Orlando Health Pulmonary and Sleep Medicine Group
Oviedo

Welcome to Our Practice

Thank you for choosing Orlando Health Pulmonary and Sleep Medicine Group to serve your health care needs. We pledge to provide you with the very best medical care.

Below are the services we are able to provide to our patients:

- Asthma management- Diagnosis, treatment and asthma education for patients
- Outpatient Pulmonary Function Testing- Pre & Post spirometry, flow volume loop, lung volumes, Dlco and Body plethysmography
- Methacholine Challenge Testing
- Sleep Disorder Evaluation
- Fiberoptic Laryngoscopy for vocal cord evaluation
- Outpatient Bronchoscopy
- Pulmonary and Critical Care Consultation

******PLEASE READ CAREFULLY******

Please fill out this packet in its entirety and bring it with you to your scheduled appointment, as well as your insurance and identification card. If you are unable to complete this packet prior to your appointment, please arrive **30 mins prior to your appointment time to complete**, or you may be asked to reschedule your appointment.

If your insurance is an HMO Primary or Supplement or requires a referral, please contact your Primary Care Physician for an authorization/referral. As a courtesy, our office will request, but to expedite the process, patients are encouraged to request their referral/authorization prior to the appointment. You **must** have your authorization prior to your appointment or we will be unable to see you.

******In order for the doctor to see you, we need to have a copy of your X-Ray films/images. If you do not have them at the time of your visit we will have to reschedule your appointment.****

Please bring in complete medication list with all instructions and dosage. *

If you have any questions regarding your appointment or our practice, please call us. We are dedicated to providing quality patient care, and we look forward to serving you.

Sincerely,
Orlando Health Pulmonary and Sleep Medicine Group

Orlando Health Pulmonary and Sleep Medicine Group
Oviedo
1000 W. Broadway St. Suite 105A
Oviedo, FL 32765
Ph 407-265-7775 • Fax 407-265-2266

Practice Guidelines

Once again we thank you for choosing South Seminole Physicians Group-Critical Care. In our efforts to provide quality patient care, we want you to have the following information regarding our office guidelines. Our hope is this information will allow us to better meet your needs.

1. There is a $25.00 fee for any no shows or cancellations less than 24 hours prior to your appointment. After 1 no shows and/or late cancellations you will receive a warning letter. If you fail to respond to the warning letter, you will receive a discharge letter.

2. Should you arrive late for your scheduled appointment or do not have your x-ray films or CDs, your appointment may have to be rescheduled.

3. Your copay and any outstanding balance are due in full at the time of service.

4. As a courtesy to our patients we verify your insurance, bill your insurance and will attempt to call you prior to your appointment as a reminder of your scheduled time and day.

5. It is the patient's responsibility to know the laboratories, hospitals, radiology centers and any other facilities or physicians whom are participants of his/her insurance. It is the patient's responsibility to obtain referrals from their primary care physician as required by his/her plan. It is the patient's responsibility to pay any out of network charges that maybe incurred.

6. When calling your provider please leave a brief message with the office staff and a phone number where our staff or the provider can reach you.

Print Name _____

Signature_____

Date: _____

Witness: _____

Orlando Health Pulmonary and Sleep Medicine Group
Patient Registration

Account #:

Today's Date: _____ Referring Physician_____

Patient's Full Name: _____ Nickname: _____
Last *First* *M.I.*

Date of Birth: _____ Social Security #:_____

Address: _____ Apt: _____ City: _____ State: _____

Zip Code: _____ Sex: [ ] Male [ ] Female Employer/School: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email:_____ Family Status: [ ] Single Adult [ ] Married [ ] Divorced [ ] Widowed

Primary Care Physician Name:_____ Phone: _____

PRIMARY INSURANCE

Name of Insurance Carrier: _____ Phone: _____

Policy/ID Number: _____ Group Number: _____

Policy Holder: ___spouse ___parent ___self Policy Holder's Full Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Soc. Security #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Name of Insurance Carrier: _____

Policy/ID Number: _____ Group Number: _____

Policy Holder: ___spouse ___parent ___self Policy Holder's Full Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Soc. Security #: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

Address:_____ City: _____ State: _____ Zip: _____

Orlando Health Pulmonary and Sleep Medicine Group

AUTHORIZATION TO DISCUSS MEDICAL CARE WITH FAMILY MEMBERS AND/OR OTHER INDIVIDUALS

Patient's Name:_____ Date of Birth:_____

I hereby authorize the physicians and staff members of Orlando Health Pulmonary and Sleep Medicine Group to discuss the medical care of the patient named above with the people listed below. This may include, but is not limited tom releasing information related to psychiatric care, drug use, alcohol abuse, HIV testing, ARC, and AIDS.

I understand this consent is revocable upon written notice, except to the extent that action has been taken in reliance on this authorization, and that this authorization shall remain in force for 5 years unless revoked.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

In an attempt to preserve the confidential nature of the doctor-patient relationship, it is requested that you select the different locations/persons with whom or where we may leave messages regarding appointments and other administrative matters. Please select the options below that apply:

____ Messages may be left on my answering service
____ I may be called at work. (Telephone number:_____)
____ Messages may be left with the following:
_____ Spouse (Name:_____)
_____ Other (Name and Relationship:_____)
_____ Other (Name and Relationship:_____)

Special instructions (if applicable):_____

_____

_____ _____
Signature of patient, parent or legal guardian Date

_____
Witness

Orlando Health Pulmonary and Sleep Medicine Group

Patient Name:	Date of Birth: Age:____ Sex: M/F:___
Marital Status: ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Separated	Place of Birth:
Referring Doctor:	Family Doctor:

PRESENT ILLNESS

1. What brings you to the doctor today? (Problems or questions to be addressed at the visit)

   _____

   _____

2. When did you first notice the problem? _____
3. Do you have any of the following? *If yes, please explain*

   a. Shortness of Breath ☐ Yes ☐ No _____
   b. Wheezing ☐ Yes ☐ No _____
   c. Cough ☐ Yes ☐ No _____
   d. Coughing up phlegm ☐ Yes ☐ No _____
   e. Coughing up blood ☐ Yes ☐ No _____
   f. Hay Fever (Allergies) ☐ Yes ☐ No _____
   g. Chest Pain ☐ Yes ☐ No _____
   h. Post Nasal Drainage ☐ Yes ☐ No _____
   i. Fever ☐ Yes ☐ No _____
   j. Difficulty Swallowing ☐ Yes ☐ No _____
   k. Indigestion/ Heartburn ☐ Yes ☐ No _____
   l. Sleep Disorder ☐ Yes ☐ No _____
   m. Snoring ☐ Yes ☐ No _____
   n. Recent Weight Change ☐ Yes ☐ No _____

PRESENT MEDICAL HISTORY

4. Have you ever been diagnosed with any of the following?

Respiratory History

Asthma ☐ Yes ☐ No_____
Bronchiectasis ☐ Yes ☐ No_____
Bronchitis ☐ Yes ☐ No_____
Cystic Fibrosis ☐ Yes ☐ No_____
Emphysema ☐ Yes ☐ No_____
Resp. infections ☐ Yes ☐ No_____
Lung Cancer ☐ Yes ☐ No_____
Nasal Polyps ☐ Yes ☐ No_____

Other Systems

Heart Disease ☐ Yes ☐ No_____
Hypertension ☐ Yes ☐ No_____
Irregular Heart Rate ☐ Yes ☐ No _____
Seizures ☐ Yes ☐ No_____
Stroke/TIA ☐ Yes ☐ No _____
Diabetes ☐ Yes ☐ No_____
Thyroid Problems ☐ Yes ☐ No_____
Colitis ☐ Yes ☐ No_____

Pleurisy	☐ Yes ☐ No_____	Heart Burn	☐ Yes ☐ No_____
Pneumonia	☐ Yes ☐ No_____	Hiatal Hernia	☐ Yes ☐ No_____
Pneumothorax	☐ Yes ☐ No_____	Stomach Ulcers	☐ Yes ☐ No_____
Pulm. Emboli	☐ Yes ☐ No_____	Arthritis	☐ Yes ☐ No_____
Pulm. Fibrosis	☐ Yes ☐ No_____	Bleeding Problems	☐ Yes ☐ No_____
Sarcoidosis	☐ Yes ☐ No_____	Cancer (*type*)	☐ Yes ☐ No_____
Tuberculosis	☐ Yes ☐ No_____	HIV/AIDS	☐ Yes ☐ No_____

5. List all previous surgeries and/or hospitalizations

When	Type of Operation/Hospitalization	Where	Physician/Surgeon

6. Please mark recent studies you have had (within the last 6 months)

Test	When	Where	Result (if known)
Chest X-Ray			
Chest CT Scan			
Pulm Function Test			
TB Skin Test			
PT/INR			

7. Have you ever been given:

Pneumonia Vaccine ☐ Yes ☐ No *(if yes, when/where)*_____
Flu (influenza) Vaccine ☐ Yes ☐ No *(if yes, when/where)*_____
Blood Transfusion ☐ Yes ☐ No *(if yes, when/where)*_____

SOCIAL HISTORY

8. Do you smoke? ☐ Yes ☐ No Years smoked:_____ Packs Per Day:_____
9. Have you ever smoked? ☐ Yes ☐ No How many years?_____ When did you quit?_____
10. Does anyone in your house smoke? ☐ Yes ☐ No
11. Do you drink alcohol? ☐ Yes ☐ No If so, How Often? ☐ Never ☐ Rarely ☐ Moderately ☐ Daily
12. Do you drink caffeinated beverages? (coffee, tea, sodas) ☐ Yes ☐ No
13. Do you use recreational drugs? ☐ Yes ☐ No If yes, what type? _____
14. Current occupation:_____ Previous, if retired:_____
15. Do you live alone? ☐ Yes ☐ No List states where you have lived:_____
16. Have you recently traveled outside of the U.S.? ☐ Yes ☐ No *If yes, when/where*_____

EXPOSURE HISTORY

17. Have you ever worked in or around any of the following?

Asbestosis ☐ Yes ☐ No _____ Animals/Pets ☐ Yes ☐ No _____
Welding ☐ Yes ☐ No _____ Metal Dust ☐ Yes ☐ No _____
Mining ☐ Yes ☐ No _____ Other Inhalants ☐ Yes ☐ No _____

FAMILY HISTORY

18. Has anyone in your immediate family been diagnosed with the following? *If so, who?*

Allergies ☐ Yes ☐ No _____ Heart Disease ☐ Yes ☐ No _____
Asthma ☐ Yes ☐ No _____ Hypertension ☐ Yes ☐ No _____
Cancer (*type*) ☐ Yes ☐ No _____ Kidney Disease ☐ Yes ☐ No _____
Cystic Fibrosis ☐ Yes ☐ No _____ Nasal Polyps ☐ Yes ☐ No _____
Diabetes ☐ Yes ☐ No _____ Sinusitis ☐ Yes ☐ No _____
Emphysema ☐ Yes ☐ No _____ Other Lung Disease ☐ Yes ☐ No _____

ALLERGIES TO MEDICATIONS

19. List all medication allergies: _____

20. Are there any medications you stopped taking in the past month? ☐ Yes ☐ No _____

21. Are you currently taking aspirin or any blood thinners? ☐ Yes ☐ No _____

22. **List all Current Medications:**

Medication Name	Dose	Frequency	**Medication Name**	Dose	Frequency

**Please complete the following:*

REVIEW OF SYSTEMS

Constitutional

Fever	☐ Y ☐ N
Chills	☐ Y ☐ N
Feeling Tired	☐ Y ☐ N
Feeling Poorly	☐ Y ☐ N
Difficulty Sleeping	☐ Y ☐ N
Weight Gain	☐ Y ☐ N
Weight Loss	☐ Y ☐ N

Eyes

Eye pain	☐ Y ☐ N
Red Eyes	☐ Y ☐ N
Discharge	☐ Y ☐ N
Itchy eyes	☐ Y ☐ N
Blurred Vision	☐ Y ☐ N

Ear, Nose Throat

Sore Throat	☐ Y ☐ N
Hoarseness	☐ Y ☐ N
Nasal Congestion	☐ Y ☐ N
Sneezing	☐ Y ☐ N
Earache	☐ Y ☐ N
Loss of Hearing	☐ Y ☐ N
White Patches, Mouth	☐ Y ☐ N

Cardiovascular

Chest Pain	☐ Y ☐ N
Palpitations	☐ Y ☐ N
Rapid Heart Rate	☐ Y ☐ N
Light-headedness	☐ Y ☐ N
Lower Extremity, Swelling	☐ Y ☐ N

Respiratory

Wheezing	☐ Y ☐ N
Shortness of Breath	☐ Y ☐ N
Cough	☐ Y ☐ N
Coughing Blood	☐ Y ☐ N

Gastrointestinal

Abdominal Pain	☐ Y ☐ N
Menstrual Pain	☐ Y ☐ N
Nausea	☐ Y ☐ N
Diarrhea	☐ Y ☐ N
Difficulty Passing Gas	☐ Y ☐ N
Constipation	☐ Y ☐ N
Rectal Bleeding	☐ Y ☐ N
Vomiting Blood	☐ Y ☐ N

Genitourinary

Urinary Pain	☐ Y ☐ N
Frequency Urinating	☐ Y ☐ N
Loss of Bladder Control	☐ Y ☐ N
Pelvic Pain	☐ Y ☐ N
Upper Abdomen/Back Pain	☐ Y ☐ N
Blood in Urine	☐ Y ☐ N

Musculoskeletal

Back Pain	☐ Y ☐ N
Joint Pain	☐ Y ☐ N
Neck Pain	☐ Y ☐ N
Joint Swelling	☐ Y ☐ N
Joint Stiffness	☐ Y ☐ N
Muscle Aches	☐ Y ☐ N
Muscle Cramps	☐ Y ☐ N
Muscle Stiffness	☐ Y ☐ N

Skin

Rash	☐ Y ☐ N
Lesions	☐ Y ☐ N
Itching	☐ Y ☐ N
Painful, without rash/sore	☐ Y ☐ N
Redness	☐ Y ☐ N
Swelling	☐ Y ☐ N

Neurological

Headache	☐ Y ☐ N
Confusion	☐ Y ☐ N
Dizziness	☐ Y ☐ N
Fainting	☐ Y ☐ N
Seizures	☐ Y ☐ N
Leg Numbness	☐ Y ☐ N
Muscle Contractions, Involuntary	☐ Y ☐ N

Psychiatric

Difficulty Sleeping	☐ Y ☐ N
Feeling Hopeless	☐ Y ☐ N
Feeling Worthless	☐ Y ☐ N
Paranoid Thoughts	☐ Y ☐ N

Endocrine

Hot flashes	☐ Y ☐ N
Night Sweats	☐ Y ☐ N
Muscle Weakness	☐ Y ☐ N
Excessive Urination	☐ Y ☐ N
Generalized Weakness	☐ Y ☐ N
Increased Appetite	☐ Y ☐ N

Hematologic/ Lymphatic

Swollen Glands	☐ Y ☐ N
Swollen Glands, Neck	☐ Y ☐ N
Easy Bleeding	☐ Y ☐ N
Easy Bruising	☐ Y ☐ N
Recurring Infections	☐ Y ☐ N

Allergy/Immunology

Hives	☐ Y ☐ N
Nasal Itching	☐ Y ☐ N

*** Please fill out ONLY if coming in for Sleep Apnea****

CPAP CLINIC FOLLOW-UP REPORT

Name: **Date:** **Date of Birth:**

Please enter the number which best describes how likely you would be to doze off in each situation

0=I Would Never Doze Off
1=I would Have A Slight Chance Of Dozing
2=I Would Have A Moderate Chance Of Dozing
3=I Would Have A High Chance Of Dozing

Situation	Chance of Dozing
• Sitting and reading.....	_____
• Watching TV.....	_____
• Sitting inactive in a public place (e.g, a theatre or a meeting).....	_____
• As a passenger in a car for an hour without a break.....	_____
• Lying down to rest.....	_____
• Sitting and talking to someone.....	_____
• Sitting quietly after lunch without alcohol.....	_____
• In a car, while stopped for a few minutes in traffic.....	_____

Complete Items Below ONLY if you have had a CPAP or BIPAP ordered

1. **If you have CPAP, BIPAP or OXYGEN equipment, what company set up your equipment? (Company Name & Phone #_____ Approximate date you started using the equipment_____**
2. **Was the use, cleaning and care of the equipment explained completely to you by the company? ☐ Yes ☐ No**
3. **Have you had any problems with the equipment company? ☐ Yes ☐ No If yes please explain_____**
4. **If you had a CPAP or BIPAP ordered, how many hours a night are you using your equipment? _____hrs/night How many days a week? _____day/week**
5. **If you are not using your equipment as ordered, why not? Explain in detail**

   _____

   _____
6. **Do you feel your treatment has improved your quality of life and health?**
   ☐ Yes ☐ No If yes, how?
   ☐ Have lost weight ☐ Have more energy ☐ Socialize more ☐ Overall health is better
   ☐ I feel better

OTHER COMMENTS:

_____

ORLANDO HEALTH | Physicians
Pulmonary and Sleep Medicine Group

Patient Pharmacy Information

Name:	DOB:	Date:

To better serve your healthcare needs, we will be changing to electronic health records (EHR). You will notice your doctors and nurses using computers more and paper less. This may change the way you currently receive your prescriptions, whether it be a one-time medication or daily medication.

We will be sending your prescriptions to your pharmacy electronically instead of giving you a paper prescription in the office. **In order to make this change, we will need your pharmacy information to be filled in below to ensure that your prescriptions are sent to the most convenient pick-up location for you.** *Please note some prescriptions may still need to be printed or handwritten.*

Thank you for your help in making this a smooth transition.

Pharmacy	Pharmacy Address	Phone/Fax
☐ **CVS Pharmacy**		Ph: Fax:
☐ **Publix**		Ph: Fax:
☐ **Scripts Pharmacy-** *Arnold Palmer Hospital*	92 Miller St. Orlando, FL 32806	Ph: 407.237.6337 Fax: 321.841.9102
☐ **Scripts Pharmacy-** *Dr. P Phillips Hospital*	9400 Turkey Lake Rd. Orlando, FL 32819	Ph: 321.842.7230 Fax:321.842.7265
☐ **Scripts Pharmacy-** *MD Anderson Cancer Center*	1400 S. Orange Ave, Orlando, FL 32806	Ph: 321.841.2818 Fax: 321.841.2819
☐ Target		Ph: Fax:
☐ Walgreens		Ph: Fax:
☐ Walmart		Ph: Fax:
******Please insert pharmacy information below if not listed above******		
Pharmacy	**Pharmacy Address**	**Phone/Fax**
☐		
☐		
☐		