PULMONARY & SLEEP CONSULTANTS

Name_____ DOB_____
PCP_____ Date_____

Review of Systems:

□ Fever	□ Weight gain/ loss	□ Night sweats	□ Fatigue	□ Appetite loss
□ Nasal congestion	□ Sore throat	□ Hoarseness	□ Post nasal drip	□ Nose bleeds
□ Hay Fever /Allergies	□ Shortness of breath	□ Cough	□ Phlegm / Sputum	□ Blood in sputum
□ Wheezing	□ Chest pain	□ Palpitations	□ Leg swelling	□ Leg pain when walking
□ Heartburn / Acid reflux	□ Overnight urination	□ Joint pain	□ Back pain	□ Anxiety / Depression
□ Headache	□ Dry mouth	□ Insomnia	□ Snoring	□ Unrefreshing sleep
□ Daytime sleepiness	□ Leg cramps / Kicks	□ Choking in sleep	□ Sleep talking	□ Sleep walking

Past Medical History:

□ Asthma	□ COPD	□ Emphysema	□ Sarcoidosis	□ Pulmonary Fibrosis
□ Pulmonary Hypertension	□ Pulmonary Embolism	□ DVT / Blood Clot	□ TB / Positive PPD	□ Sleep Apnea
□ Narcolepsy	□ Restless Legs	□ Hypertension	□ Abnormal Cholesterol	□ Heart Attack / Angina
□ CHF / Heart failure	□ Irregular Heart Rhythm	□ Stroke / TIA	□ GERD / Hiatal Hernia	□ GI Bleed / Ulcers
□ Diabetes	□ Hyperthyroidism	□ Hypothyroidism	□ Renal failure / Dialysis	□ Osteoporosis
□ Arthritis	□ Lung Cancer	□ Other Cancers: _____		
□ Other Illness: _____				

Past Surgical History:

□ Tonsillectomy / Adenoidectomy □ Gastric Bypass Surgery □ Lung Surgery: _____
□ Cholecystectomy (Gall Bladder) □ Cardiac Stents □ Heart Bypass (CABG)

Social History:

Marital Status □ M □ S □ W □
Alcohol □ Yes □ No
Pets □ Yes □ No
Work Status □ Employed □ Unemployed □ Retired □ Disabled

Smoking History

□ Never Smoked
□ Yes # of years _____ # of packs/ day _____ □ Quit smoking, When? _____

Allergies:

□ None □ Yes_____

Immunization:

`` □ Influenza □ Pneumovax

Family History: (Which Family Member has it?)

□ Asthma	M F B S GF GM	□ Hypertension	M F B S GF GM	□ COPD	M F B S GF GM
□ Heart Disease	M F B S GF GM	□ Emphysema	M F B S GF GM	□ Stroke	M F B S GF GM
□ Diabetes	M F B S GF GM	□ Sleep Apnea	M F B S GF GM	□ Cancer	M F B S GF GM

□ Other: _____

Medications:

4512 Kirkwood Highway, Suite #300-B, Mill Creek Medical Center, DE 19808
Tele: 302-994-4010 Fax: 302-994-4080

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PCP_____ Date_____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	

1-6	Congratulations, you are getting enough sleep!
7-10	You are sleepy.
10-16	You are very sleepy.
16-24	You are dangerously sleepy.

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Patient Content for Use and Disclosure of Protected Health Information

The individual whose signature-appears below hereby attests to the following statement:

With my consent, Pulmonary & Sleep Consultants may use and disclose protected health information (PHI) about me to carry out treatment, payments and healthcare operations (TPO). Please refer to Pulmonary & Sleep Consultants Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, Pulmonary & Sleep Consultants may disclose my PHI to the following individuals (family, relatives, or friends) who may assist in my care.

Name	Relationship	Best Number to reach

I have the right to review the Notice of Privacy Practices prior to signing the consent. Pulmonary & Sleep Consultants, reserves the right to revise its Notice of Privacy Practices at any time. A written copy of our Notice of Privacy Practices may be obtained by forwarding a written request to our office.

CONSENT FOR CALLS TO PROVIDED CONTACT NUMBER

With my consent, Pulmonary & Sleep Consultants, may call my home or other designated location and leave message on my voice mail or with a person listed above in reference to any item that may assist Pulmonary & Sleep Consultants, in carrying out TPO, such as appointment reminder, insurance items and any call pertaining to my clinical care, including radiology, laboratory results, among others.

CONSENT FOR MAIL

With my consent, Pulmonary & Sleep Consultants, may mail to my home or other designated location any item that may assist Pulmonary & Sleep Consultants, in carrying out TPO such as appointment reminder cards and patient statements.

I have the right to request that Pulmonary & Sleep Consultants, restricts how it uses or discloses my PHI to carry out the TPO, However, Pulmonary & Sleep Consultants is not required to agree to my requested restrictions. I may revoke my consent in writing except to the extent that Pulmonary & Sleep Consultants has already made disclosure in reliance upon my prior consent.

By signing this form, I am consenting to Pulmonary & Sleep Consultants, use and disclosure of my PHI to carry out TPO.

If I do not sign this consent, Pulmonary & Sleep Consultants, may decline to provide services to me.

Signed by: _____ Date: _____

4512 Kirkwood Highway, Suite 300 B, Wilmington, DE 19808
Phone: 302-994-4010 Fax: 302-994-4080

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____
Patient's Name

_____
Date of Birth

_____
Address

_____
City State Zip code

I, _____, hereby authorize _____ to disclose confidential information from the above named patient's medical records, including laboratory results, radiology testing results, medications, hospitalization information, office notes, and treatment plan to Pulmonary & Sleep Consultants, LLC

I understand that this authorization will expire in 180 days, and that it may be revoked at any time in writing. I further understand that continued treatment of the above named patient is not contingent upon receipt of this information, and this information is subject to redisclosure by the recipient, and will no longer be protected.

Please send requested information to:

Pulmonary & Sleep Consultants, LLC
4512 Kirkwood Highway, Suite 300-B
Wilmington, DE 19808
Fax: 302-994-4080

_____
Signature of Patient or Legal Guardian

_____ Date: _____
Relationship