Dear Patient:

You have an appointment scheduled with SIMEDHealth Pulmonology.

You should read through this package and complete all indicated areas. Some paperwork is related to your health history, some is used for billing purposes and some is related to our ability to obtain and share information and records regarding previous medical treatment and diagnostic tests. You must bring this paperwork with you to your first appointment.

Please arrive at least FIFTEEN (15) minutes before your appointment. We need to collect the enclosed paperwork and scan copies of your insurance cards, check your vitals, etc.… We will call to remind you of your appointment approximately TWO BUSINESS DAYS before your appointment. If you get a message from us reminding you of your appointment, please call back at (352) 375-0302 to verify you are coming to your appointment. Unconfirmed appointments and late arrivals may be canceled. Please do not bring children to your appointment.

When you come to the appointment, you will also need to bring:

- List of all medications currently being taken (or just bring the bottles)
- Your current insurance card(s) and a picture ID
- Payment for co-pays, co-insurance, and/or deductible for services rendered
- Other (Only those checked off apply to you):
    - ☐ CD of recent ___________________________
    - ☐ Copy of report of/for ________________________________
    - ☐ Get **chest x-ray** at SIMEDHealth Imaging – 4343 Newberry Road, Suite 6. (352) 224-2475.

Payment for Services and Insurance Billing: Co-Pays, deductibles and co-insurance are due AT TIME OF SERVICE. Payment plans can be arranged by calling out office and asking to speak with the billing coordinator prior to your appointment at (352) 375-0302. We are providers for most insurance, but it is your responsibility to verify that we are within your plan's network for best benefits. We will bill most insurances (even if we are not on your plan), but you are ultimately responsible for any charges not covered (paid) by your insurance. If your visit requires a pre-authorization, please bring that authorization number with you. Payment of co-pays and co-insurance are due at the time of service. Please do not ask us to bill you for the amounts that are due at the time of service.

Our Patient Lobby: Our Physicians, Advanced Care Practitioners, and Respiratory Therapists each see patients on separate schedules. Our patient lobby does get full and sometimes a patient who arrives after you may go back before you. You must always sign in at the receptionist desk when you arrive so that the staff knows you are here. However, if you feel that your wait is too long, please speak to one of our receptionists immediately.

Speaking With Your Physician: Please call the office at (352) 375-0302. Physicians try to call patients back within one business day. If you feel you are having an emergency, go to the nearest emergency room rather than calling our office. Our physicians are on call 24/7 at (352) 375-0302. Non-emergent requests should be

made Mon-Fri between 8am and 5pm. Refills are handled only for medications our doctors prescribe during office visits. If you need a refill before a visit, please try to call the office at least 2 business days before you need the refill.

Our goal is to provide you with excellent care and support and we are honored to be part of your health care team. If we may be of service in any way, please let us know.

As a reminder, please arrive at least FIFTEEN MINUTES BEFORE YOUR APPOINTMENT TIME to allow time for check-in and paperwork prior to seeing the provider.

Your appointment time is the time we want to put you in the clinic to see the physician. Some paperwork must be completed at every visit and we will also take your vitals and review your medications at every visit BEFORE the physician visit – if you do not get here before your visit time, your visit will run late and so will the visits of those patients scheduled after you.

Thank you!
Doctors and Staff of SIMEDHealth Pulmonology

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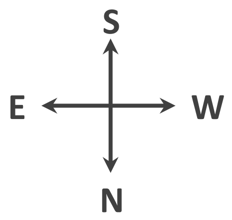

Suite 6 – SIMEDHealth Pulmonology

4343 W Newberry Road, Gainesville, FL 32607
(352) 375-0302 | **SIMED**Health.com

1. **Enter South entrance into main lobby**
2. **Take stairs or elevator up to 1st floor**
3. **Once on 1st floor, take right, then left into hall**
4. **Enter Suite 6 on right**

★ **Your Destination**

Screening For Obstructive Sleep Apnea (OSA)

Patient Name: ______________________________ DOB: ___________ Age: _______ M / F

Question		
Do you use, or are you supposed to use, a breathing machine (CPAP or BiPAP) while you sleep?	YES	NO
Have you ever had a sleep study or polysomnogram (in which you slept overnight in a sleep lab while connected to test equipment) to determine if you have a sleep disorder?	YES	NO
In the last five years has any spouse or bed partner commented that you snore?	YES	NO
In the last five years has any spouse or bed partner commented that you make noises (gasps or snorts) when you are sleeping?	YES	NO
In the last five years has any spouse or bed partner commented that you stop breathing or pause in breathing for more than 10 seconds at a time?	YES	NO
Do any of your blood relatives (NOT those who married into your family) have obstructive sleep apnea or use a breathing machine while they sleep at night?	YES	NO

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. This is called the Epworth Scale.

Sitting and reading ______

Watching TV ______

Sitting inactive in a public place (for example a movie 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 Epworth Scale:________

0 No Chance of Dozing

1 Slight Chance of Dozing

2 Moderate Chance of Dozing

3 High Chance of Dozing

Thank you – this paperwork will become part of your permanent health care record with SIMEDHealth Pulmonology.

Patient Name: ______________________________________ Today's Date: ___________________

Date of Birth: ______________________________________ Birthplace: ____________________

Allergies to Medication(s): ____

____

List hospitalizations you have had. Please be thorough and include surgeries to remove adenoids/tonsils, as well as hospitalizations for head injury, seizures and/or heart conditions.

Problem or Diagnosis	Date

List all medications your currently take. Please include prescription and non-prescription (over the counter) medications of all types, sleep or non-sleep related. Please also indicate if you are on supplemental oxygen.

Name of Medication	Dosage	How Often	Reason

Additional information about your health / chief complaint: ______________________________________

____

Smoking History: ☐ Smoker ☐ Non-Smoker ☐ Former Smoker

If former smoker, age started _____ Age stopped _______ Average packs per day ________

Do you consume alcoholic beverages? ☐ Yes ☐ No Average number of drinks per day _______

States / countries you have lived other than place of birth: __________________________________

____

Occupations held (past and present): ____

____

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Patient Name: ____ Today's Date: ____________________

Please answer the following health history questions regarding your family.

Family Member	If living, age now. If deceased, age at death.	If deceased, cause of death	If alive, any medical problems
Mother			
Father			
Brother(s) / Sister(s)			

Have you ever been diagnosed as having any of the following? Mark only those that apply to you.

Issue	✓	**Issue**	✓	**Issue**	✓
Asthma		Stomach Ulcers		Thyroid Trouble	
Emphysema		Cirrhosis		Anemia	
Cough		Liver Disease		Kidney Stones	
Sputum		Glaucoma		Kidney Infections	
Chest Pains		Gallstones		Arthritis	
Venous Blood Clots		Hepatitis		Rheumatic Fever	
Occupational Hazards		Nervous Stomach		Cancer	
Tuberculosis		Colitis		High Blood Pressure	
Shortness of Breath		Weight Loss		Bleeding	
Diabetes		How many pounds lost?		Yellow Jaundice	
Heart Trouble		Weight Gain		Gout	
Heart Attack		How many pounds gained?		Mental Illness	

Have you ever received a pneumococcal vaccine (Pneumovax)? □ Yes □ No □ Unsure If yes, when? _______

If you are here to be evaluated for a sleep condition, please continue to the next page and answer the following questions.

If you are not a sleep patient, you may STOP HERE.

Patient Name: ______________________________________ Today's Date: ___________________

FOR SLEEP PATIENTS ONLY:

This questionnaire helps determine the nature of your sleep problem. It is very important to be as accurate as possible when answering these questions. Additionally, your bed-partner may be able to assist you. Please make sure you put your name on each page.

Describe your sleep problem(s) in your own words: ____

____

____

Describe how and when the problem(s) began: ____

____

____

Describe any treatments you have received for the problem(s): _______________________________________

____

____

____

Has this been a continuous or intermittent problem?

□ Intermittent, occasional problem □ Frequent Problem □ Continuous, almost every night

How long has your sleep bothered you?

□ Longer than 2 years □ 1-2 Years □ several months □ within the last 3 months □ within last month

Do you have a family history of snoring or other sleep disorders? □ No □ Yes

If yes, please describe: ____

____

____

Please mark NO or YES for the following questions:

Are you unable to sleep in a flat position due to shortness of breath? □ No □ Yes

Have you ever sustained a brain concussion, head injury or serious blow to the head? □ No □ Yes

Do you have spells of seizures? □ No □ Yes

Do you have high blood pressure? □ No □ Yes

Have you experienced weight gain in the last year? □ No □ Yes

If yes, approximately how many pounds? ___________

Has your shirt collar size increased recently? □ No □ Yes

If yes, approximately how many inches? ___________

Do you smoke? □ No □ Yes

If yes, how many packs per day? ___________

If yes, how many years have you smoked? ___________

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Patient Name: ________________________ Today's Date: ______________

<u>Please mark NO or YES for the following questions:</u>

Are you a former smoker? ☐ No ☐ Yes

If yes, how many packs per day? __________

If yes, how many years did you smoke? __________

If yes, when did you quit smoking? __________

Do you drink alcohol? ☐ No ☐ Yes

If yes, estimate the number of drinks you have per day:

________ Workday ________ days off

If yes, do you drink alcohol after 6:00pm? Mark one

☐ NEVER ☐ RARELY ☐ OCCASIONALLY ☐ FREQUENTLY ☐ ALWAYS

Males: Have you experienced difficulties with sexual function? ☐ No ☐ Yes

☐ NEVER ☐ RARELY ☐ OCCASIONALLY ☐ FREQUENTLY ☐ ALWAYS

Females: Does your sleep problem vary according to the stage of your menstrual cycle? ☐ No ☐ Yes

☐ NEVER ☐ RARELY ☐ OCCASIONALLY ☐ FREQUENTLY ☐ ALWAYS

Females: Have you gone through menopause or a hysterectomy? ☐ No ☐ Yes

<u>Your Sleep Habits:</u>

How many hours of sleep do you usually get per night? __________

What time do your normally go to bed on: Weekdays __________

Days off __________

What time do you usually wake up on: Weekdays __________

Days off __________

How long does it take you to fall asleep? __________

How many times do you typically wake up at night? __________

If you wake up, on average, how long do you stay awake? __________

What shift do you work? ☐ Day ☐ Evening ☐ Night

How often do you rotate shifts? __________

<u>Please select the correct response to the following questions:</u>

QUESTION	**RESPONSE (please select ONE)**				
Does your job require overnight travel?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Are you able to fall asleep and awaken on a day to day, week to week basis according to your schedule?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you nap during the day or evening?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you feel refreshed after a typical night's sleep?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you feel refreshed after a short nap?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you get sleepy while driving?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Have you had an accident or near-accident when driving due to excessive sleepiness?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you fall asleep when you want to stay awake (movies, theater, church, watching TV)?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Are you able to fight off excessive sleepiness?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you have memory or concentration problems?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS

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Patient Name: ____ Today's Date: ____________________

Please select the correct response to the following questions:

Question					
Do you experience vivid, dreamlike scenes upon awakening or falling asleep?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
When you are angry or laugh, do you ever feel as though you might fall?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Are you ever unable to move or speak upon falling asleep or awakening?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you ever have trouble falling asleep when you first go to bed?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
When you try to fall asleep, does your mind race with many thoughts?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
When you try to fall asleep do you feel pain?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Does pain ever wake you up, disrupt your sleep, or keep you from going back to sleep?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Are you a light sleeper, easily awakened?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Is your sleep disturbed because of your bed-partner or others in your household?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you snore?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Does your snoring stop for brief periods during the night (as seen by others)?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Does your breathing stop during sleep (as seen by others)?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Is your bed partner disturbed by your snoring?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you wake up choking or gasping for breath?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you have night sweats?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you have heartburn at night?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you have nasal / sinus congestion at night?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Are you a restless sleeper, tossing and turning at night?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you experience any type of leg or back pain during the night?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you wake up with sore or aching muscles or joints (including leg or back pain)?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you grind or clinch your teeth during sleep?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Did you walk or talk in your sleep as a child or adolescent?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you now walk or talk in your sleep?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS
Do you have frightening dreams or nightmares?	☐ NEVER	☐ RARELY	☐ OCCASIONALLY	☐ FREQUENTLY	☐ ALWAYS

Are there any things you want us to know about your sleep problem? ____

____

____

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