FLORIDA LUNG & SLEEP ASSOCIATES

Pulmonary, Critical Care, and Sleep Medicine

2625 Lee Boulevard, Suite 100, Lehigh Acres, FL 33971
Phone: (239) 369-3333 Fax: (239) 369-4837
Alaa El-Gendy, MD, M.Sc., FCCP

Dear Patient:

On behalf of the medical staff and employees, I would like to welcome you to **Florida Lung & Sleep Associates, PA**.

Since we opened our doors in 2002, our mission has continued to evolve and to improve the health status of our patients through prevention, education, and quality care. We feel it is our privilege to provide quality care and we have the responsibility to provide preventive and educational opportunities to the residents of Lehigh Acres.

What to Expect During the Consultation

Plan to spend a total of about 1-2 hours in our office on the day of your appointment. I will discuss the health related issues that prompted you or your primary physician to seek the consultation; I will perform a comprehensive physical examination and direct further care as needed.

Preparing For the Visit

Please complete the enclosed patient information and clinical history form. Please complete all sides of this form at your convenience and bring it along with you to your first exam. This will minimize your waiting time. If you wish, you can even fax or mail the forms in advance of your arrival. Your assistance in obtaining your medical record is greatly appreciated.

If you find you need to reschedule or cancel your appointment, please call us at least one day in advance. If there is any other information I can provide please give the office a call and one of our trained courteous staff will be glad to assist you.

YOU WILL NEED THE FOLLOWING FOR YOUR APPOINTMENT:

1. DRIVERS LICENSE/ID CARD
2. HEALTH INSURANCE CARD
3. MEDICATION **BOTTLES**

We are conveniently located on Lee Blvd; next to Wal-Mart. We look forward to seeing you on your scheduled appointment.

Sincerely,
Alaa El-Gendy, MD. M.Sc., FCCP

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PATINET'S PERSONAL INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	PREFFERED NAME:	GENDER: ❍ Male ❍ Female

DATE OF BIRTH: / /	SSN: - -	MARITAL STATUS: ❍ Single ❍ Married ❍ Divorced ❍ Widow	PREFERRED LANGUAGE: ❍English ❍ Spanish ❍ Other: _____

RACE:
❍ White/Caucasian ❍ Black or African ❍ Asian American
❍ American Indian ❍ Native Hawaiian/Pacific Islander ❍ Other Race

ETHNICITY:
❍ Not Hispanic or Latino
❍ Hispanic or Latino

HOME PHONE: ( ) -	CELL PHONE: ( ) -	PREFERRED CONTACT METHOD: ❍ Home Phone ❍ Cell Phone

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

EMAIL ADDRESS:	***Your email address will be used strictly for FLSA patient portal and will not be sold to a third party vendor or receive spam email.***

EMPLOYER/SCHOOL INFORMATION

EMPLOYER/SCHOOL NAME:	WORK PHONE: ( ) -

PATIENT'S RESPONSIBLE PARTY INFORMATION

Relationship to Patient:
❍ **Self (If Self Skip This Section)** ❍ Spouse ❍ Other:

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:	PREFFERED NAME:	GENDER: ❍ Male ❍ Female

DATE OF BIRTH: / /	SSN: - -	HOME PHONE: ( ) -	CELL PHONE: ( ) -

STREET ADDRESS:	CITY:	STATE:	ZIP CODE:

EMERGENCY CONTACT

LAST NAME:	FIRST NAME:	RELATIONSHIP:

HOME PHONE: ( ) -	CELL PHONE: ( ) -

PATIENT'S REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT US?
❍ Primary Care Physician ❍ Advertising
❍ Patient in the Practice ❍ Insurance
❍ Specialist Physician ❍ Hospital
❍ Word of Mouth
❍ Other: _____

NAME(S) OF OTHER PHYSICIAN(S) WHO CARE FOR YOU:

FLORIDA LUNG & SLEEP ASSOCIATES (FLSA)
BILLING AND COLLECTION PROCEDURES

*****PLEASE PRESENT YOUR INSURANCE CARD(S) & PHOTO ID FOR COPYING*****

One of the services offered by our office is the billing of your insurance. We are committed to help you receive the maximum allowable benefits under your policy. In order to reach this goal, it is important that you read and understand the following:

1. All payments, co-payments, deductibles, and any other services rendered that is not covered by your insurance are to be paid up front. If you have no insurance, your bill will be estimated before your visit and the full amount of your bill will be due before services are rendered.
2. Our decision to accept your insurance will be made after proof of eligibility and verification of coverage is made. You are responsible for all services not covered by your insurance company.
3. In the event that charges are billed to you, all payments not received within 10 days will be subject to late fees. There will be service charges of $30.00 for all returned checks.
4. It is your responsibility to notify us of any changes in employment, insurance, address, or phone numbers.
5. I hereby authorize & assign all payments for all medical services rendered to FLSA. I understand that I am financially responsible for any services not covered by my insurance.
6. I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amount outstanding.
7. I hereby authorize FLSA to furnish any information to all insurance carriers concerning my wellness and treatments.
8. If you are unable to keep your appointment, please notify us at least 24 hours in advance so that we may reschedule. Otherwise there will be **$50.00 No Show Fee**.

Should you have any further questions about our policies or procedures, feel free to ask. Remember that we are here to help you.

PRIVACY NOTICE, TREATMENT AUTHORIZATION, & PICTURE AUTHORIZATION

- I have received the "Privacy Notice".
- FLSA may leave any messages on my answering machine in the event that I am not home.
- I give consent to take my picture for verification & internal use only.
- I hereby authorize FLSA staff to perform any necessary diagnostic procedures, administration of medicine and/or therapy during today's visit, as well as future visits.
- I hereby authorize FLSA to treat me and use my personal health information for any healthcare related purposes.
- I give FLSA the authority to download my medication history from all and any pharmacies.
- FLSA and its staff may discuss my medical history with the following:

_____	_____
Name	Relation
_____	_____
Name	Relation

I HAVE READ AND AGREE TO THE BILLING AND COLLECTION PROCEDURES, PRIVACY NOTICE, TREATMENT AUTHORIZATION, & PICTURE AUTHORIZATION AND FULLY UNDERSTAND IT AND HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS:

Signature: _____ Date: _____/_____/_____

Patient Name: _____

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AUTHORIZATION TO RECEIVE AND RELEASE MEDICAL RECORDS INFORMATION

This will authorize Florida Lung & Sleep Associates (FLSA) to receive and release ***all*** general medical records from my health record in accordance with Florida Statutes and Florida and Federal Administrative Rules and Regulations.

THIS BOX TO BE COMPLETED BY FLSA **(as needed)** Receive From:	THIS BOX TO BE COMPLETED BY PATIENT Send to the following providers:

If any of the following will impact on your treatment in our office, please check so we can request & receive records. I understand that any information relating to HIV testing, AIDS and any AIDS related syndromes that might be contained therein may ONLY be released by checking the box so indicated below, whether or not it is contained in treatment summaries, psychiatric/psychological works-ups, history & physical, lab work or any other information.

❍ HIV/AIDS related info
❍ Psychiatric/Psychological

I understand that I have the right to refuse this authorization and that FLSA is released from all legal liability that may arise from the release of the information requested.

Prohibition and Redisclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further redisclosure is strictly prohibited.

This authorization will be valid seven years from the date of the signature below unless revoked in writing. Written revocation is effective upon receipt by the medical records department of FLSA.

Patients Signature: _____ **Date:** _____/_____/_____

Patient Name (Please Print): _____ **DOB:** _____/_____/_____

If patient is a minor or unable to sign:

Guardian Signature: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

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Review of Systems

Constitutional			**Gastrointestinal**			**Endocrine**		
Weight loss	Yes	No	Nausea	Yes	No	Excess thirst	Yes	No
Weight gain	Yes	No	Vomiting	Yes	No	Excess urination	Yes	No
Fevers	Yes	No	Diarrhea	Yes	No	Cold intolerance	Yes	No
Chills	Yes	No	Vomiting blood	Yes	No	Heat intolerance	Yes	No
Night sweats	Yes	No	Black stool	Yes	No	Hair Loss	Yes	No
Fatigue	Yes	No	Other:			Other:		
Eyes			**Genitourinary**			**Psychiatric**		
Blurry vision	Yes	No	Bloody urine	Yes	No	Depression	Yes	No
Glasses	Yes	No	Difficulty urinating	Yes	No	Anxiety	Yes	No
Decreased vision	Yes	No	Hesitancy	Yes	No	Hearing Voices	Yes	No
Discharge	Yes	No	Incontinence	Yes	No	Feeling Stressed	Yes	No
Eye pain	Yes	No	Nighttime Urination	Yes	No	Frightening Visions/Sounds	Yes	No
Other:			Other:			Other:		
Ears/Nose/Throat			**Musculoskeletal**			**Hem/Lymphatic**		
Sore Throat	Yes	No	Joint pain	Yes	No	Easy bruising	Yes	No
Hoarseness	Yes	No	Muscle pain	Yes	No	Bleeding disorder	Yes	No
Nose Bleeds	Yes	No	Muscle weakness	Yes	No	Blood clots	Yes	No
Hearing Problems	Yes	No	Joint swelling	Yes	No	Swollen glands	Yes	No
Dentures	Yes	No	Back Pain	Yes	No	Other:		
Other:			Other:			**Allergic/Immune**		
Respiratory			**Skin**			Seasonal Allergy	Yes	No
Short of breath	Yes	No	Rash	Yes	No	Hay fever	Yes	No
Cough	Yes	No	Itchiness	Yes	No	Hives	Yes	No
Coughing blood	Yes	No	Poor Wound Healing	Yes	No	Other:		
Wheezing	Yes	No	Nail changes	Yes	No	**Sleep**		
Excessive Sputum	Yes	No	Suspicious Lesions	Yes	No	Wake up too early	Yes	No
Other:			Other:			Difficulty staying asleep	Yes	No
Cardiovascular			**Neurological**			Sleepy all day	Yes	No
Chest pain	Yes	No	Memory Loss	Yes	No	Stop breathing during sleep	Yes	No
Poor circulation	Yes	No	Numbness	Yes	No	Snoring	Yes	No
Racing heart	Yes	No	Poor Balance	Yes	No	Gasping for breath	Yes	No
Leg Edema	Yes	No	Tremors	Yes	No	Crawling sensation in legs	Yes	No
Shortness of breath laying down flat	Yes	No	Dizziness	Yes	No	Not feeling restored upon awakening	Yes	No
Fainting	Yes	No	Other:			Other:		
Other:								

Print Name: _____ **DOB:** ____/____/_____**Date:** ____/____/_____

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Sleep Questionnaire

Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

My sleep problem began:
☐ This month ☐ Within last three months ☐ Four months-12 months ☐ 1-2 years ☐ More than 2 years ☐ Since childhood

Severity: ☐ Mild ☐ Moderate ☐ Severe

Quality: ☐ Worsening ☐ Waxing and Waning

General Sleep Complaints:					
• Snoring	☐ Yes	☐ No	• Waking up gasping for air	☐ Yes	☐ No
• Sleepy during daytime	☐ Yes	☐ No	• Insomnia	☐ Yes	☐ No
• Wake up with headaches	☐ Yes	☐ No	• Difficulty falling asleep	☐ Yes	☐ No
• Awakening from sleep with dry mouth	☐ Yes	☐ No	• Awakening in the middle of the night	☐ Yes	☐ No
• Falling asleep against will	☐ Yes	☐ No	• Early morning awakening	☐ Yes	☐ No
• Feeling restored in the morning	☐ Yes	☐ No	• Violent behavior while asleep	☐ Yes	☐ No
• Stopping breathing at night	☐ Yes	☐ No	• Waking up with crawling aching sensations in legs	☐ Yes	☐ No

Sleep Treatment History: I was diagnosed with sleep problems before: ☐ Yes ☐ No					
If yes, I was previously diagnosed with:			**When?**	**Where?**	**Treatment:**
• Sleep Apnea:	☐ Yes	☐ No			
• Restless Legs Syndrome	☐ Yes	☐ No			
• Periodic Limb Movements	☐ Yes	☐ No			
• Narcolepsy	☐ Yes	☐ No			
• Insomnia	☐ Yes	☐ No			

The Epworth Sleepiness Scale:

How likely are you to doze off, take a nap or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you

Would never doze [0]. **Moderate chance of dozing [2].**
Slight chance of dozing [1]. **High chance of dozing [3].**

Sitting and reading	○[0]	○[1]	○[2]	○[3]
Watching TV	○[0]	○[1]	○[2]	○[3]
Sitting inactive in a public place (e.g. a theater or a meeting)	○[0]	○[1]	○[2]	○[3]
As a passenger in a car for an hour without a break	○[0]	○[1]	○[2]	○[3]
Lying down to rest in the afternoon when circumstances permit	○[0]	○[1]	○[2]	○[3]
Sitting and talking to someone	○[0]	○[1]	○[2]	○[3]
Sitting quietly after a lunch without alcohol	○[0]	○[1]	○[2]	○[3]
In a car, while stopped for a few minutes in the traffic	○[0]	○[1]	○[2]	○[3]
	TOTAL POINTS: _____			

NAME: _____

Snoring/OSA/Daytime Sleepiness:		
• Snoring worse on your back	☐ Yes	☐ No
• Snoring drives bed partner from the bedroom	☐ Yes	☐ No
• Snoring is loud enough to be heard from other rooms	☐ Yes	☐ No
• Snoring prevents you from sharing rooms when traveling	☐ Yes	☐ No
• Witnessed apneas during sleep	☐ Yes	☐ No
• Waking up short of breath or gasping for air	☐ Yes	☐ No
• Frequent breathing through the mouth	☐ Yes	☐ No
• Do the sleep problems limit your daily activities	☐ Yes	☐ No
• Drowsiness affects work	☐ Yes	☐ No
• Drowsiness while driving	☐ Yes	☐ No
• Involved in car accidents due to inattention or sleepiness	☐ Yes	☐ No
• Having difficulty waking up in the morning	☐ Yes	☐ No
• Nasal passage blockage	☐ Yes	☐ No
• Deviated septum	☐ Yes	☐ No
• Awakening in the morning with mouth dryness	☐ Yes	☐ No
• Awakening in the middle of the night with mouth dryness	☐ Yes	☐ No
• Feeling of tightness in the throat	☐ Yes	☐ No
• Feeling of pain in the throat	☐ Yes	☐ No
• Enlarged tonsils	☐ Yes	☐ No
• Dreaming of suffocating	☐ Yes	☐ No
• Feeling sad or depressed	☐ Yes	☐ No
• Cranky or irritable	☐ Yes	☐ No
• Lacking energy	☐ Yes	☐ No
• Having trouble remembering things	☐ Yes	☐ No
• Sweating excessively during the night	☐ Yes	☐ No
Causes Disturbing Sleep:		
• Bed partner snoring	☐ Yes	☐ No
• Headache	☐ Yes	☐ No
• Heartburn	☐ Yes	☐ No
• Lower back pain	☐ Yes	☐ No
• Upper back pain	☐ Yes	☐ No
• Chest Pain	☐ Yes	☐ No
• Abdominal Pain	☐ Yes	☐ No
• Joint Pain	☐ Yes	☐ No
• Itching	☐ Yes	☐ No
Restless Leg Syndrome:		
• Uncomfortable sensation in the legs	☐ Yes	☐ No
• Uncomfortable sensation in the leg worsens at night	☐ Yes	☐ No
• Irresistible desire or urge to move the legs comes on with rest	☐ Yes	☐ No
• Irresistible desire to move legs relieved by movement	☐ Yes	☐ No
• Family history of restless legs syndrome	☐ Yes	☐ No
• Restless sleeper	☐ Yes	☐ No
• Jerking in sleep	☐ Yes	☐ No
• Bed messy when awakening in the morning	☐ Yes	☐ No
Narcolepsy Symptoms:		
• Temporary paralysis with intense emotions, ie angry, surprised, laughing. (cataplexy)	☐ Yes	☐ No
• Weak limbs occurring temporarily with sporting activities (cataplexy)	☐ Yes	☐ No
• Vivid dreams during naps	☐ Yes	☐ No
• Vivid dreams as waking up	☐ Yes	☐ No
• Vivid dreams as falling asleep	☐ Yes	☐ No

NAME: _____

Orthopnea:		
• Using extra pillows? How many: ____	☐ Yes	☐ No
• Sleeping upright	☐ Yes	☐ No
Medication:		
• Currently taking medication to help sleep	☐ Yes	☐ No
• Current medication is helping	☐ Yes	☐ No
• Recently stopped medication	☐ Yes	☐ No
• Recently changed medication	☐ Yes	☐ No
• Feel medication is causing problem	☐ Yes	☐ No
Parasomnias:		
• Sleep walking	☐ Yes	☐ No
• Sleep talking	☐ Yes	☐ No
• Screaming in the middle of the night	☐ Yes	☐ No
• Sleep related eating disorder	☐ Yes	☐ No
• Nightmares	☐ Yes	☐ No
• Sleep paralysis	☐ Yes	☐ No
• Sleep related groaning	☐ Yes	☐ No
• Dream enactment (REM sleep behavior disorder)	☐ Yes	☐ No
• Sexomnia	☐ Yes	☐ No
• Aggression towards self or sleep partner	☐ Yes	☐ No
Associated Symptoms:		
• Hypertension	☐ Yes	☐ No
• History of stroke	☐ Yes	☐ No
• Heart disease	☐ Yes	☐ No
• Increased motor activity at night	☐ Yes	☐ No
• Impotence	☐ Yes	☐ No
• Poor sleep hygiene	☐ Yes	☐ No
• Family history of sleep disorder	☐ Yes	☐ No
• Does not try to get enough sleep	☐ Yes	☐ No

Sleep Habits:		
	Weekdays (workdays)	**Weekends(off days)**
Begin work time:	_____AM/PM	_____AM/PM
End work time:	_____AM/PM	_____AM/PM
My usual bedtime is:	_____AM/PM	_____AM/PM
My usual wake up is:	_____AM/PM	_____AM/PM
How long do you actually sleep at night?	_____H	_____H
What do you feel is your ideal amount of sleep?	_____H	_____H
How many naps/nodes do you take?	_____	_____
How long do naps/nodes usually last?	_____MIN/H	_____MIN/H
After taking a nap/node I usually feel (check one):	○ refreshed ○ groggy/sleepy	○ refreshed ○ groggy/sleepy

Bed Partner Questionnaire: To be answered by the bed partner or the roommate

Check any of the following behaviors that you have observed the above named person doing during sleep.

○ Light snoring	○ Pauses in breathing	○ Sitting up in bed not awake
○ Loud snoring	○ Sleepwalking	○ Kicking with legs
○ Biting tongue	○ Sleep talking	○ Head rocking or banging
○ Grinding teeth	○ Getting out of bed but not awake	○ Becoming very rigid or shaking

How long have you been aware of the sleep behavior(s) that you checked above?	Describe in more detail (as best you can) the behavior(s) check above. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.
_____	_____