



# North Point Pulmonary Associates

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Welcome to our practice!

On behalf of North Point Pulmonary Associates, we welcome and thank you for choosing our practice. It is our desire to make your visit a pleasant one and to work with you to establish a positive treatment plan.

Please help us provide the best medical care by bringing the following items:

- **All of your medications.** If you are unable to bring the bottles, please bring a list of medications, the dosage, and the number of times taken daily, including all over-the-counter medications
- **Previous sleep study records** (If you have had a sleep study previously)
- If you are currently on CPAP or BiPAP, please bring your machine
- **Completed History and Demographic forms**
- **Insurance card**
- **Photo identification**
- **Insurance referral from your primary care physician**

**We request all History and Demographic documents be completed prior to your appointment and ask that you arrive 30 minutes early. If documents aren't completed, we will need to reschedule your appointment.**

Thank you for your assistance and we look forward to meeting you!

Dr. Daniel Callahan  
Dr. Eduardo Egea  
Dr. Esther Lee  
Dr. Simha Jagadeesh  
Dr. Sunil Vallurupalli  
Dr. Juan C. Cadavid  
Michael Rayburn, PA-C  
Crystal Kuhn, NP-C



# Family History

Please check all that apply:

	MOTHER	FATHER	SIBLING	GRANDPARENT	AUNT/UNCLE
Cancer (Indicate Type)					
Respiratory Disease					
Mental Illness					
High Blood Pressure					
Kidney Disease					
Diabetes					
Heart Disease					
Blood Clot					
Tuberculosis					
Other:					
Other:					

**AGE OF DEATH:**

Mother \_\_\_\_\_ Father \_\_\_\_\_ Siblings \_\_\_\_\_ Grandparents \_\_\_\_\_

**Social History** (please check one)

\_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Domestic Partner

**Have you ever had x-ray dye?** YES/NO

**Allergic to x-ray dye?** YES/NO

**Have you ever smoked?** YES/NO

How many packs per day? \_\_\_\_\_

**For how many years?** \_\_\_\_\_

If you no longer smoke, when did you quit? \_\_\_\_\_

**Do you consume alcohol?** \_\_\_\_ Currently \_\_\_\_ In the past \_\_\_\_ Never

If currently how much? \_\_\_\_\_

**Do you or have you ever used recreational drugs?** \_\_\_\_\_

**Do you exercise?** \_\_\_\_\_

**How often?** \_\_\_\_\_

**Have you ever used diet pills?** \_\_\_\_\_

**Medication** \_\_\_\_\_

*Last time taken:* \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Are you exposed to any pets?** dogs, cats, birds, rodents or wild animals YES/NO

Describe \_\_\_\_\_

**Have you ever worked in/with?**

\_\_ MINE \_\_ BRICK PLANT \_\_ FOUNDRY \_\_ QUARRY \_\_ POTTERY \_\_ COTTON/FLAX/HEMP/MILL \_\_ NONE

**Have you ever been exposed to?**

\_\_ ASBESTOS \_\_ BERYLLIUM \_\_ ACIDS \_\_ LEAD \_\_ SOLVENTS \_\_ COAL DUST \_\_ GRINDING DUST \_\_ NONE

**Have you ever served in the military?** YES/NO

What Branch? \_\_\_\_\_

Dates of Service? \_\_\_\_\_

**Have you ever lived in any of the following areas?** (please circle)

ARIZONA, CALIFORNIA, OHIO VALLEY any other SOUTHERN STATES



## Review of Systems

Welcome, so that we may provide you with the best care possible, please assist us by completing the following form. Remember — always bring an updated list of all your medications including inhalers.

Please mark all that apply:

**GENERAL**  NONE

- Fevers
- Night Sweats
- Fatigue
- Appetite Loss
- Recent weight Changes

**EYES**  NONE

- Glaucoma
- Cataracts
- Macular Degeneration

**EAR/NOSE/THROAT**  NONE

- Nasal Congestion
- Postnasal Drip
- Voice Hoarseness
- Sinus Disease
- Seasonal Allergies

**CARDIAC**  NONE

- Heart Attack (MI)
- Valvular Heart Disease
- Heart Murmur
- Rheumatic Fever
- Abnormal Cholesterol
- Congenital Heart Defect
- Hypertension
- Palpitations
- Heart Rhythm Disorder
- Pacemaker or Cardiac Defibrillator (ICD)
- Claudication/Leg Pains
- Passing out/Syncope

**RESPIRATORY**  NONE

- Dry Cough
- Cough with phlegm
- Coughing up blood
- Shortness of breath at rest
- Shortness of breath with activity
- Wheezing
- Chest Tightness

**SLEEP**  NONE

- Morning Headaches

- Excessive Daytime Sleepiness
- Excessive Snoring
- Restless Sleep
- Sleep Disturbance Secondary to Breathing
- CPAP/BiPAP use

**GASTROINTESTINAL**  NONE

- Heartburn/Reflux
- Difficulty/Painful Swallowing
- Abdominal Pain
- Blood in Stool or Vomit
- Nausea/Vomiting
- Colostomy/Ileostomy
- Hepatitis or Jaundice

**GENITOURINARY**  NONE

- Painful Urination
- Frequent Urination
- Blood in Urine
- Incontinence/loss of bowel or bladder function
- Frequent bladder/Kidney infections
- Enlarged Prostate

**GYNECOLOGICAL**  NONE

- Are you presently or could you be pregnant? Y N
- Abnormal Mammogram
  - Abnormal Pap smear
  - Hysterectomy

Present or past history of cancer:

Breast Y N  
Please describe: \_\_\_\_\_

Ovarian Y N  
Please describe: \_\_\_\_\_

Uterine Y N  
Please describe: \_\_\_\_\_

**MUSCULOSKELETAL:**  NONE

- Last DEXA: \_\_\_\_\_
- Osteoarthritis
  - Osteopenia/Osteoporosis
  - Rheumatoid Arthritis
  - Fibromyalgia

- Gout
- Disc Problems
- Back Pain
- Trouble Walking
- Frequent Falls
- Pain in Legs with Walking
- Joint Pain (other than arthritis)
- Bone Pain

**NEUROLOGICAL**  NONE

- Fainting Spells
- Balance Problems
- Tremors
- Dizziness
- Seizures
- Mini strokes/TIA
- Stroke
- Headaches/Migraines
- Muscle Weakness
- Memory Problems
- Difficulty Swallowing
- History of Polio

**BLOOD DISORDERS**  NONE

- Anemia
- Impaired Immune System
- Low Platelets
- Unusual Bleeding
- Blood Clots (in legs or lungs)

**ENDOCRINE**  NONE

- Thyroid Problems
- Goiter
- Graves Disease
- Diabetes

**MENTAL/EMOTIONAL**  NONE

- Excessive Stress
- Anxiety
- Depression
- Suicidal Thoughts
- Sleeping Difficulty
- Phobias (i.e. claustrophobia)





**NH**  
**NORTHSIDE HOSPITAL**  
**SLEEP DISORDERS CENTER**

AFFIX PATIENT LABELS OVER THIS BOX  
 ↓ BAR CODE MUST FALL BETWEEN THESE LINES ↑

Patient Name: \_\_\_\_\_

Gender (circle one):    Male        Female        Age: \_\_\_\_\_

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 decide how you would react to these situations. Use the following scale to choose the most appropriate number for each one.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

<b><u>SITUATION</u></b>	<b><u>CHANCE OF DOZING (circle one)</u></b>			
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting, inactive in a public place (e.g., theater or 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 lunch without alcohol.	0	1	2	3
In a car, while stopped for a few minutes in traffic.	0	1	2	3

**TOTAL SCORE:** \_\_\_\_\_

**AVERAGE AMOUNT OF SLEEP PER NIGHT:** \_\_\_\_\_

**SIGN HERE:** Completed by: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date/Time: \_\_\_\_\_

# A Northside Network Provider

English - Spanish

**[OPTIONAL FORM – NOT REQUIRED TO BE COMPLETED]**

Practice Name: \_\_\_\_\_

Name of Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

\_\_\_\_\_

Federal privacy regulations allow a health care provider, in certain limited circumstances, to discuss your health information, such as details about your care and treatment, with family members and close personal friends who are involved in your care. Depending on the circumstances, health care providers may be prevented from discussing your health information with someone who you might want them to. For that reason, some patients want to specifically authorize healthcare providers to engage in healthcare discussions with certain family members, friends, or other individuals. This form allows you to designate family members, friends or others with whom the practice listed above can communicate about your health care.

By signing below, you understand and acknowledge the following:

- The practice listed above is authorized to engage in discussion about your health care with the individuals listed on this form.
- This form does not restrict a healthcare provider from discussing your health information with individuals not listed on this form if such discussions are permitted by law.
- This form permits verbal communication only. This form does not allow the individuals listed below to obtain copies of your medical records.
- This form applies only to the practice listed above. If you receive health care from other Northside affiliated medical practices, you will need to complete a new form for each practice.
- This form is entirely voluntary and optional. Refusing to sign this form will not impact your care provided at this practice.
- Changes to this form must be made in person at the practice listed above.

This form can be revoked by submitting a written request to the Practice Manager of the Northside affiliated physician practice identified at the top of this form. You have the right to revoke this form in writing at any time except to the extent action has already been taken in reliance on it. The consent remains in effect until you revoke it in writing or sign a new form.

First and Last Name	Relationship	Phone Number

\_\_\_\_\_  
Signature of Patient or Legal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Interpreter (if applicable)  
Note to staff: if telephone interpretation provided,  
record name of company and interpreter ID number.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Reason patient unable to sign

**Please complete this form and return it to the Practice Manager**



# A Northside Network Provider

English - Spanish

Name of Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Physician Practice Name: \_\_\_\_\_

The Northside Hospital Office Practice identified above is hereby authorized to **(Please mark appropriate box):**

**Release to OR**  **Receive from** the following person(s) or entity(ies) or class of person(s) or entity(ies) **(Please identify by name or general description and provide address, if known):** \_\_\_\_\_

The following protected health information regarding the patient **(Please mark appropriate box(es)):**  Complete Medical Record

Abstract of Medical Record (physician dictated reports & diagnostic reports)  Labs only  Radiology only  EKG only

Other **(Please specify clearly)** \_\_\_\_\_

For the following dates of service: Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**In the following format:**  Paper  Electronic **Need records certified:**  Yes  No

I understand that in some instances my medical record may also include my health information from other healthcare facilities owned and/or operated by Northside Hospital.

**Unless you state otherwise**, this authorization **includes** the release and disclosure of **all medical records and information**, including but not limited to, paper and electronic records, x-rays, films, and other documents, except as otherwise noted below. This authorization **includes** the release of any information regarding **treatment or referral for substance abuse, including drugs and alcohol**, except for patients treated for substance abuse at the Northside Hospital Behavioral Health Recovery Program. (See Page 2 for additional information). If you have received genetic testing, for example for the breast cancer gene, a different consent form is required.

**Unless you state otherwise by marking one or both boxes below**, this authorization **includes** the release and disclosure of records and information which may include (i) **HIV/AIDS** confidential information and/or (ii) **privileged mental health communications** between the patient and a mental healthcare provider, and **you affirmatively waive any protections from disclosure** that might otherwise apply. **HIV/AIDS confidential information** is defined by Georgia law to include the fact that a patient has had an HIV test or been counseled about HIV, even if the test is negative. **NOTE:** Unless otherwise permitted by law, the release of **HIV/AIDS** confidential information and/or **privileged mental health communications** can be authorized only by the patient or an individual who is legally authorized to make a living patient's healthcare decisions, including a legal guardian, health care agent, or parent of a minor.

I **object** to the release of **HIV/AIDS** confidential information.

I **object** to the release of any **privileged mental health communications** under Georgia law.

The purpose of the requested disclosure is: \_\_\_\_\_

I understand that my/ the patient's treatment at a Northside Hospital Physician Practice Office and/or Northside Hospital will not be affected if I refuse to sign this authorization. I also understand my right to revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it or if the authorization was provided as a condition of obtaining insurance coverage. **Note:** This authorization can be revoked by submitting a written request to the **Practice Coordinator at the Northside Hospital Physician Practice Office identified above**.

This authorization for the release of protected health information shall remain in effect until the **earlier** of any of the following dates:

- (a) \_\_\_\_\_ **(in this blank, you may include a specific expiration date or event, such as conclusion of a lawsuit);**  
(b) the date I revoke this authorization in writing; or (c) three (3) years from the date on which I signed this authorization. If I signed this authorization on behalf of a minor, it will expire when the minor turns 18, marries or becomes emancipated under Georgia law.

**Note: Please read BOTH SIDES of this form and complete all applicable lines below, with your signature, date and time. By signing this authorization, you affirmatively represent that (i) you are the patient OR (ii) the patient is alive and you are legally authorized to make his or her healthcare decisions, including the release of medical records.**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date AM/PM  
Time

\_\_\_\_\_  
Interpreter (if applicable)

Note to staff: if telephone interpretation provided, record name of company and interpreter ID number.

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative,  
Including Legal Guardian, Health Care Agent, or Parent of Minor Child

\_\_\_\_\_  
Print name:

\_\_\_\_\_  
Relationship to patient:

\_\_\_\_\_  
Reason patient unable to sign:

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND INFORMATION

**Note:** To authorize the disclosure of psychotherapy notes, the additional form entitled *Authorization for Release of Psychotherapy Notes* will need to be completed. To authorize the disclosure of patient records from the Northside Hospital Behavioral Health Recovery Program, the additional form entitled *Authorization for Release of Alcohol and Drug Abuse Patient Records* will need to be completed.

I understand the potential that medical records and information disclosed pursuant to this authorization in whatever form and/or means provided (including, but not limited to, electronic transmission, paper copies, CDs, films, and flash drives) may be subject to re-disclosure by the recipient and may no longer be subject to protections under the federal privacy laws and regulations. I further understand that any electronic format of my health information that I receive may not be encrypted or password protected and I am responsible for taking precautions to protect the data and storing it in a secure manner. By choosing to receive my health information electronically, I acknowledge and accept the risk of doing so. I hereby release the Northside Hospital Physician Office Practice, Northside Hospital, Inc., and their agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release, receipt, and/or re-disclosure of the medical records and information I have authorized above.

### NOTICE TO RECEIVING AGENCY OR INDIVIDUAL

**Disclosure or receipt of the information authorized above does not remove any privilege or right of confidentiality with respect to the information and does not authorize re-disclosure of the information. If any of the disclosed information relates to treatment or referral for treatment for substance abuse which is protected by Federal confidentiality rules (42 C.F.R. Part 2), the following notice shall also apply.**

**This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**