

**Hickory Office**

1321 North Center Street  
Hickory, NC 28601  
Phone: 828-322-3898  
Fax: 828-322-5485



[www.foothillsinternalmed.com](http://www.foothillsinternalmed.com)

**Hudson Office**

286 Pine Mountain Road  
Hudson, NC 28638  
Phone: 828-728-1998  
Fax: 828-728-1996

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## NEW PATIENT REGISTRATION PACKET

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Dear Patient:

You can return this packet as well as copies of your insurance cards in person, by fax at 828-322-5485 or by mail to 1321 North Center Street, Hickory, NC 28601.

Once the registration packet and copies of your *health insurance cards are received*, we will mail you your appointment information in the mail.

If the Patient Information and Insurance Information sections on the Patient Registration Sheet are incomplete and we do not receive a copy of your insurance cards, we will be unable to make your appointment. *Please make sure to fill out all forms in the registration packet completely.*

The only exception to this would be if you are UN-INSURED and paying cash for the weight loss program. In that instance, you need to make sure the Patient Information section is filled out. We also want to inform you that payment of the initial \$350.00 fee will be required at the time of your lab appointment. *Payment will be accepted in cash or credit card only.*

Please review our office policies listed on this web site before your scheduled appointment.

If you have any questions feel free to call the front desk at either office 828-322-3898 for the Hickory location and 828-728-1998 for the Hudson location.

## Hickory Office

1321 North Center Street  
Hickory, NC 28601  
Phone: 828-322-3898  
Fax: 828-322-5485



[www.foothillsinternalmed.com](http://www.foothillsinternalmed.com)

## Hudson Office

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Phone: 828-728-1998  
Fax: 828-728-1996

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# OFFICE POLICIES

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**Office Visits:** To help us make the most informed decision about your medical care, please bring the following to your appointment:

1. Medicine bottles for all medication you are currently taking.
2. All medical records pertinent to your exam (stress tests, ultrasounds, radiological reports, etc.).

Please arrive 10 minutes before any appointment. If you are a new patient, an EKG will also be performed during this exam. Please do not wear any lotion on your arms, chest, or legs; it will keep the EKG sensors from sticking to your skin and will interfere with a proper EKG reading.

**Lab Appointments:** For the most accurate results, we recommend that you do not eat anything for 8-10 hours before your lab appointment. However, we do recommend you drink several glasses of water, black coffee, or any other unsweetened/diet drink. Your blood draw will be easier if you are hydrated. It is very important that you make this lab appointment. Analyzing your blood work beforehand allows us to discuss the best treatment options during your exam. If you are unable to make your scheduled lab appointment, please call us as soon as possible so we may help you reschedule. If you miss your lab appointment, and we do not hear from you, your exam will be cancelled.

**Financial:** Please remember to bring your most current insurance card(s) to your appointment. You will be asked to show them before every appointment. All co-pays, deductibles, and any charges not covered by insurance are due at the time of service. We accept MasterCard, Visa, cash, checks, and CareCredit. There is a \$25 service charge for returned checks.

If you are participating in the weight loss program please be aware that all shots are to be paid for with either cash, credit card or CareCredit. Checks will not be accepted.

**Cancellations:** Our office gives a reminder call 48 hours in advance of your scheduled appointment. If you need to cancel or reschedule your appointment, please give a 24 hour notice to allow sick patients to be seen. There is a \$50 charge for unkept appointments.

**Prescription Refills:** When you need a refill of a medication that has been previously prescribed for you, please call your pharmacy and ask them to fax a refill request to our Hickory office at 828-322-5485 or our Hudson office at 828-728-2930. We can then fax them a prescription. For your wellbeing, do not wait until you are down to your last pill because you should allow 24 hours for the prescription order to be processed and filled. New prescriptions typically require an appointment in order to evaluate the appropriateness of the medication for you. However, narcotics will never be prescribed or refilled after office hours or on weekends.

**Telephone:** Every attempt is made to take care of each patient's needs during the same business day you call. Please make sure to give us a current contact number for yourself as well as the number of your pharmacy in case a prescription needs to be called in for you.

**Emergencies:** After hours medical needs are to be taken care of at the nearest urgent care or emergency room. We offer medical appointments starting at 8:00 and ending at 6:00 p.m. in Hickory and 5:00 p.m. in Hudson to accommodate our patients' scheduling needs. Our offices always will be glad to fit in a sick patient into our schedule during business hours.

**Patient Access to Medical Records:** Medical records are confidential documents and will be released only when permitted by law or with proper written authorization by the patient. Physicians are responsible for safeguarding and protecting the medical records and for providing adequate security measures.

Medical records will be copied for transfer to another physician at no cost to the patient the first time they are requested. For any additional requests, there will be a reasonable fee for the preparation and/or photocopying of medical records. Transferred records will either be faxed to the new physician's office or they can be signed for and picked up at our office by the patient or approved family member. We will not mail complete medical records.

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## PATIENT REGISTRATION

### PATIENT INFORMATION

Mr./Ms./Miss (check one) \_\_\_\_\_  
FIRST NAME LAST NAME M.I.

MAILING ADDRESS CITY STATE ZIP  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE OF BIRTH (M/D/Y) M  F  SEX (M/F) SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYMENT OCCUPATION NAME OF EMPLOYER  
Are you a Student? Yes  No   
NAME OF SCHOOL \_\_\_\_\_

### CONTACT INFORMATION

It may be necessary to communicate with you regarding a change in your appointment, instructions, and other information regarding your treatment. In the event we are unable to reach you personally, please give us instructions regarding the best way to communicate with you.

Please check all that apply and complete the necessary information:

- Yes  No  Message may be left on my **HOME** answering machine for me.  
My **HOME** phone number is \_\_\_\_\_
- Yes  No  Message may be left for me at my **WORK** voicemail or with a co-worker.  
My **WORK** number is \_\_\_\_\_
- Yes  No  Messages may be communicated via **EMAIL**.  
My **EMAIL** address is \_\_\_\_\_
- Yes  No  Message may be left on my **CELL PHONE**.  
My **CELL PHONE** number is \_\_\_\_\_
- Yes  No  Messages may be left for me with my **PARTNER**.  
**His/Her** name and number is \_\_\_\_\_

Other persons authorized to receive information on my behalf and to be considered my **EMERGENCY** contact(s) are:

CONTACT #1 NAME CONTACT'S PHONE#  
CONTACT #2 NAME CONTACT'S PHONE#

*I hereby release, discharge and agree to hold harmless all parties whom the consent is given from any liability that may arise from the release of information to those authorized above. I realize that I may revoke this consent in writing in the future.*

\_\_\_\_\_  
Patient Signature Date: \_\_/\_\_/\_\_

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## INSURANCE & REFERRAL INFORMATION

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PRIMARY INSURANCE	INSURED'S NAME	INSURED'S BIRTHDATE
INSURED'S EMPLOYER	RELATIONSHIP TO PATIENT	INSURED'S SS#
ID#	GROUP #	

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SECONDARY INSURANCE	INSURED'S NAME	____/____/____ INSURED'S BIRTHDATE
INSURED'S EMPLOYER	RELATIONSHIP TO PATIENT	INSURED'S SS#
ID#	GROUP #	

### REFERRAL INFORMATION

How did you hear of our clinic?  Yellow Pages  Newspaper  Internet  
Friend or Healthcare Provider: \_\_\_\_\_

### ASSIGNMENT OF BENEFITS FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Foothills Internal Medicine, and any assisting medical provider for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further understand that any sums due me if less than \$50.00 will be credited to my medical account. I agree that a photocopy of this agreement shall be as valid as the original.

*I have read and understand all of the above and have given truthful information to the best of my knowledge.*

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Patient Signature	____/____/____ Date
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## CURRENT PRESCRIPTION MEDICATION LIST

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PERFERRED PHARMACY \_\_\_\_\_

PHARMACY'S PHONE# \_\_\_\_\_

Please list any allergies to medication including specific ttypes of X-ray dyes and drugs:

\_\_\_\_\_  
\_\_\_\_\_

### CURRENT MEDICATION LIST

Please list the name of all prescriptions and over-the-counter medications you are currently taking. This list should include any vitamins, herbs, or any other nutritional supplements. Make sure to list the current dose, strength, and frequency it is taken.

EXAMPLE:

Name of medication: Aspirin

Dose or strength of medication: 500 mg

Directions: take one by mouth daily

1. Name of medication: \_\_\_\_\_

Dose or strength of medication: \_\_\_\_\_

Directions: \_\_\_\_\_

2. Name of medication: \_\_\_\_\_

Dose or strength of medication: \_\_\_\_\_

Directions: \_\_\_\_\_

3. Name of medication: \_\_\_\_\_

Dose or strength of medication: \_\_\_\_\_

Directions: \_\_\_\_\_

4. Name of medication: \_\_\_\_\_

Dose or strength of medication: \_\_\_\_\_

Directions: \_\_\_\_\_

5. Name of medication: \_\_\_\_\_

Dose or strength of medication: \_\_\_\_\_

Directions: \_\_\_\_\_

**PLEASE REMEMBER TO BRING ALL OF YOUR MEDICATION BOTTLES  
(EVEN THOSE PRESCRIBED BY OTHER PHYSICIANS) TO ALL OF YOUR APPOINTMENTS.**

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## PATIENT CONSENT FORM

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\_\_\_\_\_  
PATIENT NAME

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE OF BIRTH (M/D/Y)

**Consent for Treatment:**

I hereby give consent to Foothills Internal Medicine to provide whatever treatment the physician/provider may deem necessary to the patient.

**Consent for Insurance Billing:**

Foothills Internal Medicine will submit claims to the insurance companies that they are contracted with. I understand that I am responsible for all deductibles, copays, and charges not covered by insurance at the time of service. I also understand that I will need to bring my current insurance card(s) to each visit along with whatever my copay or coinsurance is.

**Acknowledgment of Unkept Appointment Policy:**

Foothills Internal Medicine gives a reminder call 48 hours in advance of scheduled appointments. If you need to cancel or reschedule we ask that you give us 24 hours notice. If we do not have adequate notice we are unable to fill the appointment slot that we had reserved for you. There is a \$50 charge for all unkept provider appointments.

**Authorization to Release Information:**

I hereby authorize Foothills Internal Medicine to release any information acquired in the course of my treatment to any insurance company including Medicare. I also authorize the payment of claims directly to Foothills Internal Medicine.

**Signature for treatment, insurance policy, and authorization to release information:**

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
TODAY'S DATE

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**Acknowledgement of Receipt of Notice of Privacy Practices**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our practice to ask questions about our privacy practices. By signing this form, you have agreed that you have had the opportunity to read our Notice of Privacy Practices..

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## MEDICAL RECORDS RELEASE

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I \_\_\_\_\_, request my medical records including current and previous records, which are part of my medical background be released to Foothills Internal Medicine.

**Persons Authorized to Disclose Information**  
(WHERE RECORDS ARE COMING FROM)

Provider's name: \_\_\_\_\_  
Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Patient Authorizing Release**

Patients Name: \_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE OF BIRTH (M/D/Y) SOCIAL SECURITY NUMBER  
Other Names Used In The Past: \_\_\_\_\_

***This authorization is effective for one year unless revoked or terminated by the patient.***

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
TODAY'S DATE

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## AUTHORIZATION OF HEALTH INFORMATION DISCLOSURE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

FOOTHILLS INTERNAL MEDICINE  
1321 N. CENTER STREET  
HICKORY, NC 28601

FOOTHILLS INTERNAL MEDICINE  
286 PINE MOUNTAIN ROAD  
HUDSON, NC 28638

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

\_\_\_\_\_ Complete health records

\_\_\_\_\_ Lab results/X-ray reports

\_\_\_\_\_ Physical exam

\_\_\_\_\_ Consultation reports

\_\_\_\_\_ Immunization record

\_\_\_\_\_ Other (please specify: \_\_\_\_\_)

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and be used by the following individual or organization.

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the practice administrator. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Signature of witness

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## CARE INFORMATION

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Fill out this form so that we can take better care of you!

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_/\_\_\_\_/\_\_\_\_  
TODAY'S DATE

Do you have any moles, skin tags or warts that you want removed? Yes  No

When was your last complete physical exam? \_\_\_\_/\_\_\_\_/\_\_\_\_ (A complete physical should include an EKG, labs and if you are female, a pelvic exam.)

Are you interested in losing weight? Yes  No

Do you have problems sleeping? Yes  No

Do you need help to stop smoking or drinking alcohol? Yes  No

Are you interested in Botox or Juvederm? Yes  No

Are there any other cosmetic procedures that you are interested in? (such as sclerotherapy-removal of varicose or spider veins, cellulite removal, acne therapies) If so, what? \_\_\_\_\_

What other health care providers do you see? (list providers name and specialty)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Listed below is the standard of care you should be receiving for your age group. Please review and discuss with your health care provider.**

**If you are Ages 18-30:**

- Have you had your cholesterol and triglycerides checked every 5 years? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a dental exam every 1 to 3 years? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had an eye exam every 1 to 3 years? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a clinical breast exam every year? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a pelvic exam and pap smear every year? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Are you at risk for sexually transmitted diseases? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had Chlamydia testing? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE LOOK AT LIST OF IMMUNIZATIONS ON THE BACK OF THIS PAGE.**

**If you are Ages 30-64:**

- Have you had your cholesterol checked yearly? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a digital rectal exam yearly since 40 years old? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a fecal occult blood test yearly since 40 years old? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a colonoscopy at age 50 years and every 10 years thereafter if normal? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a dental exam every 6-12 months? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_

- Have you had an eye exam every 2-4 years? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Do you have problems with your balance or dizziness? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Male: Have you had a yearly prostate specific antigen and prostate exam since being 40 years old?  
Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Male: Have you had a testosterone test done? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a yearly clinical breast exam? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a yearly mammogram since being 40 years old? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a yearly pelvic exam and pap smear? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Is menopause affecting you? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_

**If you are Ages 65 and over:**

- Have you had a yearly hearing test? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a yearly fecal occult blood test? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a colonoscopy every 10 years? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had yearly cholesterol levels? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a dental exam every 6-12 months? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you had a yearly eye exam? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Do you have problems with your balance or dizziness? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a yearly mammogram until age 75 if normal? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a clinical breast exam until age 75 if normal? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Female: Have you had a bone density test yearly? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Male: Have you had a yearly prostate specific antigen test? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Male: Have you had a testosterone test done? Yes  No  Last known \_\_\_\_/\_\_\_\_/\_\_\_\_

**Have you had your immunizations?**

- Tetanus-diphtheria booster-once, between ages 14-16 and then a booster every 10 years  
Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Influenza vaccine yearly
- Pneumococcal vaccine-once, everyone over 65; and for below age 65 for medical or other indications  
Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Measles, mumps, rubella (MMR) or varicella (chicken pox)-1-2 doses, for persons without proof of immunity with occupational or other indications; once, for women of childbearing age without proof of rubella immunity.  
Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Hepatitis A and hepatitis B vaccines-once, for persons in health care occupations or working with blood, intravenous drug users, those having multiple sexual persons or having sex with a hepatitis-infected persons.  
Last known \_\_\_\_/\_\_\_\_/\_\_\_\_
- Meningococcal (polysaccharide)-once, for persons with medical indications or other specific indications.  
Last known \_\_\_\_/\_\_\_\_/\_\_\_\_

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**MEDICAL HISTORY**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Current problem: \_\_\_\_\_

**Family History:** Age / Major Illness

Mother \_\_\_\_\_  
Father \_\_\_\_\_  
Brothers \_\_\_\_\_  
Sisters \_\_\_\_\_  
Grandparents \_\_\_\_\_

**Social History :** M  S  D  W

Occupation \_\_\_\_\_  
Children (ages) \_\_\_\_\_  
Tobacco: Y  N  Coffee: Y  N  Alcohol: Y  N   
Exposure to Industrial Fumes? Y  N

**Patient's Past Medical History:** (check if possible)

- \_\_\_ High Blood Pressure
- \_\_\_ Diabetes
- \_\_\_ Protein or Blood in Urine
- \_\_\_ Kidney Disease
- \_\_\_ Kidney Stones
- \_\_\_ Liver Disease
- \_\_\_ Chest Pain
- \_\_\_ Heart Attack
- \_\_\_ Arrhythmias
- \_\_\_ Thyroid Disease
- \_\_\_ High Cholesterol
- \_\_\_ Stroke
- \_\_\_ Arthritis
- \_\_\_ Phlebitis
- \_\_\_ Lung Problems, Disease
- \_\_\_ Cancer, Abnormal Mammogram
- \_\_\_ TB
- \_\_\_ Weight Loss/Gain
- \_\_\_ Diverticulosis, Blood in Stool
- \_\_\_ Migraine Headache
- \_\_\_ Ulcers
- \_\_\_ Skin Disease, Rash
- \_\_\_ Hiatal Hernia
- \_\_\_ Depression or Anxiety
- \_\_\_ Gout
- \_\_\_ Anemia
- \_\_\_ Seizures
- \_\_\_ Vasculitis
- \_\_\_ Abnormal Pap Smears
- \_\_\_ Erection Difficulties
- \_\_\_ Sexual Difficulties

**Review Symptoms:** (check if possible)

- General:**
- \_\_\_ weight change/year
- \_\_\_ appetite change
- \_\_\_ fatigue/malaise
- Head:**
- \_\_\_ headaches
- \_\_\_ eyes, vision
- \_\_\_ ears, hearing
- \_\_\_ nose
- \_\_\_ throat, swallowing
- Neck:**
- \_\_\_ swelling
- \_\_\_ tenderness
- Chest:**
- \_\_\_ pain
- \_\_\_ pressure
- Breasts:**
- \_\_\_ tenderness
- \_\_\_ lumps
- Lungs:**
- \_\_\_ wheezing
- \_\_\_ chronic cough
- \_\_\_ shortness of breath
- GU (urinary):**
- \_\_\_ pain
- \_\_\_ frequency
- \_\_\_ blood
- \_\_\_ erectile dysfunction

**Bones:**

- \_\_\_ gout
- \_\_\_ joint pain
- \_\_\_ swelling

**GYN:**

- \_\_\_ LMP \_\_\_\_\_
- \_\_\_ # pregnancies
- \_\_\_ # children

**Neuro:**

- \_\_\_ numbness
- \_\_\_ tingling
- \_\_\_ weakness
- \_\_\_ dizziness
- \_\_\_ fainting

**Extremities:**

- \_\_\_ swelling, edema
- \_\_\_ coolness, blue color
- \_\_\_ painful calves when walking

**Skin:**

- \_\_\_ rashes, lesions, unusual moles

**GI (digestive):**

- \_\_\_ abdominal pain
- \_\_\_ nausea, vomiting
- \_\_\_ black tarry stool
- \_\_\_ red blood in stool
- \_\_\_ constipation

**Surgeries:** Procedure / Date / Surgeon

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations:** Location / Date / Problem

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## SLEEP APNEA SCREENING TOOL

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*This tool was developed by David White, M.D., Harvard Medical School, Boston, MA and assists us in determining whether you have Sleep Apnea. Please write the value of your answer in the spaces given.*

\_\_\_\_/\_\_\_\_/\_\_\_\_  
TODAY'S DATE

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE OF BIRTH

1. Snoring:

- a) Do you snore on most nights (more than 3 nights per week)?  
Yes (2) No (0) \_\_\_\_\_
- b) Is your snoring loud? Can it be heard through a door or wall?  
Yes (2) No (0) \_\_\_\_\_

2. Has it ever been reported to you that you stop breathing or gasp during sleep?

Never (0) Occasionally (3) Frequently (5) \_\_\_\_\_

3. What is your collar size?

Male: Less than 17 inches (0) More than 17 inches (5) \_\_\_\_\_  
Female: Less than 16 inches (0) More than 17 inches (5) \_\_\_\_\_

4. Do you occasionally fall asleep during the day when

- a) You are busy or active?  
Yes (2) No (0) \_\_\_\_\_
- b) You are driving or stopped at a light?  
Yes (2) No (0) \_\_\_\_\_

5. Have you had or are you being treated for high blood pressure?

Yes (1) No (0) \_\_\_\_\_

**TOTAL** \_\_\_\_\_

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## SELF ASSESSMENT FOR BREATHING PROBLEMS

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\_\_\_\_/\_\_\_\_/\_\_\_\_  
TODAY'S DATE

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_/\_\_\_\_/\_\_\_\_  
DATE OF BIRTH

If you are having breathing difficulties, complete this questionnaire. If for some or all of these and symptoms of emphysema, chronic bronchitis, and COPD fit you, a pulmonary function test upon check out. The earlier COPD is diagnosed, the more effective treatment will be.

1. Do you experience sever shortness of breath when you exercise or climb the stairs?  
Yes  No
2. Do you have a persistent cough that has lasted for more than a month?  
Yes  No
3. Have you noticed an increase in sputum production, thicker sputum, or a change in sputum color?  
Yes  No
4. Do you have risk factors like smoking or family members with COPD?  
Yes  No
5. Do you have problems sleeping?  
Yes  No
6. Do you sleep better while sitting up?  
Yes  No
7. Have you had an unexplained increase or decrease in weight?  
Yes  No
8. Do you feel more tired and have less energy than usual?  
Yes  No