CRITICAL CARE, PULMONARY & SLEEP ASSOCIATES
A PROFESSIONAL LLP

WELCOME TO OUR PRACTICE

We look forward to meeting you and helping you resolve your health concerns. Please complete the enclosed paperwork and bring it to your appointment. **We wish you the best of health and look forward to working with you.**

Locations

Our primary office is in Lakewood, we handle all scheduling and medical record requests through this office.

CCPSA West Clinic:
274 Union Blvd, Suite 200, Lakewood, CO 80228
Take 6th Avenue West, exit on the Union/Simms exit. Turn left (south) onto Union Blvd, our office is on the left (east) side, between the Sheraton Hotel and First Bank. The front door faces south.

CCPSA South Clinic:
10371 Parkglenn Way, Suite 230 Parker, CO 80134
Just over 1 mile south of Advent Health Parker Hospital.
Take CO-83 S / S Parker Rd. Turn left onto E. Plaza Drive
Merge to the left which will be Parkglenn way. Dairy Queen is on the corner. We will be on your left-hand side in the Parker Healthcare Center.

CCPSA North Clinic:
14300 Orchard Parkway, 3rd floor POD 2 Westminster, CO 80023
From I-25 North: Take 144th Avenue exit 226. Turn left on 144th Ave, and then turn left onto Delaware St. Park near the main entrance to the Common Spirit St. Anthony North Hospital, valet is available free of charge.
From I-25 South: Take 144th Avenue exit 226. Turn right on 144th Ave, then left onto Delaware St.

CCPSA Central Clinic:
206 W County Line Road, Suite 260 Highlands Ranch, CO 80129
Conveniently located off Broadway and C-470. Once you exit C-470 at Broadway, turn left if you were heading east or turn right if you were heading west. Take a left onto County Line Road and then take a left at the next stoplight. Our office building will be on the left-hand side. We are located on the second floor just off the elevator in suite 260.

The Goodland, Kansas location is a Satellite location. The medical assistants at this location may collect paperwork and copy insurance cards, but they do not have access to our medical records. If you have questions or need help with anything, please call our primary office at 303- 951-0600.

Patient Information

Please fill this out completely and accurately

Patient Information Date: ___________

Name: ____Date of Birth: ____________________

Address: ____________________________City: ____________State:______Zip:_____________

Phone: Home: Mobile: __________________Other: __________________

Sex: Female ☐ Male ☐

E-Mail: ____

Primary Care Physician: ______________________Referring Physician: ____________________

Marital Status: ____________Interpreter Needed: Yes /No Language: ____________________

Emergency Contact:

Name _______________________Phone__________________Relationship__________________

Insurance Information

Insurance Name:_____________________________Effective Date of Policy: _____________

Medicare ID (if applicable)_____________________________

Policy/ID# ___________________________Group Name & Number_____________________

Address____City State____Zip_____________

Secondary Insurance Information

Insurance Name:_____________________________Effective Date of Policy: _____________

Policy/ID# ___________________________Group Name & Number_____________________

Guarantor: This is the person who holds the insurance if other than patient

Name: ____Date of Birth: ______________________

Address: ______________________________City: ____________State:______Zip:___________

Phone: Home: ____________________Work: ____________________Other: ______________

Sex (circle one): Female Male

Employer: ___________________________Employer's Address: _________________________

Employment status (circle one): Full time Part time Student

CRITICAL CARE, PULMONARY & SLEEP ASSOCIATES
A PROFESSIONAL LLP

Consent to Leave or Send Medical Information

To protect your privacy and conform with the Health Insurance Portability and Accountability Act, we have developed a policy on leaving medical information.

Without your written consent:

1) We will not discuss or leave medical information with anyone except the patient.
2) We will not leave any information on voicemail.
3) We will not mail or fax any information.

I, (printed name of patient) ______________________________ Date of birth_________________ give Critical Care, Pulmonary, and Sleep Associates permission to release my medical information to the following:

Please consider whom you want to have access to your medical information.

My voicemail #____________________________(home/mobile/work)
My voicemail #____________________________(home/mobile/work)
My fax #____________________________
My email ____
Name_____________________ Relation_______________ #_________________________
Name_____________________ Relation_______________ #_________________________
Name_____________________ Relation_______________ #_________________________
Name_____________________ Relation_______________ #_________________________

Medical information may be mailed to:
____
____
____

I fully understand that this consent will remain until revoked in writing.

___________________________ ____________________________________ __________
Patient /Proxy Printed Name Patient/Proxy Signature Date

Notice of Privacy Practices, Patient Rights, and Responsibility

You are responsible for understanding your insurance policy and the requirements therein, including referrals for specialists. Failure to obtain a referral may result in insurance refusal to pay for your office visit. In addition, you are responsible for all charges, which your insurance carrier may not pay. You agree to pay all co-pay amounts due at the time services are rendered.

By signing this form, you are granting consent to Critical Care, Pulmonary and Sleep Associates, Prof. LLP to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, we will notify you. You may obtain a copy of the notice by contacting us at 303-951-0600. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

Critical Care, Pulmonary & Sleep Assoc. endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

You authorize payment of medical benefits to be paid directly to Critical Care, Pulmonary and Sleep Associates, Prof. LLP as indicated by the signature on file/accept assignment on the claim form. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Our practice may use secure digital tools, including artificial intelligence (AI), to support clinical, operational, and administrative functions. These tools may assist with tasks such as documentation, scheduling, care coordination, quality improvement, and analysis of health information to support your care. AI tools do not replace clinical judgment. All medical decisions, diagnoses, and treatment recommendations are made by licensed healthcare professionals. Any AI or digital tools used by our practice are subject to strict privacy, security, and contractual requirements to protect your information.

I understand that Critical Care, Pulmonary and Sleep Associates honors and adheres to the laws and principles of The Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Rule therein.

Signature is certification that you have read and understand the above and that the information you have provided is true and correct.

______________________________	____	___________
Patient /Proxy Printed Name	Patient/Proxy Signature	Date

CRITICAL CARE, PULMONARY & SLEEP ASSOCIATES
A PROFESSIONAL LLP

Patient Rights The right to:

- Be informed of your patient rights in advance of receiving or discontinuing care when possible.
- Be communicated with in a manner you can understand which considers your age, language, understanding and ability including, but not limited to, access to sign language interpreter services and communication aides, at no cost. Such communication will include communication with your companion
- Receive safe, respectful, nondiscriminatory care in accordance with the Colorado Anti-Discrimination Act (CADA).
- To be accompanied by a service animal, as defined by the Americans with Disabilities Act (ADA), in all areas of the practice where patients are normally allowed to go. Service animals must *remain under the control of their handler at all times* and may be excluded only if the animal is out of control or poses a direct threat to the health or safety of others.
- Be informed of the names and functions of all physicians and other health care professionals who provide direct care to the patient.
- Be informed of your diagnosis, treatment options, risks, benefits, and outcomes.
- Be free from all forms of abuse, neglect, mistreatment, or exploitation.
- Be involved in treatment decisions.
- Be treated with respect and dignity.
- To receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- To receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- Give informed consent or refuse treatment within legal limits.
- Have access to your medical records within a reasonable timeframe
- Have Privacy and confidentiality as outlined in the Notice of Privacy Practices

Patient Responsibilities

- To provide the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- To report unexpected changes in his or her condition to the health care provider.
- To report to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- To follow the treatment plan recommended by the health care provider.
- To keep appointments and, when he or she is unable to do so for any reason, for notifying the health care provider
- To assume responsibility for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- To assure that the financial obligations of his or her health care are fulfilled as promptly as possible.
- To follow health care facility rules and regulations affecting patient care and conduct.
- To follow facility policies, procedures, rules and regulations
- To be considerate of the rights of other patients and facility personnel
- To treat staff, patients, and visitors respectfully. Verbal or physical intimidation, sexual harassment, violence, or the threat of violence towards anyone will not be tolerated and will be reported to the appropriate authorities as appropriate. Such behavior will lead to immediate patient dismissal from practice.

Signature is certification that you have read and understand the above and that the information you have provided is true and correct.

Patient /Proxy Printed Name	Patient/Proxy Signature	Date

CRITICAL CARE, PULMONARY & SLEEP ASSOCIATES
A PROFESSIONAL LLP

What to Expect

We are partners in your health care. Our goal is to provide our patients with excellent and timely health care. We need your active participation to make that happen. PRIOR TO YOUR APPOINTMENT

- We will make every attempt to gather your relevant medical records prior to your appointment.
- If your appointment has been scheduled less than 2 weeks prior, we may ask you to bring discs with imaging (chest x-rays, CT, or PET scans) to your appointment.
- **Please call your insurance company to clarify if you need a referral**.
- If your insurance requires a referral from your PCP to see a specialist, we will need this before your appointment

DAY OF YOUR APPOINTMENT

- We ask that you arrive 15 minutes before your scheduled appointment, if you have not completed your paperwork, please arrive 30 minutes before your scheduled appointment.
- If you are more than 10 minutes late, we may ask you to reschedule your appointment.
- If you do not have proper paperwork completed, we may ask you to reschedule your appointment.
- **If you are a pulmonary patient**, we will do a breathing test & 2-3min exercise test as part of your visit.
- **If you are a sleep patient on PAP therapy**, please bring your PAP machine and data card to the appointment.

AFTER YOUR VISIT

- The physician will send the consult note to your primary care doctor and specialists within 2 business days.
- Orders for diagnostic tests or medical equipment (oxygen or PAP therapy) are sent within 2 business days.
- Testing can be delayed due to insurance requirements for prior authorization.
- If you are a sleep patient prescribed CPAP, please contact us when you receive your equipment.
- If you are not contacted about STAT testing or equipment within 24 hours, please call our office.
- If you are not contacted about testing or equipment within 10 business days, please call our office.

TEST RESULTS

Per CCPSA policy (which all patients acknowledge), test results are typically released within the timeframes below after your test is completed. **While some results may be posted sooner, providers require time to review and interpret all results before communicating them to you.**

- CT scans & chest X-rays: Available within 1–2 weeks
- Home or hospital sleep studies: Available within 1 month, unless results are deemed urgent
- Nocturnal oximetry: Available within 1 month
- Pulmonary function tests (PFTs): Available within 2–4 weeks
- Laboratory tests (blood & pathology): Available within 1–2 weeks (Some cultures may take up to 8 weeks)

If you are experiencing delays receiving durable medical equipment (oxygen, PAP devices, etc.) please contact the Durable Medical Equipment company.

PRESCRIPTION REFILLS

- Please contact your pharmacy and have them fax prescription request to your physician.
- Allow 24-48 business hours for routine prescription renewals.
- Please request a refill when you have 10 to 14 days left on your prescription so that you do not run out of your medication. **We will not refill any prescriptions via the answering service after hours or on weekends.** Refills must go through your pharmacy or be requested during normal business hours.
- Some refills may also require an office visit, particularly when you have not been seen by your physician for some time. This is to ensure that medications are used safely and effectively. Patients will be notified if an appointment is needed by the clinic.

My signature below acknowledges that I have read and understand the above statements.

____________________ ________________________ ________

Patient /Proxy Printed Name | Patient/Proxy Signature | Date

CRITICAL CARE, PULMONARY & SLEEP ASSOCIATES
A PROFESSIONAL LLP

General Consent for Care and Treatment

TO THE PATIENT*: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides Critical Care, Pulmonary and Sleep Associates with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. (3) you consent to a shared Electronic Health Record. (4) you consent to virtual, telephone, web and/or E-visits (as performed via the Patient Portal) and that these visits will be billed, and you are responsible for any co-pays, deductibles or other costs related to these services. (5) you consent to CCPSA using your contact information, including address, phone, (for both calls and text messages) and the online MyChart portal to contact you regarding future appointments and necessary care. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

Our practice may use secure digital tools, including artificial intelligence (AI), to support clinical, operational, and administrative functions. These tools may assist with tasks such as documentation, scheduling, care coordination, quality improvement, and analysis of health information to support your care. AI tools do no replace clinical judgment. All medical decisions, diagnoses, and treatment recommendations are made by licensed healthcare professionals. Any AI or digital tools used by our practice are subject to strict privacy, security, and contractual requirements to protect your information.

I voluntarily request a physician, and/or advanced practice provider (Nurse Practitioner, Physician Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	____	___________
Patient /Proxy Printed Name	Patient/Proxy Signature	Date

CRITICAL CARE, PULMONARY & SLEEP ASSOCIATES
A PROFESSIONAL LLP

Financial Responsibility and Insurance Acknowledgment Consent

I understand and agree that **I am financially responsible for all charges incurred** for services provided by Critical Care, Pulmonary and Sleep Associates, including but not limited to:

- Office visits (in-person and virtual)
- Diagnostic testing, labs, imaging, and procedures
- Professional services not covered by my insurance
- Co-payments, co-insurance, and deductibles
- Charges denied by insurance due to eligibility issues, out-of-network, lack of authorization, or non-covered services
- Other fees assessed including no-show fees, paperwork fees, etc.

I understand that **insurance verification is not a guarantee of payment**, and that final determination of benefits is made by my insurance carrier. I authorize CCPSA to bill my insurance on my behalf and to release necessary information to my insurer for payment and healthcare operations.

If my insurance does not cover services rendered, or if I am uninsured, I agree to pay all charges according to CCPSA's billing policies. I understand that **balances not paid in a timely manner may be subject to collection efforts**, as permitted by law.

Insurance Network Verification Disclaimer
Please note: It is the patient's responsibility to verify whether this provider is in-network with their insurance plan prior to receiving services. Network participation may vary by plan and is subject to change. Out-of-network services may result in higher out-of-pocket costs, which the patient will be responsible for. If you have questions about your coverage, please contact your insurance company directly.

No Show Policy / Late Cancellation Policy: To be fair to all patients, cancellations within 24 hours and No-Shows will be charged $50. No Show and late cancellation fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Insurance will not cover fees for late cancellation or No Show. Patients who No-Show or cancel their appointment with less than 24 hours' notice two (2) or more times in a 12-month period, may be dismissed from the practice.

If you are requesting CCPSA to complete any type of paperwork, FMLA, Disability, etc., there is a $25 flat fee. Please note, if you have not been seen within 1 year, an appointment will be required prior to completion of paperwork.

I acknowledge that I am responsible for keeping my insurance and contact information current and accurate.

______________________________ ____ ___________

Patient /Proxy Printed Name | Patient/Proxy Signature | Date

CRITICAL CARE, PULMONARY & SLEEP
ASSOCIATES A PROFESSIONAL LLP

PULMONARY and SLEEP QUESTIONNAIRE

Today's Date ____________________________**Name** ____

Information about you helps us understand you and your health concerns, as well as decide on treatment. This questionnaire will become part of your medical record and will be regarded as confidential in nature. Please fill in the blanks or check the appropriate answers as accurately as possible.

Age_____ Birthdate_______________ Approximate altitude at which you live: ________________________

Occupation:_________________________________ If retired, prior occupation:_________________________

Primary Care Physician _________________________ Referring Physician _______________________________

Please list any other physicians you see and why: ____

____

Pharmacy: ____________________________ Pharmacy Phone #:_______________________________________

What is your preferred language: __________________

REASON FOR VISIT: Please list below the main reason(s) or symptom(s) for which you are seeing us today:

____

____

MEDICATION ALLERGIES:

Are you allergic to any medications? Yes ☐ No ☐

If yes, please below list the drug and your reaction (rash, hives, shortness of breath, etc.)

____

____

IMMUNIZATIONS:

Have you had a flu shot? Yes ☐ No ☐ If yes, when? _________________

Have you had a Pneumovax (pneumonia)(PCV23)vaccine? Yes ☐ No ☐ If yes, when?_______________

Have you had a Prevnar13 (pneumonia) (PCV13) vaccine? Yes ☐ No ☐ If yes, when?________________

Have you had a Prevnar20 (pneumonia) (PCV 20) vaccine? Yes ☐ No ☐ If yes, when?________________

Have you received your Covid vaccine? Yes ☐ No ☐ If yes, when? __________________________________

Have you received any Covid vaccine boosters? Yes ☐ No ☐ If yes, when? ____________

Have you had skin testing for TB (ppd)? Yes ☐ No ☐

If yes, was the skin test result Positive ☐ or Negative ☐

Do you use oxygen during the day? Yes ☐ **No** ☐ If yes, how much?: at rest ______ with exertion ________

Do you use oxygen at night? Yes ☐ **No** ☐ If yes, how much? ________

Do you use PAP at night? Yes ☐ **No** ☐

If yes, which kind? CPAP ☐ BIPAP ☐ ASV ☐ Auto-CPAP ☐ NIV (Trilogy) ☐

Please tell us who your oxygen/PAP/DME company is: ____

PATIENT MEDICAL/SURGICAL HISTORY:

Please check all that ***apply to you*** now or have applied in the past.

Alpha 1 antitrypsin		COPD/emphysema		Hypertension		Pulmonary hypertension	
Anemia		Coronary artery disease		Idiopathic pulm fibrosis (IPF)		Sarcoidosis	
Asthma		Cystic fibrosis		Interstitial lung disease (ILD)		Scleroderma	
Atelectasis		Deep vein thrombosis		Kidney disease		Seasonal allergies	
Atrial fibrillation		Dermato/polymyositis		Liver disease/hepatitis		Sinus disease	
Bronchiectasis		Diabetes		Lung nodule		Sjogrens syndrome	
Bronchitis		Diastolic dysfunction		Lupus		Sleep apnea - central	
Cancer – lung		GERD/heartburn		Memory loss		Sleep apnea - obstructive	
Cancer – other		Glaucoma		Parkinson's disease		Stroke/TIA	
Chronic pain		Heart attack/MI		Pleural effusion		Thyroid disease	
Chronic resp failure		Heart murmur		Pneumonia		Tuberculosis	
CHF/heart failure		HIV/AIDS		Pulmonary embolism		Other:	

Please check if you have had any of the following procedures in the past and *list when/where performed:*

Bronchoscopy		Cardiac cath (left or right)	
Lung biopsy		CABG/bypass	
Thoracentesis		Heart valve replacement	

Please list any other surgical history: ____

PATIENT SOCIAL HISTORY:

Smoking

Actively smoking ☐ Never smoked ☐ Not Smoking Presently ☐ Age you quit: ____Year you quit: ________

Cigarettes ☐ How many packs per day? ___ Cigars ☐ Pipe ☐ Marijuana ☐ How many years? ______

Do you chew/snuff tobacco? Yes ☐ No ☐ If yes, how much? ______________________________

Secondhand smoke exposure? Yes ☐ No ☐ If yes, how often are you exposed? Minimally ☐ or Daily ☐

Alcohol

Do you drink alcohol? Yes ☐ No ☐ Beer ☐ Wine ☐ Hard Liquor ☐ How many drinks/week? ________

Caffeine

Do you drink caffeine? Yes ☐ No ☐ If yes, how many drinks/day? ___Coffee ☐ Tea ☐ Cola ☐ Other ☐

Drugs

Do you use drugs? Yes ☐ No ☐ If yes, Marijuana ☐ Cocaine ☐ Methamphetamine ☐ Other ☐ ________

FAMILY MEDICAL HISTORY:

Please place an "X" indicating immediate family members that have been diagnosed with any of the following:

Relative	Asthma	Blood Clots	Cancer & Type	Cystic Fibrosis	Lung Disease	Tuberculosis (TB)	Other	Alive & Well	Age Deceased if applicable
Mother									
Father									
Sibling									
Child									

ADVANCED DIRECTIVES

Do you have an advance directive? Yes ☐ No ☐ (if yes, please provide this to us now or a future visit)

Do you have a Colorado MOST form? Yes ☐ No ☐ (if yes, please provide this to us now or a future visit)

Do you have a documented Do Not Resuscitate (DNR) in place? Yes ☐ No ☐

GENERAL REVIEW OF SYMPTOMS: *(Please check box only if currently having symptoms)*

Respiratory		How long? (in days, months, years)	How severe? (mild, moderate, severe)	Anything make worse/better? (please describe)
Shortness of breath				
Dry Cough				
Wet/Productive cough				
Coughing up blood				
Wheeze				
Chest pain with cough/breath				
Chest tightness				

General/Constitutional		**Skin**		**Cardiovascular**	
Fatigue		Hives		Chest pain	
Fever		Itching		Feet/leg swelling	
Night Sweats		Blisters/Sores/Rash		Rapid heartbeat	
Weight gain		Flushing		Hand swelling	
Weight loss		Cyanosis/Bluish Discoloration		**Allergies**	
Psychologic		**Genitourinary**		Seasonal allergies:	
Difficulty concentrating		Urinary frequency		Spring ☐ Summer ☐ Fall ☐ Winter ☐	
Depressed mood		Nocturia		Environmental allergies	
Anxiety		**Gastrointestinal**		Food allergies	
Endocrine		Acid reflux/Heartburn		**Rheumatologic**	
Excessive thirst		Trouble swallowing		Morning stiffness	
Excessive urination		Painful swallowing		Difficulty standing	
Heat intolerance		Abdominal pain		Joint swelling	
Cold intolerance		Diarrhea		Rash to face	
Hematology		Nausea		Raynaud's phenomenon	
Adenopathy		Vomiting		Dry Eyes	
Easy bruising		Blood in stool		Dry Mouth	
Neurological		**HEENT**			
Headaches		Hoarse voice			
Dizziness/lightheadedness		Runny nose		**Other symptoms:**	
Decreased vision		Sore throat			
Passing out		Nasal congestion			
Difficulty walking		Facial swelling			
Musculoskeletal		Neck swelling			
Leg cramps					
General muscle weakness					
Palpable cord					

EXPOSURES: *please check box if* ***exposed currently or in past*** *to any of the following*

Pet birds		Swamp cooler		Tuberculosis (TB)	
Dogs		Mold/mildew/water damage		Asbestos	
Cats		Humidifier		Industrial dusts (mining, silica, stone, etc)	
Indoor hot tub				Industrial toxins (beryllium, etc)	

Have you ever used one of the following medications: Amiodarone ☐ Methotrexate ☐ Chemotherapy ☐ Macrobid ☐

TESTING/TREATMENT YOU HAVE RECEIVED FOR YOUR RESPIRATORY/LUNG ISSUES:

Testing/Treatment	**Date**	**Place Performed**
Chest X-Ray		
Cat Scan of Chest (CT)		
PET Scan		
Pulmonary Function Tests (PFT)		
Echocardiogram of heart		
Stress test of heart		
Nocturnal Oximetry (nighttime O2 testing)		
Sleep Study		
Other (please specify)		

CURRENT MEDICATIONS:

NAME **Please list the exact medication name (generic vs. brand name)**	**STRENGH/DOSE**	**HOW OFTEN DO YOU TAKE THIS MED?**

Please complete this page ONLY if you have a SLEEP DISORDER (such as sleep apnea, etc) or have CONCERNS ABOUT YOUR SLEEP:

(Please also complete the LAST PAGE of this packet titled Epworth Sleepiness Scale)

Have you had a sleep study before? Yes ☐ No ☐ If yes, when ______________ Where______________

Was it a home test or an in-lab study: Home ☐ In-lab ☐

Have you been diagnosed with any sleep problem(s) listed below? (Check all that apply)

Obstructive sleep apnea ☐ Central sleep apnea ☐ Narcolepsy ☐ Restless leg syndrome ☐ Insomnia ☐

Are you currently using any of the following: CPAP ☐ BIPAP ☐ ASV ☐ Auto-CPAP ☐ NIV (Trilogy) ☐

What are your machine's current settings (if known): ________________________________

If you have used any of these machines in the past, but are no longer using, please explain why not:

____

Are you currently using an oral appliance while sleeping? Yes ☐ No ☐

SLEEP PROBLEMS – Please check the appropriate frequency with which it occurs:

	Always	Rarely	Never		Always	Rarely	Never
Do you feel fatigued during the day?				Talk in your sleep			
Is sleep refreshing to you?				Eat in your sleep			
Snoring				Walk in your sleep			
Snoring loud enough to hear in another room				Grind teeth at night			
Wake up gasping				Wake up confused at night			
Witnessed apnea by bed partner				Act out your dreams			
Constantly tired or fatigued				If yes, do you hurt yourself or someone else? Yes ☐ No ☐			
Difficulty falling asleep				Hard time falling asleep			
Frequent awakening from sleep				Hard time staying asleep			
Sudden, irresistible urge to sleep				Temporary paralysis or weakness			
Sore throat when waking				Hallucinations when asleep			
Headache when waking				Mind is awake but body feels asleep			
Restless legs if seated or lying down				Do you nap? (if yes, see below below)			
Restless legs that interfere w/sleep				How long are naps? _____ hrs What time of day?________			
Legs twitch of kick while sleeping				Are they refreshing? Yes ☐ No ☐			

Do you have any of the following (check all that apply)

Tempo-mandibular joint problems (TMJ) ☐ Nighttime urination ☐ Number of times per night? ___________

(men only) Testosterone medication ☐ Impotence ☐ *(women only)* Menopause ☐

Sleep schedule:

Usual bedtime	_______ am/pm	Usual rise time	________ am/pm
Total time in bed	_______ hours		
Number of awakenings	______ per night	Time needed to fall back asleep	________min/hrs

Sleep Hygiene:

	Yes	No		Yes	No
Do you exercise on a daily basis?			If you can't sleep, do you watch the clock?		
If yes, within two hours before bed?					

If and when you travel, is your sleep: Worse ☐ Better ☐ Same ☐

Do you do any of the following in bed? Eat ☐ Smoke ☐ Read ☐ Watch TV ☐

In what position(s) do you sleep (check all that apply): Back ☐ Side ☐ Stomach ☐ Sitting up ☐

With a wedge ☐ Propped up with more than three pillows ☐ Other: ______________________________

Please check if you have had any of the following procedures in the past and *list when/where performed:*

Deviated nasal septum repair Date:		Laser uvuloplasty (LAUP) Date:	
Removal of tonsils/adenoids Date:		Uvulo palatal pharyngoplasty (UPP) Date:	
Inspire device placement Date:		Remede device placement Date:	

EPWORTH SLEEPINESS SCALE

(Please ONLY complete this page if you have a sleep concerns, or carry a sleep diagnosis such as sleep apnea)

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out 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 **2 -** Moderate chance **3 -** High chance

Situation	Chance of Dozing
Sitting and Reading	____________
Watching Television	____________
Sitting inactively in a public place (theatre, meeting)	____________
As a passenger in a car for an hour without a break	____________
Lying down to rest in the afternoon	____________
Sitting and talking to someone	____________
Sitting quietly after lunch without alcohol	____________
In a car, while stopping for a few minutes in traffic	____________

TOTAL:____________