Please answer every question below. The information requested will be part of your complete medical chart and will be handled in a confidential manner.

GENERAL PATIENT INFORMATION

LAST NAME | FIRST | MIDDLE

STREET ADDRESS | CITY | STATE, ZIP | EMAIL (optional)

( ) DAYTIME PHONE ☐ HOME ☐ WORK ☐ OTHER | CONTACT BY ☐ PHONE ☐ MAIL ☐ SECURE MESSAGE | DATE OF BIRTH | AGE

( ) EVENING PHONE ☐ HOME ☐ WORK ☐ OTHER | SOCIAL SECURITY NUMBER

EMPLOYER (NAME/COMPANY) | CITY | STATE | ( ) PHONE NUMBER

▲*The federal government has asked that all physician offices begin collecting information on our patients' race and ethnicity. We are asking for your help in completing the questions below, however you are not required to respond.*

If you decline to respond, please check here ☐

ETHNICITY

I am of Hispanic or Latino descent:

☐ Yes ☐ No

Preferred Language: ____________________

RACE I am (check any):

☐ White or Caucasian ☐ Black or African-American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native

☐ Other (please list): ____________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY | GROUP OR LOCAL NUMBER

ADDRESS | SUBSCRIBERS DATE OF BIRTH | ID#

SUBSCRIBERS NAME | SUBSCRIBERS RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

SECONDARY INSURANCE COMPANY | GROUP OR LOCAL NUMBER

ADDRESS | SUBSCRIBERS DATE OF BIRTH | ID#

SUBSCRIBERS NAME | SUBSCRIBERS RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER

INSURANCE AUTHORIZATION & RELEASE OF INFORMATION

I hereby authorize and request my insurance company, including MEDICARE or TRICARE, to pay the physicians of Oregon Lung Specialists, LLC the amount due on my claim for service rendered to me or my dependents. I further agree to be personally responsible for the balance due on my account with Oregon Lung Specialists, LLC should the insurance company not pay my claim in full.

I authorize the release of medical information necessary to process my claim and request payment of benefits to the party who accepts assignment.

I hereby authorize Oregon Lung Specialists, LLC to send my medical evaluation(s) to my referring physician, primary care physician and/or insurance company(s).

Lastly, I authorize the following family member(s)/caregiver(s) to discuss my medical condition and/or billing information with physicians and staff of Oregon Lung Specialists, LLC. Please list name, relationship, and phone number in case of an emergency for any/all contacts.

If you decline to respond, please check here ☐

Name	Relationship	Phone Number

Signature ____________________ Date __________

(Patient or Authorized Person)

Name Date of birth Oregon Lung Specialists, LLC

MEDICAL HISTORY

Which Doctor Referred You To Our Office?: ______________________________

Briefly, what is the main reason for seeing the doctor?

2) Please provide a complete list of past and present medical problems (use other side is necessary):

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

3) Please list prior surgeries (use other side is necessary):

1.	4.
2.	5.
3.	6.

4) Please bring to clinic a complete list of your current medications and their dosages. Include all prescription, over-the-counter, and herbal/natural remedies. You may want to bring your current medications with you to the clinic.

5) Do you have any known ALLERGIES TO MEDICATIONS? ☐ **YES** PLEASE LIST BELOW ☐ No ☐ Don't Know

6) Have you had any recent CHEST x-rays or CT scans? ☐ Yes ☐ No: If yes, please provide the name of the facility where we can request your x-ray studies (if known). In addition, the date of the study is helpful:

7) About you:

• ☐ Married ☐ Single ☐ Widowed ☐ Divorced	• do you have a history of excessive alcohol use? ☐ Yes ☐ No
• Place of Birth	• Are you currently drinking alcoholic beverages? ☐ Yes ☐ No
• military service?: ☐ No: ☐ Yes: Branch ______________	• Do you drink on a daily basis? ☐ Yes ☐ No if yes, how much ______________________ weekly ☐ Yes ☐ No if yes, how much ________________________
• past & present occupation(s):	• any inhalation exposures (e.g. asbestos, work in a mine or quarry or sandblasting, work in a sawmill, any heavy dust, fumes, or chemical that caused respiratory symptoms)? ☐ Yes ☐ No ☐ Don't Know
• any known HIV risk factors ☐ Yes ☐ No ☐ Don't Know (e.g.: intravenous drug use, blood transfusion before March 1985 or, unprotected sex with partner of positive or of known HIV status, hemophilia, your mother infected at time of birth, immigrant from Haiti or East Africa)?	• what is the *most* you have smoked on a regular basis?: ☐ Never ☐ <1pk/day ☐ 1-2 pk/day ☐ >2 pk/day
• any animals at home? ☐ Yes ☐ No • any birds at home? ☐ Yes ☐ No	age when first began:______________ age when last used:_______________ any significant 2nd hand smoke exposure?: ☐ Yes ☐ No

8) Have you been immunized for?:

Influenza?	☐ Yes	☐ No	☐ Don't Know	date of last vaccination (if known):_________________
Pneumovax?	☐ Yes	☐ No	☐ Don't Know	date of last vaccination (if known):_________________
Prevnar 13?	☐ Yes	☐ No	☐ Don't Know	date of last vaccination (if known):_________________

REVIEW OF SYSTEMS

Please circle any symptoms that are significant problems. Use the space at the right to *briefly* explain or add additional comments. Items not circles will be assumed to be absent or not significant.

GENERAL:

weight change | fever-chills | night sweats

EYES:

loss of vision | blurred vision | eye pain

EARS, NOSE, MOUTH, THROAT:

sinus congestion | post-nasal drip | ringing in ears | nose bleeds

CARDIOVASCULAR:

chest pain | ankle swelling | palpitations/fluttering | racing heart beat

RESPIRATORY:

wheeze | cough | snoring | shortness of breath

GASTOINTESTINAL:

heartburn | swallowing problem

GENITOURINARY:

incontinence | bed wetting | frequent bathroom trips at night

MUSCULOSKELETAL:

muscle pain | joint pain | back or neck pain | carpal tunnel syndrome | arthritis

SKIN:

rash(s) | diffuse itching

NEUROLOGIC:

headaches | tremor | burning in feet | seizures

PSYCHIATRIC:

depressed | panic attacks | insomnia | claustrophobia

ENDOCRINE:

hot flashes | fatigue | hot/cold intolerance

HEMATOLOGIC/LYMPHATIC:

easy bruising | excessive bleeding | swollen lymph nodes

ALLERGIC/IMMUNOLOGIC:

hives | seasonal allergies

SLEEP HISTORY FORM

Instructions:
For the questions below, please, fill in the blank, circle the appropriate answer or check box if your answer is 'yes'. Comments may be written on the back. If you have any questions, please ask at any time. Be as complete as possible. It helps us help you. *Thank you.*

Name: ______________________________ **Date:** ______________

Date of Birth: ________________

Typical Sleep Times

Usual time to go to bed ________ Usual time to fall asleep ________ Usual time spent asleep ________

Usual # of awakenings ______ Usual time to get up ______ Usual # of naps _____ When _____ How Long _____

Family History: (Please note any known sleep problems such as sleep apnea, insomnia, restless legs, narcolepsy, sleep-walking, sleep-eating, or nightmares)

Father: ______________________________

Mother: ______________________________

Siblings: ______________________________

Children: ______________________________

Please describe your problem (whether medical or sleep related), how it started and how long it has been present:

EPWORTH SLEEPINESS SCALE

Please indicate the likelihood that you would asleep in the following situations (scale of 0-3). This refers to your usual way of life in recent times. 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 television	________
Sitting, inactive in a public place (e.g.; 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 lunch without alcohol	________
In a car while stopped for a few minutes in traffic	________
TOTAL	________

Sleepiness or Fatigue Complaints

Check box if answer is "yes"

Do you have:

- Difficulty concentrating? ☐

Are you sleepy while driving? ☐

Does excessive sleepiness or fatigue interfere with your daily activities? ☐

Have you been told that you snore frequently or that your snoring disturbs others? ☐

Has anyone ever told you or notices that you stop breathing when you sleep? ☐

Do you experience drowsiness or have you recently fallen asleep while driving? ☐

Do you take naps or fall asleep during the day? ☐

Other Night Time Problems

Check box if answer is "yes"

Do you:

- Have night sweats? ☐
- Grind your teeth at night? ☐
- Have vivid or disturbing dreams? ☐
- Chronic pain that wakes you up at night? ☐

Do you:

- Sleep walk? ☐
- Sleep talk? ☐
- Sleep eat? ☐
- Wet the bed? ☐

Are you awakened by spontaneous leg jerks or uncomfortable sensations in your legs? ☐

Difficulty Going to Sleep or Sleeping

Check box if answer is "yes"

To help sleep, do you:

- Use prescribed medications? ☐
- Use over-the-counter medications? ☐
- Eat food or drink liquids? ☐

Do you regularly or frequently wake up during the night? ☐

Is difficulty falling asleep a recurring or bothersome problem for you? ☐

Do you awaken early in the morning still sleepy and unable to fall back asleep? ☐

Do you sleep better:

- On days off work or on weekends? ☐
- When away from home? ☐

If you work regularly, do you work at night or on a swing shift? ☐

Do you usually wake up refreshed? ☐

Do you have any difficulty with sleep due to worrying or anxiety? ☐

Sleep Related History Habits

Check box if answer is "yes"

Do you:

- Drink caffeinated beverages? ☐
- If yes, how much per day ________________

Do you regularly:

- Read or work in bed? ☐
- Eat late at night or in bed? ☐
- Watch TV in bed? ☐

Miscellaneous

Check box if answer is "yes"

Do you get an uncomfortable, crawling, or strange sensation in your legs along with an urge to move them? ☐

Has your weight increased over the past five years? ☐

If yes, by how much? ________________

Do you see, hear, or feel things before your fall asleep that seem to be part of a dream? ☐

Have you or do you lose muscle control or go limp when you are surprised, are laughing or get angry? ☐

Do you ever have the sensation of being unable to move as you fall asleep? ☐

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue.

The FFS questionnaire contains none statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.

- It is important that you circle a number (1 to 7) for every question.

FSS Questionnaire							
During the past week, I have found that:	**Disagree**		**----------------------------**				**Agree**
My motivation is lower when I am fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Exercise brings on my fatigue.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
I am easily fatigued.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with my physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue causes frequent problems for me.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
My fatigue prevents sustaining physical functioning.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with carrying out certain duties and responsibilities.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue is among my three most disabling symptoms.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Fatigue interferes with my work, family or social life	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Total Score:						