

Review of Systems:

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

Past Medical History:

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

Past Surgical History:

- | | | |
|---|---|--|
| <input type="checkbox"/> Tonsillectomy / Adenoidectomy | <input type="checkbox"/> Gastric Bypass Surgery | <input type="checkbox"/> Lung Surgery: _____ |
| <input type="checkbox"/> Cholecystectomy (Gall Bladder) | <input type="checkbox"/> Cardiac Stents | <input type="checkbox"/> 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?)

- | | | | | | |
|--|---------------|---------------------------------------|---------------|---------------------------------|---------------|
| <input type="checkbox"/> Asthma | M F B S GF GM | <input type="checkbox"/> Hypertension | M F B S GF GM | <input type="checkbox"/> COPD | M F B S GF GM |
| <input type="checkbox"/> Heart Disease | M F B S GF GM | <input type="checkbox"/> Emphysema | M F B S GF GM | <input type="checkbox"/> Stroke | M F B S GF GM |
| <input type="checkbox"/> Diabetes | M F B S GF GM | <input type="checkbox"/> Sleep Apnea | M F B S GF GM | <input type="checkbox"/> Cancer | M F B S GF GM |
| <input type="checkbox"/> Other: _____ | | | | | |

Medications:

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	<input type="text"/>
Watching TV	<input type="text"/>
Sitting inactive in a public place (e.g a theater or a meeting)	<input type="text"/>
As a passenger in a car for an hour without a break	<input type="text"/>
Lying down to rest in the afternoon when circumstances permit	<input type="text"/>
Sitting and talking to someone	<input type="text"/>
Sitting quietly after a lunch without alcohol	<input type="text"/>
In a car, while stopped for a few minutes in traffic	<input type="text"/>
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.



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: _____



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