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PULMONARY & SLEEP ASSOCIATES OF HUNTSVILLE, P.C.

Board Certified in Critical Care, Sleep and Pulmonary Medicine

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PATIENT HISTORY FORM

Welcome to Pulmonary and Sleep Associates of Huntsville. In order to ensure your best care, it is important that you take the time to complete both sides of this medical questionnaire. Thanks.

Name ______________________ Date of Birth ____________
Referring Doctor ______________ Primary Doctor ______________
Cardiologists ______________ Other Physicians ______________
Pharmacy Name ______________ Pharmacy Phone Number ______________
The reason for your visit: ______________________________

____

Past Medical History:

Past Medical History: (Please Circle All That Apply) ❑ **None**

Heart:
- Angina
- Atrial Fibrillation
- Atrial Flutter
- Blood Clots
- Cerebrovascular Disease
- Congestive Heart Failure
- Coronary Disease
- Endocarditis
- Fast Heart Rate
- Heart Attack
- Heart Valve Disease
- High Cholesterol
- Hypertension
- Peripheral Vascular Disease
- Slow Heart Rate
- Stroke
- Varicose Veins

Lungs:
- Asthma
- COPD
- Sleep Apnea
  - Use CPAP
- Tuberculosis

Mental:
- Anxiety
- Depression

Gastrointestinal:
- Acid Reflux
- Cirrhosis
- Crohn's Disease
- Diverticulitis
- GI Bleed
- Hepatitis
- Liver Disease
- Stomach Ulcers

Urinary:
- Dialysis
- Erectile Dysfunction
- Kidney Disease
- Kidney Stones

Skeletal:
- Arthritis
- Osteoporosis

Neurological:
- Fainting
- Parkinson's Disease
- Seizures

Hematology/Oncology:
- Anemia
- Autoimmune Disease
- Blood Transfusion
- Brain Tumor
- Cancer
- Chemotherapy
- Radiation Therapy
- Hemochromatosis
- HIV

Other:
- Diabetes
- Hypothyroidism
- Hyperthyroidism
- Lupus
- Fibromyalgia
- Rheumatic Fever (Childhood)

Any Additional Illnesses? ______________________________

Past Surgical History: ❑ **None**

❑ Abdominal Surgery
❑ Amputation
❑ Angioplasty
❑ AV Fistula Creation
❑ Aortic Valve Repaired
❑ Aortic Valve Replaced
❑ Appendix Removed
❑ Back Surgery
❑ Bladder Surgery
❑ Brain Surgery
❑ Bronchoscopy
❑ Carotid Artery
❑ Carpal Tunnel
❑ Cataract Removal
❑ Colon Surgery
❑ Defibrillator Implanted
❑ Dialysis Catheter
❑ Gallbladder
❑ Gastric Bypass
❑ Heart Bypass
❑ Hemorrhoid Surgery
❑ Hip Replacement
❑ Hysterectomy
❑ Kidney removed
❑ Kidney Transplant
❑ Knee Arthroscopy
❑ Knee Replacement
❑ Kyphoplasty
❑ Lung Removed
❑ Mitral Valve Repair
❑ Mitral Valve Replaced
❑ Pacemaker Implanted
❑ Pain Epidural Injections
❑ Prostate Surgery
❑ Shoulder Surgery
❑ Sleep Apnea Surgery
❑ Thyroid Surgery
❑ Tonsils Removed
❑ Vascular Surgery

Anesthesia Problems
❑ No ❑ Yes
Surgical Complications
❑ No ❑ Yes
Post Operative Complications
❑ No ❑ Yes

Vaccinations / Skin Test

Vaccine	Month/Year
Influenza	
Pneumonia	
PPD/TB skin test	

Medications	Dose	Times per day

Medications	Dose	Times per day

Any allergies to medications, etc.? ______________________
Reaction: ______________________

Please continue on other side

Social History:

History of tobacco use:

Do you smoke cigarettes / cigars? Y / N

If so, how many per day? ____________

How many years have you smoked? ____________

If you used to smoke, how long ago did you quit? _____

History of Alcohol Use:

Do you consume alcohol? Y / N

If so, how many drinks per week? ____________

Environmental History:

Have you ever been exposed to any harmful substances?

Name of Harmful Substance	# of years

Illicit Drug Use:

Do you use illegal drugs? Y / N

If so, what type and how often? ____________

____

Marital Status:(circle one)

Single / Married / Divorced / Widowed

Children:

Number of children: ____________

Occupational Information:

List all occupations and how long you worked at each:

Occupation	# of years

Family History:

Family Member	Living	Deceased	Age/Age at death	Health Condition or Cause of Death
Father				
Mother				
Spouse				
Siblings				

System Review: (Please check all that apply.)

General: ❑ Fevers ❑ Chills ❑ Night sweats ❑ Weight loss ❑ Weight gain ❑ Headaches

Pulmonary: ❑ Shortness of breath ❑ Cough ❑ Wheezing ❑ Phlegm ❑ Cough up blood

Sleep: ❑ Difficulty in sleeping ❑ Snoring ❑ Morning headaches ❑ Daytime sleepiness ❑ Stop breathing during sleep

Eyes: ❑ Bluriness of vision ❑ Dry eyes ❑ Light sensitivity

ENT: ❑ Decreased hearing ❑ Loss of smell ❑ Runny or stuffy nose ❑ Sinus pain/drainage ❑ Sore throat ❑ Thrush ❑ Hoarseness of voice

Cardiac: ❑ Chest pains ❑ Palpitations ❑ Heart murmur ❑ Leg Swelling

Gastrointestinal: ❑ Nausea ❑ Vomiting ❑ Heartburn ❑ Difficulty to swallow ❑ Abdominal pain ❑ Blood in stool

Genitourinary: ❑ Pain with urination ❑ Blood in urine ❑ Frequent Urinary tract infections

Musculoskeletal: ❑ Joint pain ❑ Joint swelling ❑ Muscle pain ❑ Back pain

Hematology: ❑ Bruise easily ❑ Bleeding disorder ❑ History of blood transfusion ❑ Anemia

Skin: ❑ Rashes ❑ Tattoos ❑ Itching ❑ Skin discoloration

Psychiatric: ❑ Depression ❑ Anxiety ❑ Suicide attempts

Neurological: ❑ Seizures ❑ Paralysis ❑ Dizziness ❑ Numbness/tingling ❑ Memory loss

Please bring a list of all medications to appointment.

Signature:____________________ **Date:** ____________

Pulmonary and Sleep
Associates of Huntsville

725 Madison Street • Huntsville, AL 35801
1041 Balch Road, Suite 175 • Madison, AL 35758

INITIALS	OFFICE USE ONLY

Date: ______________________

PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First	MARITAL: S / M / W / D / SEP	DATE OF BIRTH	AGE	SEX

RACE: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN / WHITE ☐ NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER ☐ AMERICAN INDIAN / ALASKA NATIVE ☐ DECLINED ☐ UNKNOWN

PRIMARY LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER ______________

ETHNICITY: ☐ HISPANIC ☐ NON-HISPANIC ☐ DECLINED ☐ UNKNOWN

ADDRESS	CITY , STATE & ZIP

SOCIAL SECURITY NO.	MAIN PHONE NO.	SECONDARY PHONE NO.	EMAIL
	( )	( )	

OCCUPATION (INDICATE IF STUDENT)	EMPLOYER	HOW LONG EMPLOYED?	RELIGION (OPTIONAL)

EMPLOYERS ADDRESS	CITY, STATE & ZIP

HUSBAND, WIFE, PARENT OR GUARDIAN NAME	DATE OF BIRTH	SSN

EMPLOYER OF ABOVE NAME	CITY & STATE	ZIP CODE	BUSINESS PHONE NO.
			( )

PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE	RELATIONSHIP	HOME TELEPHONE NO.	BUSINESS PHONE NO.
		( )	( )

ADDRESS	CITY, STATE & ZIP

REFERRING PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )
FAMILY PHYSICIAN			
ADDRESS	CITY & STATE	ZIP CODE	PHONE ( )

PERSON RESPONSIBLE FOR BILL: ______________________

IF OTHER THAN PARENT, S.S.# ______________________

ADDRESS OF RESPONSIBLE PARTY ______________________

PRIMARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
SECONDARY INSURANCE CO.	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	
OTHER INSURANCE	NAME OF POLICY HOLDER	POLICY HOLDER DOB	COPAY
CONTRACT NUMBER	GROUP NUMBER	EMPLOYED BY:	

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Pulmonary and Sleep Associates of Huntsville for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Pulmonary and Sleep Associates of Huntsville to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

Signature: ______________________ Date: ______________

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER

DISCLOSURES & PRIVACY PRACTICES

Patient Name: ______________________________ **DOB:** ____________

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

	Phone Number	OK to leave message with detailed information	Leave message with call-back number only
Home Phone			
Work Phone			
Cell Phone			

I acknowledge that I have received a copy of the Notice of Privacy Practices and that Pulmonary and Sleep Associates of Huntsville may, at its discretion change the terms and conditions of this notice.

(Please Initial) _____

Release of Medication History Authorization:

I give Pulmonary and Sleep Associates of Huntsville permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed as part of my medical records release.

(Please Initial) _____

Pulmonary and Sleep Associates of Huntsville and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

Name	Relationship	Phone Number

Printed Name: ______________________________

Signature: ______________________________ Date: ____________

Pulmonary & Sleep Associates
of Huntsville

FINANCIAL POLICY

PSA believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance payment in full is expected at the time of your visit. We do ask for a copy of a picture ID due to the many cases of identity theft in the news lately. (Please do not be offended!)

2. **INSURANCE.** We are participating providers with several insurance plans. We will file all insurance claims as a courtesy to you. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay PSA within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayments to you.

   If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed by PSA are considered covered unless limited by your specific insurance policy.

3. **RETURNED CHECKS** will incur a $50.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $50 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $50 service fee and collections action. All returned checks written to PSA are subject to collections and will be prosecuted by Madison County District Attorney.

4. **BILLING OFFICE**: If you have questions in regard to any of your billing statements, our insurance staff at PSA is available to assist you. CALL 256-883-2110.

5. **CANCELLATIONS OR MISSED APPOINTMENTS**: If you do not cancel your appointment at least 24 hours before, or if you-no-show, we may assess you a $25.00 missed appointment fee that must be paid prior to scheduling another appointment. This charge will not be filed with your insurance.

6. **RESPONSIBILITY FOR PAYMENT**: I understand that I, personally, am financially responsible to PSA for charges not covered by the assignment of insurance benefits. **SELF PAY PATIENTS**. All monies owed are expected on date of service. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. PSA will be happy to assist you with a patient financial arrangement however, the first visit will need to be paid in full prior to any arrangements being made.

7. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby, assign, transfer, and set over directly to PSA sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said office. I authorize PSA to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to PSA. I authorize PSA to release all medical information (including, but not limited to, information on psychiatric conditions, Sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

8. **COLLECTION FEES:** I understand that in the event my account is placed in collections status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the PSA financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_______________________________ Date:___________________

Signature of Patient

ADVANCED CARE PLANNING

Patient Name - ______________________________ **DOB -** ______________

This form is intended for you to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy.

Place your initials by only ONE answer:

__________ I do not want to name a health care proxy at this time.

__________ I would like to discuss advanced care planning with my family and will discuss this further with my doctor at a later date.

__________ I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

FIRST Choice Health Care Proxy Name: ______________________________

Relationship to me: ______________________________

Address: ______________________________

City: ____________________ State: ______________ Zip: ______________

Day-time phone: __________________ Night-time phone: __________________

SECOND Choice Health Care Proxy Name: ______________________________

Relationship to me: ______________________________

Address: ______________________________

City: ____________________ State: ______________ Zip: ______________

Day-time phone: __________________ Night-time phone: __________________

Patient's Signature: ______________________________ **Date:** ______________

PULMONARY & SLEEP ASSOCIATES OF HUNTSVILLE

❑ 725 Madison Street
Huntsville, AL 35801
Phone 256-883-2112
Fax 256-885-0037

❑ Richard M. Sneeringer, M.D. ❑ Misbah F. Siddiqui, M.D.
❑ Murthy S. Vuppala, M.D. ❑ Saketh Shekar, M.D.
❑ W. Alan McCrory, M.D. ❑ Derek E. Wells, M.D.

❑ 1041 Balch Rd.
Suite 175
Madison, AL 35758

❑ 4810 Whitesport Circle SW
Suite 204
Huntsville, AL 35801

Authorization for Release / Request of Protected Health Information

Patient's name: ______________________ Date of Birth: __________
Address: ______________________
City/State/Zip Code: ______________________
SS#: ______________________ Patient's phone #: (   ) __________
Date of Request: ______________________ Date Needed: __________

❑ I authorize Pulmonary & Sleep Associates of Huntsville to release information to:

____
Name of Provider or Facility
____
Address
____
City, State, Zip Code
____
Phone # / Fax # (include area code)

OR

❑ I authorize Pulmonary & Sleep Associates of Huntsville to obtain information from:

____
Name of Provider or Facility
____
Address
____
City, State, Zip Code
____
Phone # / Fax # (include area code)

Purpose For This Request: (Check one) ❑ Healthcare ❑ Insurance coverage ❑ Personal ❑ Other

Type Of Records Requested: (Check one)
❑ Specific Information (Select one or more, as applicable)
- ❑ Operative report
- ❑ Laboratory test results
- ❑ Office Notes
- ❑ Other ______________________
- ❑ History & Physical
- ❑ X-ray reports
- ❑ Pulmonary Function test
- ❑ Consult
- ❑ Discharge Summary
- ❑ Sleep records

❑ All medical records related to a specific illness or injury
❑ All medical records

____
Specify illness / injury Date(s) of treatment

Physician Signature: ______________________

AUTHORIZATION VALID FOR THIS REQUEST ONLY

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a *written* request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV-related information, STD's (sexually transmitted diseases), mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient ______________________ Date __________

Witness ______________________

Date Mailed ______________________

PSA
Sleep Questionnaire

Answer these questions to the best of your ability. If you find questions that you cannot answer, mark them with a question mark. If possible, have someone familiar with your sleeping habits help you fill out this form.

Name:______________________________ DOB:________________ Age:________

GENERAL INFORMATION:

What is your primary problem with sleep? ____

How long have you had sleep problems? ________Months ________Years

SLEEP SCHEDULE AND SLEEP HYGIENE:

	Weekdays/Workdays		Weekends/Holidays
What time do you usually go to bed?	____________		____________
What time do you usually wake up?	____________		____________
How many hours do you usually sleep?	____________		____________
Do you take daytime naps?	YES	NO	
Are you usually refreshed by a night's sleep?	YES	NO	
Do you keep a fairly regular sleep/ wake schedule?	YES	NO	

Do you do any of the following in bed? (Circle all appropriate): **Read** **Watch TV** **Write** **Eat** **Worry**

Do you currently do shift work?	YES	NO
Have you done shift work in the past?	YES	NO
Do you have trouble sleeping when doing shift work?	YES	NO

If you could set your own schedule, what time would you go to bed? ____:____ ___a.m. ___p.m.

What time would you get up? ____:____ ___a.m. ___p.m.

INSOMNIA: **(Circle ALL that apply)**

Based on your experience in the last six months answer the following questions, with "night" meaning your major sleeping time.

Do you often have trouble falling to sleep? YES NO

What is the average number of minutes it takes you to fall asleep at night? ________minutes

Do you often have awakenings during the night? YES NO , If yes, average number of times per night? ____________

Do you have long periods when you awaken and are not able to go back to sleep? YES NO

Are you bothered by waking up too early and not being able to get back to sleep? YES NO

How many nights a week do you feel you have a sleep problem? __________nights per week

Is your sleep disrupted by your bed partner? YES NO ________snoring ________movement

PARASOMNIAS: **(Circle ALL that apply)**

Did you have sleep problems as a child? YES NO If yes, describe: ______________________

Do you currently have nightmares or night terrors? YES NO , How frequent? ______________

Do you grind or clench your teeth at night?	YES	NO
Have you ever been told you act out dreams?	YES	NO
Did you frequently wet the bed as a child?	YES	NO
Have you recently walked in your sleep?	YES	NO
Have you ever been told that you walk in your sleep?	YES	NO

MOVEMENT: **(Circle ALL that apply)**

Answer the following questions based on the most recent six months.

Has your bed partner ever complained of your legs kicking during the night? YES NO

Do you have restless sense of discomfort (crawling sensations) in your legs during the waking hours? YES NO

Do you exercise regularly? YES NO

EXCESSIVE SLEEPINESS: **(Circle ALL that apply)**

Do you feel excessively sleepy in the daytime? YES NO If yes, how long: _______ months / years

Have you ever had an accident or near-miss accident because of falling asleep driving? YES NO

If yes, describe: ____________________

Have you ever felt sudden muscle weakness when you laughed, got angry, or were surprised? YES NO

Have you ever been unable to move your body just as you were falling asleep or waking up? YES NO

Do you have difficulty distinguishing your dreams from reality? YES NO

If yes, describe: ____________________

How often do you wake with morning headaches? ___Never ___Monthly ___Weekly ___Daily

How often do you wake up with dry mouth or sore throat? ___Never ___Monthly ___Weekly ___Daily

Have you been told that you stop breathing during sleep? ___ Some nights ___Every night ___NO

Have you awoken with a snort, choking sensation, or shortness of breath?

___Some nights ___ Every night ___NO

How often do you snore? ___Never ___Occasionally ___ Nightly

How loud is your snoring? ___ Not very ___ Somewhat ___Very ___Don't Know

In which position(s) do you prefer to sleep? __Back __ Right Side __ Left Side __Stomach __Other

Does sleep position affect your snoring? N/A YES NO

Do you have difficulty breathing through your nose? YES NO

If yes, describe: ____________________

Have you ever had surgery on your upper airway (tonsillectomy, sinus operation, etc.)? YES NO

If yes, describe: ____________________

Do you have heartburn, gastric acid reflux, or hiatal hernia? YES NO

Do you use oxygen or any type of medical equipment when you sleep? YES NO

If yes, describe: ____________________

Have you gained weight? YES NO Have you attempted to diet? YES NO

EPWORTH SLEEPINESS SCALE:

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

0 = NEVER DOZE	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 public place	________
As a passenger in a car for an hour	________
Lying down in the afternoon	________
Sitting and talking to someone	________
Sitting quietly after lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
TOTAL SCORE	________

Any additional comments:

____