

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

5050 POPLAR AVENUE, SUITE 800

MEMPHIS, TN 38157

(901) 276-2662

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS		ETHNICITY
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP		RACE
MARITAL STATUS	STUDENT STATUS ☐ Full-Time ☐ Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE	
SEXUAL ORIENTATION		PREFERRED PRONOUN		GENDER IDENTITY				
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)				
ADDRESS				ADDRESS				
CITY, STATE ZIP				CITY, STATE ZIP				
WORK PHONE				WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS ☐ Full-time ☐ Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE	
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED				GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED		SSN#	BIRTHDATE	GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

I authorize medical treatment by my physician. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health ins. benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing.

SIGNATURE OF PATIENT/GUARDIAN

DATE

**HIPAA NOTICE OF PRIVACY PRACTICES
MID-SOUTH PULMONARY & SLEEP SPECIALISTS P.C.**

This Notice of Privacy Practices describes how your protected health information (PHI) may be used and disclosed by Mid-South Pulmonary & Sleep Specialists, PC and outlines your rights regarding that information. We may use and share your PHI for purposes of treatment, payment, and healthcare operations, as permitted by law. You have the right to access, request copies of, and request corrections to your PHI, as well as the right to request restrictions on how your information is used or shared. We are committed to protecting the confidentiality of your PHI and will notify you of any significant changes to this notice. My information can be released to the following people listed below:

This form stays in effect for twelve months unless otherwise specified.

If you have concerns or wish to file a complaint regarding the handling of your PHI, please contact Administrator, 5050 Poplar Ave., Suite 800, Memphis, TN 38157 (901) 276-2662 or the U.S. Department of Health and Human Services. This notice is effective as of date below. I have read and understand my HIPAA privacy rights.

Patient Name/Representative	Signature	Date
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Patient DOB _____

MRN _____

MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.
MEDICATION VERIFICATION SHEET

PATIENT NAME _____

CHART/MRN# _____

DATE OF VISIT _____

ALLERGIES: _____

NAME OF PHARMACY _____

Pharmacy Phone # _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING.
(INCLUDING INHALERS AND VITAMINS)

<u>MEDICATION NAME</u>	<u>DOSAGE/STRENGTH/MG</u>	<u>FREQUENCY (times per day)</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____

ARE YOU CURRENTLY TAKING ANY FORM OF BIRTH CONTROL?

YES _____

NO _____

SIGNATURE

DATE

Insomnia Severity Index

Name: _____

Date: _____

MRN: _____

The insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the "Guidelines for scoring/interpretation" below to see where your sleep difficulty fits.

For each question, please Circle the number that best describes your answer.

Please rate the CURRENT (i.e. last 2 weeks) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How **SATISFIED/DISSATISFIED** are you with your CURRENT sleep pattern?

Very Satisfied Satisfied Moderately Satisfied Dissatisfied Very Dissatisfied
0 1 2 3 4

5. How **NOTICEABLE** to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all noticeable A little Somewhat Much Very Much Noticeable
0 1 2 3 4

6. How **WORRIED/DISTRESSED** are you about your current sleep problem?

Not at all Worried A little Somewhat Much Very Much Worried
0 1 2 3 4

7. To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) **CURRENTLY**?

Not at all Interfering A little Somewhat Much Very Much Interfering
0 1 2 3 4

Guideline for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ total score

Total Score Categories:

0-7 = No clinically significant insomnia

8-14 = Subthreshold Insomnia

15-21 = Clinical insomnia (moderate Severity)

22-28 = Clinical insomnia (Severe)

PATIENT QUESTIONNAIRE
MID-SOUTH PULMONARY & SLEEP SPECIALISTS, P.C.

NAME: _____ DATE: ____/____/____

Referring Physician: _____ Primary Care Physician: _____

Marital Status: _____ Age: _____ Height: _____ Weight: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

PAST MEDICAL HISTORY (Place check ☒ Yes or No beside all conditions that apply to you.
If you have other conditions, please write them down in the space provided.

<u>Condition</u>	<u>YES</u>	<u>NO</u>		<u>Condition</u>	<u>YES</u>	<u>NO</u>
Atrial Fibrillation				Heart Disease		
Asthma				Hypertension		
Cancer;				Insomnia		
Where?				Lupus		
Seizure(s)				Restless Leg Syndrome		
Congestive Heart Failure				Sleep Apnea		
COPD				Stroke		
Coronary Artery Disease				Thyroid Disorder		
On Oxygen				Floppy/Droopy Eyelids		
Neurodegenerative Disorder: MS; Parkinson's; Alzheimer's; Other:				Neuromuscular Disorder: Muscular Dystrophy, Myasthenia Gravis, ALS, Peripheral Neuropathy; Other:		
Diabetes				Depression		
Dysrhythmia/Heart Rhythm Problem				Elevated Red Blood Cell Count (Polycythemia)		

PAST SURGICAL HISTORY Please list all surgeries you have had.

<u>SURGERY</u>	<u>DATE</u>		<u>SURGERY</u>	<u>DATE</u>

Name: _____ DOB: _____

FAMILY HISTORY Please check ☒ all that apply.

<u>Condition</u>		<u>YES</u>		<u>Condition</u>		<u>YES</u>
Asthma				Sleep Apnea		
Cancer				Stroke		
Where?				Thyroid Disorder		
COPD				Heart Disease		
Diabetes				Other:		
Hypertension						

SOCIAL HISTORY Please check ☒ all that apply.

		<u>YES</u>	<u>NO</u>
Do you smoke?			
How many years have you smoked?			
Are you a former smoker?			
When did you quit smoking?			
Have you tried to quit?			
Do you drink alcohol?			
How many alcohol drinks per day?			
What is your occupation?			

When was your last flu shot? _____

Have you had a pneumonia shot? YES NO When? _____

Do you have a Living Will or Advance Directive? YES NO

Name: _____ DOB: _____

THE EPWORTH SLEEPINESS SCALE

Use the following scale to rate how likely you are to doze or fall asleep during each of the following situations. This refers to your usual way of life in recent times.

**0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing
3 = high chance of dozing**

	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (a theater, meeting, seminar)	_____
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	_____
SCORE:	<div></div>

1. Why are you seeing a sleep specialist? _____
2. How long has this problem bothered you and how often does it occur? _____
3. Do any other members of your family have sleep problems? _____

Please check ALL that apply:

Awaken short of breath, choking or gasping _____	History of Tonsillectomy _____
Awaken with heartburn, belching, or coughing _____	Fall asleep or doze while driving _____
Have crawling/aching feelings in legs _____	Wake with stiff, sore/aching muscles _____
Sweat excessively at night _____	Have vivid dream-like scenes upon awakening/falling asleep _____
Fall asleep when laughing/crying _____	Frequent Headaches _____
Notice parts of your body jerking _____	Problems with focus & attention _____
Kick during the night _____	Memory Problems _____
Wake with pain in neck, spine, joints _____	Have loss of muscle tone when extremely emotional _____
Have morning jaw pain _____	Snore Loudly _____
Notice heart pounding, beating irregularly day/night _____	Grind teeth during sleep _____
Feel unable to move/paralyzed when waking or falling asleep _____	Bedwetting _____
Problems at school/work because of sleepiness _____	Fall asleep during the day _____

Name: _____ DOB: _____

5. Does your sleep problem interfere with your social life/activity? How? _____

6. How many hours of sleep do you usually get per night? _____
7. What time do you usually go to bed on Weekdays? _____ Weekends? _____
8. How long does it take for you to fall asleep? _____
9. How many times do you typically wake up at night? _____
10. What time do you get up in the morning on WEEKDAYS? _____ WEEKENDS? _____
11. What disturbs your sleep? _____
12. With whom are you now living? (wife, husband, children, parents, etc., please list ages)

13. Occupation? _____ Do you work split shifts or rotating (variable) shifts? _____
14. Do you drink coffee or tea within 2 hours before you go to bed? () YES () NO
15. Do you do physical exercise before bedtime? () YES () NO
16. Do you read and/or watch TV before falling asleep? () YES () NO
17. Do you take naps during the afternoon or evening? () YES () NO
18. Do you wake from naps feeling rested? () YES () NO
19. Have you ever been knocked unconscious or had serious injury to your head? () YES () NO
Please Explain _____

20. **CIRCLE IF YOU HAVE YOU EXPERIENCED ANY OF THE FOLLOWING RECENTLY:**

Depression	Anger	Anxiety	Loneliness	Suicidal Thoughts
Hopelessness	Fears	Fatigue	Nightmares	Low self-esteem

24. Have you attempted suicide in the last six months? _____
25. Are you contemplating causing harm to yourself at this point and time? _____
26. Have you been under the care of a mental health practitioner (e.g., psychiatrist, psychologist) in recent time's or currently? _____ If yes, who? _____
29. Have you had a sleep study before? YES NO When and Where? _____
30. Do you have a CPAP Machine? YES NO If yes, where was it purchased? _____