APEX Pulmonary and Sleep Medicine

Marc E. Hofmann, MD, FCCP, FAASM

## PATIENT INFORMATION

NAME: Last _____ First _____ MI_____

BIRTH DATE: _____/ _____/ _____ GENDER: ☐ Female ☐ Male MARITAL STATUS: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____

EMPLOYER: _____

EMAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

**PRIMARY INSURANCE:** _____ **SECONDARY INSURANCE:** _____

**Race**: ☐ Asian ☐ African American ☐ Caucasian ☐ Native American ☐ Hispanic ☐ American Indian ☐ Native Hawaiian ☐ Pacific Islander ☐ More than one race ☐ Other ☐ Declined **Ethnicity**: ☐ Latino/Hispanic ☐ Other ☐ Declined

**Do you have a living will?** ☐ Yes ☐ No **Do you have a power of attorney?** ☐ Yes ☐ No

Primary Care Physician: _____ Phone: ( ) _____-_____

Preferred Pharmacy: _____ Location: _____ Phone: ( ) _____-_____

## CONSENT TO TREAT/CONFIDENTIALITY

### Consent to Treat — Initials _____

I am voluntarily seeking medical treatment. I consent to examination and treatment by the physicians, nurses, and other health care professionals at Apex Pulmonary and Sleep Medicine PLLC. I also consent to any medical procedures, PFT's, sleep study, laboratory tests, or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

### Medical Records — Accept ☐ Decline ☐

Medical records cannot be sent to your primary care physician or referring physician without written permission from you. To have any part of your records sent to your 'PCP' please check ACCEPT above. By your acceptance above and signature below you are giving us permission to release your records to the physician/physicians listed on your patient registration form.

### Confirmation of Appointments

As a courtesy to you, we have an automated appointment confirmation/reminder system. This information cannot be left on your voicemail or relayed to someone else without your written permission. If necessary, provide a person we can speak with below. By your check and signature below you are giving us permission to relay this information as stated.

☐ **OK To Leave Messages Regarding Appointments on Voicemail**

☐ **DO NOT Leave Messages Regarding Appointments on Voicemail**

### Test Results

Test results cannot be left on your voicemail or discussed with another family member, even if it is your spouse without your permission. Please print the name of the person we may speak with concerning test results in the space provided below. By your check and signature below you are giving us permission to release your test results as stated.

☐ **OK To Leave Test Results on Voicemail**

☐ **DO NOT Leave Test Results on Voicemail**

### Acknowledgement of Notice of Privacy Practices — Initials _____

I am verifying that I have been offered a copy of the privacy regulation form (HIPAA) which provides me with the information of how my Protected Health Information (PHI) is used.

Permission to speak with _____ regarding appointments and test results.

_____ _____

**Patient/Patient Representative Signature** **Date**

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# FINANCIAL RESPONSIBILITY AND INSURANCE CONSENT

I, the undersigned, do hereby agree and give my consent for Apex Pulmonary & Sleep Medicine, PLLC to furnish medical care and treatment to myself or _____ which is considered necessary and appropriate in diagnosing or treating my/their physical condition.

## STATEMENT OF FINANCIAL RESPONSIBILITY

All services rendered are the responsibility of the patient and co-pays, co-insurances, and deductibles are due at the time of service. As a courtesy to our patients, we will file with your insurance carrier. The patient is responsible for all fees, regardless of insurance coverage or the usual and customary fees provided by your insurance company. Payment is expected at time of treatment unless prior arrangements have been made with our office. I understand that I will be responsible for a service charge for any returned checks. *In the event that your account is placed with a collection agency, a collection fee of up to 33.3% may be added to your account and shall become a part of the total amount due. In the event your account is place with an attorney, you will be responsible for reasonable attorney fees and court costs. You agree, that in order for us to service your account or to collect any amounts you may owe, we and our collection agencies may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We and our collection agencies may also contact you by sending text messages and/or emails, using any email address you provide to use. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, if applicable.*

## INSURANCE AUTHORIZATION AND BENEFITS ASSIGNMENT

I hereby authorize Apex Pulmonary & Sleep Medicine, PLLC to release all information necessary, including medical records, requested by insurance companies with whom I have coverage and any public agency or its agents to secure payment for myself or my dependents. I hereby authorize payment of benefits to be made directly to Apex Pulmonary & Sleep Medicine for services provided to me or my dependents.

## MEDICARE ONE-TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Apex Pulmonary & Sleep Medicine, PLLC for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable for related services.

## MEDIGAP AUTHORIZATION

I request that payment of authorized Medigap benefits be made on my behalf to Apex Pulmonary & Sleep Medicine, PLLC for any services furnished me by that provider. I authorize any holder of medical information about me to release any information needed to determine those benefits or the benefits payable for related services to my Medigap carrier.

## CLAIM FILING CONSENT

I also agree to give Medical Insurance Filing Services, Inc. authorization necessary to file insurance for medical claims on behalf of Apex Pulmonary & Sleep Medicine, PLLC.

## DISCUSSION OF YOUR ACCOUNT/PAYMENT RESPONSIBILITY

We cannot discuss your bill with anyone without written permission (this includes your spouse or any other family member) unless they have a power of attorney letter on file. If you would like us to be able to discuss your bill with someone other than you, please state the person or persons name and relationship below.

**Person authorized to speak regarding my billing account/insurance:** _____

**Relationship to patient:** _____

**DO NOT Speak to ANYONE about my billing account/insurance** ☐

Print Patient's Name _____ DOB _____

_____ _____

Patient/Patient Representative Signature Date

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# PATIENT AGREEMENT FOR PRESCRIPTIONS AND/OR CONTROLLED SUBSTANCES

**PATIENT NAME:** _____ **DOB:** _____

The purpose of this agreement is to prevent misunderstandings about medications you may be prescribed and ensure that you and your physician comply with all laws regarding the prescribing and use of controlled pharmaceuticals including DEA schedule II and IV medications (sleep aids, stimulants, wake promoting agents, and sleep consolidating agents).

This agreement also allows Dr. Hofmann and Apex Pulmonary and Sleep Medicine health care providers/employees to prescribe medications electronically mandated by state and federal laws.

I understand that this agreement is essential to the trust and confidence necessary in a doctor-patient relationship and that my doctor undertakes to treat me based on this agreement; and, that if I break this agreement, my doctor may stop prescribing controlled substances medications for me and may terminate me from further treatment at Apex Pulmonary and Sleep Medicine, PLLC. Unless otherwise indicated, **all controlled substances will be electronically prescribed to a pharmacy that accepts electronic prescribing of controlled substances (EPCS)**.

**Females only** – I certify that I am not pregnant. I agree and understand that it is my responsibility to notify my doctor if I believe I may be pregnant. I agree not to take any medication without a physician's approval if I become pregnant.

***I will not use any illegal controlled substances, including marijuana, cocaine, or heroin. Opioids will not be prescribed by Dr. Hofmann or any health care provider at Apex Pulmonary and Sleep Medicine, PLLC.***

I will not share, sell, or trade my medications with anyone.

I will not attempt to obtain controlled medicines, stimulants, or anti-anxiety medicines from anyone else, including other doctors, without Dr. Hofmann's knowledge.

I agree that refills of my prescriptions will be in alignment with all laws regarding the prescription/s and use of controlled pharmaceuticals and should be obtained only during routine office visits. It is understood that emergency refill requests may only be obtained during regular office hours Monday-Thursday 9am-4pm and Friday 9am-3pm. ***NO REFILLS WILL BE AVAILABLE AFTER HOURS, ON WEEKENDS, ON HOLIDAYS, OR WHEN THE CLINIC IS CLOSED.***

I will safeguard my medicine. No allowance/refills will be made for lost or stolen prescriptions. I will notify Apex Pulmonary and Sleep Medicine of any lost or stolen medication as soon as possible during normal business hours. I agree to contact the appropriate authorities i.e., Police, in the case of stolen controlled prescription medication.

I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency, or the board of pharmacy in the investigation of any possible misuse, sale or other diversion of my prescribed medication/s. I authorize my doctor to provide a copy of this agreement to my pharmacy. I waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I agree that if it is required to determine my compliance with medication/s management program and this agreement, I may be requested to submit to random drug testing, at my expense.

I agree that I will use my medicine at a rate no greater than the prescribed rate and I understand that the use of my medicine in a greater rate may result in my death.

I attest that the above guidelines have been fully explained to me and that my questions and concerns regarding my treatments have been adequately answered. I have been given/offered a copy of this agreement.

**I agree to use ONLY the following pharmacy for filling prescriptions of all controlled substances:**

| **Pharmacy Name** | **Address** | **Phone Number** |
|---|---|---|

_____ _____

Patient/Patient Representative Signature Date

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# PATIENT PORTAL USAGE POLICY

Over 5 million Americans have an easier way to reach their medical practice…and so can you!

Apex Pulmonary and Sleep Medicine, PLLC has partnered with Greenway Healthcare Solutions and KRYPTIQ to provide our valued patients with enhanced access and communications with our practice and providers through our secure HIPAA compliant patient portal. The portal is a gateway for registered patients to safely and securely communicate with their health care team to request appointments or prescription refills, submit questions about your personal health or account, review an electronic copy of your health summary, and receive reports from your physician, such as lab reports. Unlike our practice's office operations, the portal provides convenient, 24-hour, self-service options allowing patients to handle business and clinical operations with the practice at their convenience.

## Policies and Limitations:

The patient portal is provided as a courtesy to patients and is an optional service that we reserve the right to suspend or terminate at any time. While we strive to keep all the information in your records complete and accurate, if you identify an error or discrepancy, you agree to notify us immediately. Additionally, by using the patient portal the user agrees to provide factual and correct information. The following policies and limitations apply:

1. **Do not use portal communication if there is an emergency; dial 911 or go to the Emergency Room.**
2. No internet-based triage and treatment requests. Diagnosis can only be made, and treatment rendered after the patient schedules and **sees** the provider.
3. Sensitive or complex subject matter (HIV, mental health, work excuses, etc.) is not permitted.
4. Medication, prescriptions, and refills will be filled according to our regular clinic policy.
5. After you agree to the Policy and Procedures and sign the Consent Form, we will attempt to register you in the portal and an invitation will be sent via email from myhealthrecord.com for you to complete your patient portal registration.
6. We will normally respond to non-urgent inquiries/questions within 24 hours, but no later than 3 business days after receipt. *If you have not received a response from us within 3 working days, please CALL the office at 901-842-1392.

## Guidelines and Security:

Apex Pulmonary and Sleep Medicine, PLLC offers secure viewing and communication as a service to our patients who wish to view parts of their records and communicate with our staff. While we believe that our IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. All new and established patients have signed our HIPAA agreement form and have been given a copy of our Notice of Privacy Practices. Secure messaging can be a valuable communications tool but has certain risks. In order to manage these risks, we need to impose some conditions of participation. By signing our Consent Form, you accept the risks and agree to the conditions of participation. Please keep all portal access, user information, and instructions in a secure place. Once logged into the portal, you can go to 'Edit Account' on the top left to change your User ID or Password.

## Protecting Your Private Health Information and Risks:

While we try to ensure that all communication through the portal is secure, keeping it secure depends on two additional factors: portal communications and messaging must reach the correct email address and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you, the patient, can make sure these two factors are present. We need you to make sure we have your correct email address and you MUST inform us if it changes. If you think someone has learned your password, you should promptly go to the Patient Portal and change it. If you forgot your password, please use the 'Forgot Password' option on the portal or call the office. We understand the importance of privacy regarding your healthcare and will continue to strive to make all information as confidential and secure as possible. We will never purposefully share or give away any private information, including your email address.

**PLEASE DO NOT RETURN THE PATIENT PORTAL USAGE POLICY TO OUR OFFICE**
**KEEP THIS INFORMATION FOR YOUR RECORDS**

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# PATIENT PORTAL CONSENT FORM

Apex Pulmonary and Sleep Medicine, PLLC is offering this secure, confidential communication tool as a courtesy to our patients. It is an optional service, and we may suspend or terminate it at any time and for any reason. You acknowledge that using the patient portal is entirely voluntary and your access will not impact the quality or current level of care you receive from Apex Pulmonary and Sleep Medicine, PLLC. In addition, you agree to adhere to the policies set forth herein, as well as any other instructions or guidelines that may be imposed for online communications. You understand that this agreement will remain in effect for 12 months unless sooner modified or terminated by either party. It is your responsibility to notify Apex Pulmonary and Sleep Medicine, PLLC if there is a change to your email account or you feel that your secure password has been breached. Secure messaging and information can only be viewed by someone entering a correct username and password to log into the Patient Portal/myhealthrecord.com site. You will be emailed an invitation to complete your portal registration upon completion of this form. You agree not to hold Apex Pulmonary and Sleep Medicine, PLLC or any of its staff liable for network infractions beyond their control. **By signing below, you acknowledge that you have received, read, and fully understand Apex Pulmonary and Sleep Medicine's Patient Portal Usage Policy and understand the risks associated with online communications and consent to the conditions outlined herein.**

Patient Name: _____ Date of Birth: _____

Email address: _____
**Please provide a personal email address to which you have consistent, frequent access. DO NOT use your workplace email.**

***Spouse/representative accessing and managing patient's portal account/parent accessing child's portal***

Patient Representative Name: _____
Relationship to Patient: _____

Patient Representative Email Address: _____

Address: _____

_____

Phone Number: _____

Date of Birth: _____

_____ _____
Patient Signature Date

_____ _____
Patient Representative Signature Date

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# Examples of Use and Disclosure of Health Information (HIPAA)

For Treatment: We may disclose information obtained from you or produced by us in the process of treating you to doctors, nurses, technicians, health students, or other personnel involved in your care or the operation of our office. This information may be shared with other doctors, labs, pharmacies, diagnostic centers, or hospital personnel. This information may be in writing, computer generated data, or through telecommunications. For example, the information contained in your medical record, demographic information such as name, address, date of birth, social security number, and specific identifying health information, descriptions of symptoms, and test results. We may disclose information to family members or other caregivers identified by you for us to release information to.

For Payment: We may disclose information to any third party involved in the payment for services received from our office. This may be for prior approvals for treatment, completion of insurance forms, and other collection activities. Information disclosed may be demographic information mentioned above along with dates of services and specific services provided to you.

For Health Care Operations: We may disclose information to our staff in the process of the normal operation of our practice. This may be through the developing and maintenance of medical records, billing and insurance systems, or for the evaluation of the performance of our staff in caring for you. We may disclose information to our business associates in the process of obtaining outside transcription services, software support of our computerized billing systems, medical records storage, for training, protocol and clinical guideline development, quality assessment activities, legal services, and insurance. We may also disclose information by an automated appointment reminder system.

*We may disclose information without authorization for the following reasons:*

Emergencies: In the event of an emergency treatment, we may share information with other health care workers to obtain immediate care for you.

As required by law: You will be notified of any such disclosures.

Public Health Activities: To prevent or control disease, injuries, or disability. To report births, deaths, child abuse or neglect, victims of abuse or neglect, or in the case of suspected domestic violence, reactions to medication, or problems with products, to assist in notification of recalls of products or medications, according to FDA regulations.

Health Oversight Agencies: For activities authorized by law, such as audits, investigations, and inspections including oversight by government agencies, benefit programs, or other regulatory agencies and civil rights boards.

Legal Proceedings: In the course of judicial or administrative proceedings in response to an order of the court or tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Coroners, Funeral Directors, and Organ Donation Services: For the purpose of determination of death or identification or in the process of assisting these agencies in the performance of their duties as authorized by law. We may disclose information in reasonable anticipation of death when a willing donor has been identified and as authorized by law.

Research: We may disclose information to researchers when their research has been approved by an institutional review board and the assurance of privacy and established protocols are followed.

Military and Veterans: If you are a member of the armed forces, we may release information as required by military command authorities.

Worker's Compensation: We may release information about you for worker's compensation or similar programs providing benefits for work related injuries or illness.

This notice is provided to you as required by the Privacy Regulations of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and is designed to inform you of how your Protected Health Information (PHI) is used and disclosed in the provision of health care services to you and your rights to this information. This notice is effective as of April 30, 2020.

## Examples of Use and Disclosure of Health Information (HIPAA) continued

Apex Pulmonary and Sleep Medicine, PLLC, its physicians, staff, business associates, and other related medical personnel will abide by all Federal and State laws to protect the privacy of information that identifies you and will disclose only the minimum information required for your treatment, operations of our health care practice, to obtain payment from a third party, to contact you through an automated appointment reminder system and as required by federal, state, or local laws, to advert a serious threat to your health or safety, or in the case of a workers' compensation for the review and treatment required by law, for public health risks, for health oversight activities for legal law enforcement activities and coroner or funeral directors duties under legal guidelines for deceased persons, for national security and intelligence activities to protect the President and other Heads of State, and if you are an inmate to the correctional institution law enforcement officials of custody. If we engage in any research, we may disclose information to others in preparation to conduct this research. We ask for specific permission in that the researcher will have access to your name, address, and other identifying information.

The medical and billing records we maintain are the property of Apex Pulmonary and Sleep Medicine, PLLC. All requests for access or other information related to these rights must be submitted in writing to our office. You have the right to submit a written request for a copy of your records. We may charge for a copy of your record in accordance with state law. You have the right to request that we amend this information, and we will abide by the regulations for this amendment. You have the right to request a list of disclosures of information, other than for the treatment and obtaining of care on your behalf, after April 30, 2020 and for a period of no longer than six years. If we are unable to provide this list within 30 days of your request, we may request an extension of time of an additional 30 days. You have a right to request restrictions of limitations on the disclosure of your PHI but we are not required to agree to your request if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. You may also request confidential communications in writing.

This is a brief description of our policies and your rights in compliance with the HIPAA regulations. We will provide you with a more comprehensive description of the above upon request. We have provided examples of the above types of disclosures. We reserve the right to change this notice to comply with any changes in federal or state laws and will provide you with a new notice upon your next visit to our clinic after such changes.

If you believe your privacy rights have been violated, you may file a complaint with us without retaliation by writing to our Administrator at Apex Pulmonary and Sleep Medicine, PLLC, 130 Timber Creek Dr., Cordova, TN, 38018 or contact the Secretary of the Department of Health and Human Services.

**PLEASE DO NOT RETURN HIPAA NOTICE TO OUR OFFICE**
**KEEP THIS INFORMATION FOR YOUR RECORDS**

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# PATIENT RIGHTS AND RESPOSIBLITIES

## APEX Pulmonary and Sleep Medicine, PLLC RESPONSIBILITIES

As an individual receiving health care services from our organization, let it be known and understood that you have the following rights:

- To receive the appropriate or prescribed service in a professional manner without discrimination relative to your age, sex, race, religion, ethnic origin, sexual preference or physical or mental handicap.
- To be promptly informed if the prescribed care or services are not within the scope, mission, or philosophy of Apex Pulmonary and Sleep Medicine, PLLC and therefore be provided with transfer assistance to an appropriate care or service organization.
- To be dealt with and treated with friendliness, courtesy and respect by each and every individual representing Apex Pulmonary and Sleep Medicine, PLLC who provides treatment or services for you, and be free from neglect or abuse be it physical or mental.
- To have your privacy and your property respected at all times.
- To assist in the development and planning of your health care program that is designed to satisfy, as best as possible, your current needs.
- To be provided with adequate information from which you can give your informed consent for the commencement of service, the continuation of service, the transfer of service to another health care provider, or the termination of service.
- To express concerns or grievances or recommend modifications services provided without fear of discrimination or reprisal.
- To request and receive complete and up-to-date information relative to your condition, treatment, alternative treatments, risks of treatment within the physician's legal responsibilities of medical disclosure.
- To receive care and services within the scope of your health care plan, promptly and professionally, while being fully informed as to Apex Pulmonary and Sleep Medicine, PLLC's policies, procedures, and charges.
- To refuse care, within the boundaries set by law, and receive professional information relative to the ramifications or consequences that will or may result due to such refusal.
- To request and receive data regarding services or costs thereof privately and with confidentiality.
- To request and receive the opportunity to examine or review your medical records.
- To formulate an advance directive such as a Living Will or a Durable Power of Attorney for Health Care.
- To expect that all information received by Apex Pulmonary and Sleep Medicine, PLLC shall be kept confidential and shall not be released without written consent.
- To be involved, as appropriate, in discussions and resolutions of conflicts and ethical issues related to your care.
- To be informed of any experimental or investigational studies that are involved in your care and be provided the right to refuse any such activity.
- To the assessment and management of pain and discomfort.
- As a patient of Apex Pulmonary and Sleep Medicine, PLLC you can expect that your reports of pain will be believed, and our concerned staff will quickly respond to your concerns by contacting and informing the Medical Directors.

## PATIENT RESPONSIBILITIES

As a patient of Apex Pulmonary and Sleep Medicine, PLLC you have the responsibility to:

- Give accurate and complete heath information concerning your past illnesses, hospitalization, medication, allergies, infections, diseases, and other pertinent items.
- Assist in developing and maintaining a safe environment.
- Inform Apex Pulmonary and Sleep Medicine, PLLC when you will not be able to keep an appointment.
- Request further information concerning anything you do not understand.
- Contact your doctor whenever you notice a change in your condition.
- Contact Apex Pulmonary and Sleep Medicine, PLLC whenever you have an equipment problem.
- Contact Apex Pulmonary and Sleep Medicine, PLLC whenever you have received a change in your prescription.
- Give information regarding concerns and problems you have to Apex Pulmonary and Sleep Medicine, PLLC.
- Ensure that the financial obligation for your equipment is fulfilled as promptly as possible.
- Maintain and repair purchased equipment when equipment is no longer under warranty.
- Follow equipment care procedures as outlined on equipment orientation form if applicable.
- Follow the no smoking policy of Apex Pulmonary and Sleep Medicine, PLLC without exceptions.

**PLEASE DO NOT RETURN THE PATIENT RIGHTS AND RESPONIBILITIES TO OUR OFFICE**
**KEEP THIS INFORMATION FOR YOUR RECORDS**

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# ADULT MEDICAL HISTORY/QUESTIONNAIRE-NEW PATIENT

Name: _____ Date: _____
Insurance Carrier: _____ Referring Physician: _____
Birth date: _____ Age: _____ Sex: _____
Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐
Height: _____ Weight: _____ Neck Size: _____
Reason for visit:
_____

| General Sleep | | | |
|---|---|---|---|
| Do you snore? | Yes | No | Describe: |
| Do you choke in your sleep? | Yes | No | Describe: |
| Do you gasp in your sleep? | Yes | No | Describe: |
| Do you stop breathing in your sleep? | Yes | No | Describe: |
| Do you wake up because of snoring? | Yes | No | Describe: |
| Do up wake up because of choking? | Yes | No | Describe: |
| Do wake up because of gasping? | Yes | No | Describe: |
| Have you been told that you snore? | Yes | No | Describe: |
| Have you been told that you choke in your sleep? | Yes | No | Describe: |
| Have you been told that you gasp in your sleep? | Yes | No | Describe: |
| Have you been previously diagnosed with sleep apnea? | Yes | No | Describe: |
| Are you currently on CPAP or Bi-Level therapy? | Yes | No | Describe: |
| Are you having trouble with CPAP or Bi-Level therapy? | Yes | No | Describe: |
| If not on CPAP/Bi-Level therapy, why? | | | |
| If not on CPAP/Bi-Level therapy, what therapy are you on? | | | |

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| | | | | |
|---|---|---|---|---|
| Do you have difficulty initiating or maintaining sleep? | Yes | No | Describe: | |
| Are you bothered by waking up too early and not being able to get back to sleep? | Yes | No | If yes, please describe: | |
| Do you feel like you get to little sleep at night or during your sleep period? | Yes | No | If yes, please describe: | |
| Do you feel tired and non-refreshed when you wake up in the morning or after your sleep period? | Yes | No | If yes, please describe: | |
| How many minutes are you awake before you finally get up? | Minutes: | | | |
| On average, how long do you sleep at night or during your sleep period? | Hours: | | | |
| Are you bothered by sleepy spells during the day? | Yes | No | If yes, please describe: | |
| Do you take naps? | Yes | No | If yes, how long:<br>Feel better afterwards? Y N | |
| Are you bothered by nightmares? | Yes | No | If yes, please describe: | |
| Are you afraid of going to sleep? | Yes | No | If yes, please describe: | |
| How long have you had your sleep problem? | Weeks: | | Months: | Years: |
| How long does it take you to fall asleep at night? | Minutes: | | Hours: | |
| How many nights per weeks do you have a sleep problem? | Nights/week: | | | |
| What time do you usually go to bed? | AM: | | PM: | |
| What time do you usually get up? | AM: | | PM: | |

On average, how many times do you wake up during the night or during you sleep period?
Times/night:

Why do you wake?
Describe:

| **Have you ever been told or are you aware of having unusual behavior or activity during sleep such as?** | | | |
|---|---|---|---|
| Muscle twitches | Yes | No | If yes describe: |
| Leg discomfort | Yes | No | If yes describe: |
| Leg kicking | Yes | No | If yes describe: |
| Acting out of dreams | Yes | No | If yes describe: |
| Yelling out | Yes | No | If yes describe: |
| Punching | Yes | No | If yes describe: |
| Violent behavior | Yes | No | If yes describe: |

| **When sitting quietly for prolonged periods or when lying down to go to sleep (just prior to falling asleep) do you suffer from:** | | | |
|---|---|---|---|
| A desire to move the limbs, often associated with abnormal sensations or movements? | Yes | No | If yes describe: |
| Symptoms that are worse or present only during rest and are partially or temporarily relieved by activity? | Yes | No | If yes describe: |
| Motor restlessness? | Yes | No | If yes describe: |
| Nighttime worsening of symptoms? | Yes | No | If yes describe: |

| | | | |
|---|---|---|---|
| Have you ever fallen asleep while at a stoplight or driving? | Yes | No | If yes, describe: |
| Have you ever fallen asleep at inappropriate times? For example, during a conversation? | Yes | No | If yes, describe: |
| Have you ever fallen asleep or have generalized weakness while laughing, hearing or telling a joke, or if upset? | Yes | No | If yes, describe: |
| Do you have vivid dreams upon falling asleep or awakening from sleep? | Yes | No | If yes, describe: |
| Have you ever had periods of immobility upon awakening from sleep? | Yes | No | If yes, describe: |

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| **Do you engage in activities that keep you from falling asleep at night, such as?** | | |
|---|---|---|
| Watching TV? | Yes | No |
| Computer/cell phone usage? | Yes | No |
| Listening to music? | Yes | No |
| Reading? | Yes | No |
| Smoking? | Yes | No |
| Alcohol consumption? | Yes | No |
| Excessive caffeine intake? | Yes | No |
| Excessive eating/drinking? | Yes | No |

| **Do you:** | | |
|---|---|---|
| Stick to a sleep schedule? | Yes | No |
| Get enough morning sunlight after waking? | Yes | No |
| Exercise regularly? | Yes | No |
| Avoid daytime napping? | Yes | No |
| Avoid post-lunchtime caffeine? | Yes | No |
| Avoid nighttime nicotine? | Yes | No |
| Wind down before bedtime? | Yes | No |
| Keep bedroom cool, quiet, dark, comfortable? | Yes | No |

| | | | | |
|---|---|---|---|---|
| Does your mind race when you lay down to fall asleep? | Yes | No | | |
| Do you clock watch if unable to fall asleep? | Yes | No | | |
| What do you do or use to help you fall asleep? | Describe: | | | |
| Have you gained weight recently? | Yes | No | If yes, how much over how long? | |
| Are you aware of anything that disturbs your sleep such as indigestion, noise, pain, heart problems? | Yes | No | If yes, please describe: | |
| Do you wake up with any of the following? | Headache | Yes | No | |
| | Dry mouth | Yes | No | |
| | Sore throat | Yes | No | |
| Are you under any stress or feel depressed or anxious? | Yes | No | If yes, please describe: | |

| | | | |
|---|---|---|---|
| Do you have chronic nasal congestion? | Yes | No | |
| Do you have difficulty breathing through your nose? | Yes | No | |
| Have you had any trauma to your nose? | Yes | No | Describe: |
| Have you ever been told that you have a small airway? | Yes | No | |
| Have you ever been told that you have a deviated septum? | Yes | No | |
| Have you ever been told that you have enlarged tonsils? | Yes | No | |
| Do you still have your tonsils? | Yes | No | |

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**Patient Medical History (Circle ALL that apply)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chronic bronchitis or cough | Asthma | COPD/ emphysema | Diabetes | Cholesterol | Stroke | Sleep walking | Parkinson's disease |
| Hyperthyroidism | Hypothyroidism | Heart disease | Cerebral palsy | Cancer | Autoimmune disease | Sleep talking | Dementia |
| Rhinitis/sinusitis | Seizures | Sleep apnea | ESRD | Migraine/ chronic headaches | Depression | Nightmares | Vision problems |
| Anxiety | Bipolar disorder | Chronic pain | GERD | Narcolepsy | Insomnia | Obesity | Hearing problems |
| Suicide attempt | Psychiatric admission | Chromosomal abnormalities (Down's) | Throat infections | Hypertension | Myocardial infarction | CHF | Coronary artery disease |

Other: _____

**Surgical History (Circle ALL that apply)**

| | | | | | |
|---|---|---|---|---|---|
| Tonsillectomy | Adenoidectomy | Nasal septal surgery | Sinus surgery | Tracheostomy | Head or neck trauma |
| Uvulopalatopharyngoplasty (UPPP) | Coronary artery bypass | Cardiac stent | | | |

Other: _____

| **Social History** | | | |
|---|---|---|---|
| Tobacco: | Packs/day: | How long: | Quit when: |
| Alcohol: | How much: | How long: | Quit when: |
| Natural coffee: | Cups/day: | Decaf: | Cups/day: |
| Natural tea: | Cups/day: | Decaf: | Cups/day: |
| Caffeinated carbonated soft drinks: | Cans/glasses/day: | Decaf carbonated soft drinks: | Cans/glasses/day: |
| Social drug use (cocaine, heroin, marijuana, methamphetamine etc.): | How much: | How long: | Quit when: |

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| Medication History | | | |
|---|---|---|---|
| Medication Name | Dose | Frequency | Reason |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Allergy History |
|---|
| Seasonal allergies: |
| Medication allergies: |
| Food allergies: |

**Family History (Circle ALL that apply)**

| | | | | | |
|---|---|---|---|---|---|
| Coronary artery disease | Myocardial infarction/Heart Attack | Stroke | Hypertension | Diabetes | Asthma |
| COPD/emphysema | Glaucoma | Kidney disease | Liver disease | Blood clots | Cancer |
| Sleep apnea | Narcolepsy | Insomnia | Restless legs syndrome | Snoring | |
| Thyroid disorder | Sleep Walking | Sleep talking | | Periodic limb movement disorder | |

Other: _____

| Occupational History | | | |
|---|---|---|---|
| Do you work? | Yes | No | Job description? |
| What shift? | | | |
| What hours? | | | |

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# EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, answer the following statements as to how likely you are to **doze off or fall asleep**. Think about your usual way of life in recent times when answering. Even if you have not done some of these things recently, try to answer, to the best of your ability, how they would affect you.

Use the following scale to choose the ***MOST APPROPRIATE*** number for each situation:

0 = would ***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 a public place (for example, 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 eating lunch (without alcohol)? | |
| In a car, while stopped for a few minutes in traffic? | |
| **Total:** | |

Answer the following questions to determine if you are at risk for Obstructive Sleep Apnea:

| **Answer the questions below** | | Yes | No |
|---|---|---|---|
| S (snoring) | Do you snore loudly? | | |
| T (tired) | Do you often feel tired, fatigued, or sleepy during the day? | | |
| O (observed) | Has anyone observed you stop breathing during your sleep? | | |
| P (blood pressure) | Do you have or are you being treated for high blood pressure? | | |
| B (BMI) | BMI >35? | | |
| A (age) | Age >50? | | |
| N (neck) | Neck circumference >16 in? | | |
| G (Gender) | Male? | | |

High risk of OSA: answering yes to >3 or more items.
Low risk of OSA: answering yes to <3 items.

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Below are groups of statements. Please read each group of statements carefully. Then pick out **one statement in each group** which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY**. Circle the number beside the statement you picked. Several statements in the group may seem to apply equally well. If so, then circle the number beside each statement. Be sure to read all the statements in each group before making your choice.

1. 0 I do not feel sad.
   1 I feel sad.
   2 I am sad all the time and cannot snap out of it.
   3 I am so sad or unhappy that I cannot stand it.

2. 0 I am not particularly discouraged about the future.
   1 I feel discouraged about the future.
   2 I feel I have nothing to look forward to.
   3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
   1 I feel I have failed more than the average person.
   2 As I look back on my life, all I can see is a lot of failures.
   3 I feel I am a complete failure.

4. 0 I get as much satisfaction out of things that I used to.
   1 I do not enjoy things the way I used to.
   2 I do not get real satisfaction out of anything anymore.
   3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
   1 I feel guilty a good part of the time.
   2 I feel quite guilty most of the time.
   3 I feel guilty all the time.

6. 0 I do not feel I am being punished.
   1 I feel I may be punished.
   2 I expect to be punished.
   3 I feel I am being punished.

7. 0 I do not feel disappointed in myself.
   1 I am disappointed in myself.
   2 I am disgusted with myself.
   3 I hate myself.

8. 0 I do not feel I am any worse than anybody else.
   1 I am critical of myself for my weaknesses or mistakes.
   2 I blame myself all the time for my faults.
   3 I blame myself for everything bad that happens.

9. 0 I do not have any thoughts of killing myself.
   1 I have thoughts of killing myself, but I would not carry them out.
   2 I would like to kill myself.
   3 I would kill myself if I had the chance.

10. 0 I do not cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now.
    3 I used to be able to cry, but now I cannot cry even though I want to.

11. 0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to
    2 I feel irritated all the time.
    3 I do not get irritated at all by the things that used to irritate me.

12. 0 I have not lost interest in other people.
    1 I am less interested in other people than I used to be.
    2 I have lost most of my interest in other people.
    3 I have lost all my interest in other people.

13. 0 I make decisions about as well as I ever could.
    1 I put off making decisions more than I used to.
    2 I have greater difficulty in making decisions than before.
    3 I cannot make decisions at all anymore.

14. 0 I do not feel I look any worse than I used to.
    1 I am worried that I am looking old or unattractive.
    2 I feel that there are permanent changes in my appearance that make me look unattractive.
    3 I believe that I look ugly.

15. 0 I can work about as well as before.
    1 It takes an extra effort to get started at doing something.
    2 I must push myself very hard to do anything.
    3 I cannot do any work at all.

16. 0 I can sleep as well as usual.
    1 I do not sleep as well as I used to.
    2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
    3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I do not get any more tired than usual.
    1 I get tired more easily than I used to.
    2 I get tired from doing almost anything.
    3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
    1 My appetite is not as good as it used to be.
    2 My appetite is much worse now.
    3 I have no appetite at all anymore.

19. 0 I have not lost much weight, if any, lately.
    1 I have lost more than 5 pounds.
    2 I have lost more than 10 pounds.
    3 I have lost more than 15 pounds.
    I am purposely trying to lose weight by eating less. Yes or No

20. 0 I am no more worried about my health than usual.
    1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
    2 I am very worried about physical problems and it is hard to think of much else.
    3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent change in my interest in sex.
    1 I am less interested in sex as I used to be.
    2 I am much less interested in sex now.
    3 I have lost interest in sex completely.

Total: _____

APEX Pulmonary and Sleep Medicine

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# INSOMNIA SEVERITY INDEX

The Insomnia Severity Index has seven questions. 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 Worried At All | 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 (for example, fatigue, mood, ability to function at work/daily chores, concentration, memory, etc.) CURRENTLY?

| Not At All Interfering | A Little | Somewhat | Much | Very Much Interfering |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |

**Guidelines for Scoring/Interpretation:**

Add the scores for all seven items= _____ Your 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)

APEX
Pulmonary and Sleep Medicine

Marc E. Hofmann, MD, FCCP, FAASM

| GENERAL PULMONARY QUESTIONNAIRE *Only fill out if you are being seen for Pulmonary issues | | | |
|---|---|---|---|
| Do you have shortness of breath? | Yes | No | Describe: |
| Do you have shortness of breath at rest? | Yes | No | Describe: |
| Do you have shortness of breath with exertion? | Yes | No | Describe: |
| How far can you walk before you get short of breath and need to rest? | Yes | No | Describe: |
| Do you have a chronic and persistent cough? | Yes | No | Describe: |
| Do you cough up sputum/phlegm? | Yes | No | Describe: |
| Do you wheeze? | Yes | No | Describe: |
| Do you experience chest tightness with exertion? | Yes | No | Describe: |
| Do up experience chest tightness after exercise? | Yes | No | Describe: |
| How far can you walk before you get short of breath and need to rest? | Yes | No | Describe: |
| Are you on oxygen therapy? | Yes | No | Describe: |
| Are you on inhaler therapy? | Yes | No | Describe: |
| Have you had heavy exposure to smoke, dusts, fumes, asbestos, heavy metals, etc.? | Yes | No | Describe: |
| Which time of the year is worse for you in terms of breathing? | Yes | No | Describe: |
| How long have you had symptoms? | Yes | No | Describe: |
| Have you had a previous evaluation for your breathing problems? | Yes | No | Describe: |
| Have you had any recent hospitalizations for your condition(s)? | Yes | No | Describe: |
| Do you have significant sinus or post-nasal drip? | Yes | No | Describe: |
| Do you have recurrent chest infections? | Yes | No | Describe: |
| Do you have a strong family history of COPD? | Yes | No | Describe: |
| Do you have a strong family history of asthma? | Yes | No | Describe: |