <input type="checkbox"/> |
| Surgery on either eye | <input type="checkbox"/> | Surgery on hips/knees/ankles | <input type="checkbox"/> |
| Eye injury | <input type="checkbox"/> | Head or neck injury | <input type="checkbox"/> |
| Ear injury | <input type="checkbox"/> | Broken back/hip/knee/ankle | <input type="checkbox"/> |
-

OTHER MEDICAL AND SOCIAL HISTORY

Please indicate what tests you have had for your problem. Check all that apply.

- | <u>Test</u> | <u>Normal</u> | <u>Abnormal</u> | <u>Don't Know</u> |
|------------------------------------|--------------------------|--------------------------|--------------------------|
| Hearing Test (audiogram) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MRI of brain with injection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MRI of brain without injection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MRI of neck or back | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ENG (water or air in the ear test) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | |
|---------------------------------------|--------------------------|--------------------------|--------------------------|
| Electrocochleography (EcoG) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EEG (Brain wave test) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Auditory Brainstem Test (ABR) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tilt table test (for fainting) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rotational Chair for dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal tap (Lumbar puncture) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Posturography (standing balance test) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Doppler/Ultrasound blood flow test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MRA of head and neck blood flow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for syphilis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for Lyme disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for thyroid function | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for CBC, electrolytes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SOCIAL AND FAMILY HISTORY

Please check all that apply to you.

- | | | | | | |
|---|--------------------------|-----------------------------|--------------------------|---------|--------------------------|
| Smoke | <input type="checkbox"/> | Drink caffeinated beverages | <input type="checkbox"/> | Alcohol | <input type="checkbox"/> |
| Repeated direct exposure to loud noises | <input type="checkbox"/> | Toxic items | <input type="checkbox"/> | | |
| History of 'recreational drugs' | <input type="checkbox"/> | | | | |

Family history of the following, check all that apply.

- | | | | | | |
|--------------|--------------------------|--------------------------|--------------------------|-----------|--------------------------|
| Dizziness | <input type="checkbox"/> | Imbalance and/or falling | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Hearing loss | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> |
-

- | | | | |
|---------------------------------------|--------------------------|--------------------------|--------------------------|
| Electrocochleography (EcoG) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EEG (Brain wave test) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Auditory Brainstem Test (ABR) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tilt table test (for fainting) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rotational Chair for dizziness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal tap (Lumbar puncture) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Posturography (standing balance test) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Doppler/Ultrasound blood flow test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| MRA of head and neck blood flow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for syphilis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for Lyme disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for thyroid function | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood test for CBC, electrolytes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SOCIAL AND FAMILY HISTORY

Please check all that apply to you.

- | | | | | | |
|---|--------------------------|-----------------------------|--------------------------|---------|--------------------------|
| Smoke | <input type="checkbox"/> | Drink caffeinated beverages | <input type="checkbox"/> | Alcohol | <input type="checkbox"/> |
| Repeated direct exposure to loud noises | <input type="checkbox"/> | Toxic items | <input type="checkbox"/> | | |
| History of 'recreational drugs' | <input type="checkbox"/> | | | | |

Family history of the following, check all that apply.

- | | | | | | |
|--------------|--------------------------|--------------------------|--------------------------|-----------|--------------------------|
| Dizziness | <input type="checkbox"/> | Imbalance and/or falling | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | Stroke | <input type="checkbox"/> |
| Hearing loss | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> |
-

MEDICATIONS

Please list or attach a list of all your current medications, over the counter drugs, and medications you have tried in the past for your problem.

Name of Medication	Used for Treatment of...

PLEASE BRING THIS DOCUMENT TO YOUR APPOINTMENT!

THIS INFORMATION IS PERTINENT IN THE DIAGNOSIS OF YOUR MEDICAL PROBLEM OF WHICH YOU ARE SEEKING TREATMENT FOR.

Pacific Eye & Ear • Pacific Head & Neck • Pacific Cosmetic Surgeons Pacific Hearing & Balance

Chester F. Griffiths MD • Cadvan O. Griffiths MD • Howard R. Krauss MD • Jeremy E. Levenson MD • William W. Lee MD, FACS
Michelle A. Putnam MD • Rinaldo Canalis, MD • Gregory J. Frazer AuD, PhD • Marni L. Novick AuD CCC-A

Directions and Parking

West Los Angeles/Brentwood (Home Office)
TEL: 310.477.5558 • FAX: 310.477.7281

Brentwood
11645 Wilshire Blvd. 6th Floor
Los Angeles, CA 90025

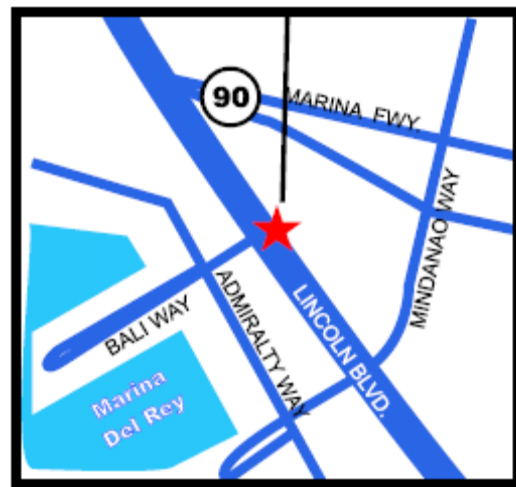


We have the whole 6th floor in the City of Hope building, between Federal and Barrington, on the corner of Barry.

PARKING: The City of Hope Building has parking below the complex at a rate of \$2.25 for the first 60 minutes with a maximum of \$15.75 (Anything longer than 1.5 hours). Unfortunately, we only validate for patients having surgery at our Surgery Center. Limited metered street parking is available on Barry and the surrounding streets. Please be sure to read all posted signs and fill the meter.

Marina del Rey Office:
TEL: 310.574.1116 • FAX: 310.477.7281

Marina del Rey
4644 Lincoln Blvd #400
Marina del Rey, CA 90292



PARKING: The Marina del Rey office shares parking with Daniel Freeman Hospital. Please enter the parking structure off Lincoln. (Please note, you can only enter the parking lot when traveling North on Lincoln.) It is \$1.50 every 20 minutes with a maximum of \$8.00. Limited street parking is available but be sure to read all posted signs

11645 Wilshire Boulevard - Suite 600 - Los Angeles, CA 90025 - Tel 310.477.5558 - Fax 310.477.7281
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An Association, not a Group Practice