

Pulmonary & Sleep Associates
515 SW Horne, Suite 200
Topeka, KS 66606
785-234-5480

PATIENT DATA SHEET

Today's Date _____ Patient Name _____
Date of Birth _____ Male Female
Home Address _____ City/State/Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Occupation _____ Marital Status M S D W
Social Security Number _____ Student Status Part Time Full Time NA
Primary Care Physician _____ Phone Number _____
Referral Physician _____ Pharmacy/location _____

Emergency Contact Information:

Name _____ Relationship _____
Home Address _____ City/State/Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____

I hereby authorize Pulmonary & Sleep Associates to release and/or discuss information regarding my medical diagnosis(es) including test results, medications prescribed, treatment plan, hospitalization, billing or other pertinent healthcare information to the person(s) listed below. I recognize that I may limit the scope of this authorization and am doing so here:

Name

Name

Relationship

Relationship

City/State/Zip

City/State/Zip

Signature _____ Relationship _____

PULMONARY & SLEEP ASSOCIATES
HEALTH HISTORY

Patient Name: _____ Today's Date: _____
Date of Birth: _____

Reason why you came here today: _____
Who sent you here: _____

Brief history of problem (include start date, symptoms, tests performed, meds taken, etc):

Influenza Vaccination: _____ Pneumonia Vaccination: _____
Last Mammography: _____ Last Colonoscopy: _____

Medical History:

<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Asthma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Emphysema	<input type="checkbox"/> GERD	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Legs
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Depression	<input type="checkbox"/> Lungs
<input type="checkbox"/> Stroke(s)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Other: _____

Comments: _____

Surgical History:

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Appendix	<input type="checkbox"/> Knee
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Hernia	<input type="checkbox"/> Sinus	<input type="checkbox"/> Hip
<input type="checkbox"/> Carotid	<input type="checkbox"/> Heart	<input type="checkbox"/> Other: _____	

Pediatrics only:

Pregnancy: Full term Preterm Delivery: Complicated Uncomplicated

Hit age-appropriate milestones (crawling, walking, etc.): Yes No

Comments: _____

Other physicians/therapists involved in care: _____

ALL PATIENTS CONTINUE

Social History:

Marital Status: M S D W Type of Residence: Home/apt Institution Asst. Living

For Office Use Only: Initials _____

Date _____

Current/former occupation(s): _____
 Alcohol use: Yes No Type/quantity/frequency: _____
 Illicit drug use: Yes No Type/quantity/frequency: _____
 Caffeine use: Yes No Type/quantity/frequency: _____
 House pets: Yes No Type(s): _____
 Tobacco history: Current Former Never
 Type(s): _____ Quantity/frequency: _____
 Quit date: _____ Total years used: _____
 Methods used to quit: _____
 Exposed to secondhand smoke: Yes No Total years: _____
 Exposed to dust, fumes, chemicals or asbestos: Yes No Total years: _____
 Describe: _____

Family History:

	<u>Father</u>	<u>Mother</u>	<u>Sister(s)</u>	<u>Brother(s)</u>	<u>Son(s)</u>	<u>Daughter(s)</u>
Current age	_____	_____	_____	_____	_____	_____
Age of death	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____
Heart disease/attack	_____	_____	_____	_____	_____	_____
Lung disease	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Cancer (type)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
High blood pressure	_____	_____	_____	_____	_____	_____
Alcohol/drug abuse	_____	_____	_____	_____	_____	_____
Sleep apnea	_____	_____	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____	_____	_____

Sleep History:

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would affect you. **Use the following scale to choose the most appropriate number for each situation: 0=would never doze; 1=slight chance of dozing; 2=moderate chance of dozing; 3=high chance of dozing.**

- | | |
|---|---|
| ___ Sitting and reading | ___ Watching television |
| ___ Sitting, inactive in a public place
(movie theater, meeting) | ___ As a passenger in a car for an hour,
without a break |
| ___ Lying down to rest after noon,
circumstances permitting | ___ In a car, while stopped for a few minutes
in traffic |
| ___ Sitting and talking to someone | ___ Sitting quietly after lunch without alcohol |
| Total: _____ | |

For Office Use Only: Initials _____

Date _____

What time do you turn the lights out to go to sleep at night: _____

How long does it take you to fall asleep, when you put your mind to it: _____

How many times do you wake up each night, on average: _____

For what reason(s): _____

Do you snore: Yes No Do you wake yourself up snoring: Yes No

Have you been told by others that you stop breathing at night: Yes No

Do you walk in your sleep: Yes No Do you talk in your sleep: Yes No

Do your legs bother you at night: Yes No In what way: _____

What time do you get up: _____ On own Alarm Snooze bar ___ times

Do you feel refreshed upon awakening: Yes No Are you excessively irritable: Yes No

Do you have morning headaches: Yes No Frequency: _____

Is your memory as good as it used to be: Yes No Concentration okay: Yes No

Do you nap during the day: Yes No Frequency: _____ Length: _____

Have you had any accidents (at work or driving) due to sleepiness: Yes No

Describe: _____

Review of Systems:

Lungs

__shortness of breath

__at rest

__with activity

__at night

__cough

__dry

__productive

color: _____

__wheezing

__bloody sputum

__difficulty breathing

while lying down

Constitutional

__fevers/chills

__night sweats

__weight gain

__weight loss

Neurologic

__passing out/fainting

__seizures

__strokes

__numbness/tingling

__tremors/shaking

ENT

__cataracts

__glaucoma

__glasses

__hearing loss

__runny nose

__hayfever

__nasal congestion

__drainage in throat

__nosebleeds

Neck

__swollen glands

__blocked arteries

__enlarged thyroid

__thyroid nodules

Gastrointestinal

__abdominal pains

__nausea/vomiting

__hemorrhoids

__red stools

__black stools

__indigestion

__heartburn/reflux

__difficulty swallowing

Cardiac

__chest pains

__chest pressure

__irregular heartbeat

__palpitations

__ankle swelling

Genitourinary

__pain with urination

__blood in urine

__decreased urine stream

__incontinence

Skin

__rashes

__unusual bruising

__suspicious lesions

__cyanosis (turning blue)

__jaundice (turning yellow)

Musculoskeletal

__weakness

__arthritis

__use of assistive device

(walker, cane, etc.)

For Office Use Only: Initials _____

Date _____

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim. I also authorize the release of medical information to any physician involved in my care, necessary to ensure continuity of care. I permit a copy of this authorization to be used in place of the original.

Initials: _____

ASSIGNMENT OF BENEFITS

I hereby authorize Pulmonary & Sleep Associates to apply for benefits on my behalf for covered services rendered by any of our providers or by their orders. I request that payment from my insurance company be made directly to Pulmonary & Sleep Associates (or the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for charges not covered by this assignment. I permit a copy of this authorization to be used in place of the original. Either my insurance company or I may revoke this authorization at any time in writing.

Initials: _____

AUTHORIZATION FOR COMMUNICATION

I hereby authorize Pulmonary & Sleep Associates to communicate in person, or by message, through the phone number(s) and address(es) I have provided. I understand that simple information such as appointment reminders may be left on my answering machine, but that detailed information regarding my health or financial status will only be communicated in person. I understand that I may limit this communication at any time, by providing a written request.

Initials: _____

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I have reviewed a copy of Pulmonary & Sleep Associates' Privacy Policy Notice. I understand that I may request a copy of it at any time.

Initials: _____

CONSENT FOR RESEARCH

I understand that I may be contacted regarding voluntary participation in research, at the discretion of my provider. I further understand that I may decline participation at any time, without negative consequences. I am giving my consent for initial contact unless my refusal is documented here _____.

Initials: _____

Signature of patient or legal guardian: _____

Date: _____

