Capitol Area Pulmonary Associates

3960 Patient Care Dr. Suite 109
Lansing, MI 48911
Phone: (517) 574-5645 Fax: (517) 574-5688

PATIENT INFORMATION

Today's Date ___________________

First Name _________________________ M.I. ______ Last Name _________________________ Suffix ______

Sex: ☐ Male ☐ Female Date of Birth _____________ Age _____ E-mail ______________________________

Street Address____________________________ Apt.____ City___________________ State_____ Zip_______

Home Tel.(____) ________________ Cell Phone (____) _______________ Work Tel. (____) ______________

Employer ______________________________________ Occupation ____________________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Ethnicity ________________________________

In case of emergency, please contact __________________________ Tel. Cell Phone (____) ________________

RESPONSIBLE PARTY

☐ Self (If self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ DPOA ☐ Other: _______________________

First Name _________________________ M.I. ______ Last Name _________________________ Suffix ______

Sex: ☐ Male ☐ Female Date of Birth _____________ Age _____ E-mail
____

Street Address____________________________ Apt.____ City___________________ State_____ Zip_______

Home Tel.(____) ________________ Cell Phone (____) _______________ Work Tel. (____) ______________

SOCIAL HISTORY

Occupation ___________________________________ If retired, when? __________________________________

Do you or have you ever smoked? ☐ Yes ☐ No Packs per day? __________ How long?___________________

If you quit smoking, when? ____

Do you drink alcohol? ☐ Yes ☐ No How often? ________ Times per week How much?___________________

SLEEP SCHEDULE

What is your main sleep related problem? ____

How long have you had this problem? ____

Approximately what time do you wake up on WEEKDAYS? ________ ☐ A.M. ☐ P.M.

Approximately what time do you go to bed on WEEKDAYS? ________ ☐ A.M. ☐ P.M.

Approximately what time do you wake up on WEEKENDS? ________ ☐ A.M. ☐ P.M.

Approximately what time do you go to bed on WEEKENDS? ________ ☐ A.M. ☐ P.M.

Do you nap? ☐ Yes ☐ No How often do you nap? ____ Times per week. How long are the naps? _____ mins

Do you share a bed with someone? ☐ Yes ☐ No ☐ Sometimes

Are you a shift worker? ☐ Yes ☐ No If yes, what times do you work? ______________________________

SNORING & BREATHING HISTORY

Please circle the appropriate answer

Do you snore?	Yes	No	Sometimes
Do you snore loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night?	Yes	No	Sometimes
Does your sleep position affect your snoring?	Yes	No	Sometimes
Have you awakened from choking or short of breath?	Yes	No	Sometimes
Has anyone observed you stop choking/gasping during your sleep?	Yes	No	Sometimes
Has anyone noticed that you stop breathing while asleep?	Yes	No	Sometimes
Do you have morning headaches?	Yes	No	Sometimes
Do you awaken more than twice to urinate during the night?	Yes	No	Sometimes
Do you wake up refreshed in the morning?	Yes	No	Sometimes
Do you awaken with an acid or sour taste in your mouth?	Yes	No	Sometimes
Do you have difficulty sleeping on your back?	Yes	No	Sometimes

SLEEP HISTORY

Please circle the appropriate answer

Question			
Do you have difficulty falling asleep?	Yes	No	Sometimes
Do you have difficulty staying asleep?	Yes	No	Sometimes
Do you wake up too early and cannot get back to sleep?	Yes	No	Sometimes
Do you have thoughts racing through your mind that make it difficult to sleep?	Yes	No	Sometimes
Have you fallen asleep unexpectedly?	Yes	No	Sometimes
Have you ever fallen asleep while driving drowsy?	Yes	No	Sometimes
Have you ever had a motor vehicle crash due to drowsy driving?	Yes	No	Sometimes
Have you experienced “sleep attacks” (a sudden irresistible urge to sleep)?	Yes	No	Sometimes
Have you experienced sudden muscle weakness in response to emotions?	Yes	No	Sometimes
Have you experienced an inability to move while falling asleep or waking up?	Yes	No	Sometimes
Do you kick or jerk your arms or legs during sleep?	Yes	No	Sometimes
Have you experienced an urge to move your legs accompanied by an uncomfortable sensation?	Yes	No	Sometimes
Do you have an urge to move your legs that worsens with rest or inactivity like lying down or sitting?	Yes	No	Sometimes
Do you have an urge to move your legs that is relieved by walking or stretching?	Yes	No	Sometimes
Do you have an urge to move and an unpleasant sensation in your legs that occurs only at night?	Yes	No	Sometimes
Do you often feel tired, fatigued, or sleeping during the daytime?	Yes	No	Sometimes
Do you talk in your sleep?	Yes	No	Sometimes
Do you have nightmares?	Yes	No	Sometimes
Have you ever acted out your dreams?	Yes	No	Sometimes
Do you grind your teeth?	Yes	No	Sometimes

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Please circle the most appropriate answer using the following scale.

0 = Never	1 = Occasionally	2 = Often	3 = Usually

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
At a public place like a theater or meeting	0	1	2	3
While a passenger in a car for one hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting down after lunch	0	1	2	3
Stopped at a stoplight	0	1	2	3

Please add the numbers you chose. What is your score? __________ out of 24

HEALTH & MEDICAL HISTORY

Are you updated on your Pneumonia vaccine? ☐ Yes ☐ No When? ______________________________

Are you updated on your Prevnar 13 vaccine? ☐ Yes ☐ No When? ______________________________

Are you updated on your Influenza vaccine? ☐ Yes ☐ No When? ______________________________

Are you updated on your COVID-19 vaccine? ☐ Yes ☐ No When? ______________________________

Do you have any known allergies? ☐ Yes ☐ No Please list ______________________________

Today's Date ________________ Weight ____________ lbs Height ____________ft ____________inches

Weight 1 year ago ______________________ lbs Weight 5 years ago __________________________ lbs

Is your body mass index (BMI) more than 35kg/m2? ☐ Yes ☐ No

Is your shirt collar 16 inches or larger? ☐ Yes ☐ No

Have you ever had a sleep study in the past? ☐ Yes ☐ No

If yes, when? ______________ Where? ____

Do you use home CPAP or BIPAP? ☐ Yes ☐ No

Who prescribed it? _________________________ What pressure setting? _______________________________

Do you use home oxygen? ☐ Yes ☐ No If yes, what liter/flow setting? _________________________________

Do you have or are being treated for high blood pressure? ☐ Yes ☐ No

Do you have a pacemaker/defibrillator with a pacemaker? ☐ Yes ☐ No

Have you ever had a tonsillectomy? ☐ Yes ☐ No If yes, when? _______________________________________

Have you ever had a sinus or nasal surgery? ☐ Yes ☐ No If yes, when? _________________________________

Have you ever broken your nose? ☐ Yes ☐ No If yes, when? ____

Have you ever had any type of head injury? ☐ Yes ☐ No If yes, when? ________________________________

Have you had surgery to promote weight loss? ☐ Yes ☐ No If yes, when? ______________________________

Do you current have, or have you ever had: (Please circle the appropriate box)

Hypertension	Yes	No	Acid Reflux (heartburn)	Yes	No
Heart Attack	Yes	No	Artritis	Yes	No
Congestive Heart Failure	Yes	No	Fibromyalgia	Yes	No
Sexual Dysfunction / Loss of Libido	Yes	No	Cardiac Arrhythmias	Yes	No
Diabetes	Yes	No	Depression	Yes	No
Lung Problems / COPD / Asthma	Yes	No	Anxiety	Yes	No
Dementia	Yes	No	Stroke / TIA	Yes	No
Seizures	Yes	No	Claustrophobia	Yes	No

Other ____

FAMILY HISTORY

Does any member of your family have the following? (Please circle appropriate box)

Sleep Apnea?	Yes	No	Relationship:

Narcolepsy?	Yes	No	Relationship:
Seizure Disorder?	Yes	No	Relationship:
Depression?	Yes	No	Relationship:
Hypertension?	Yes	No	Relationship:
Stroke?	Yes	No	Relationship:
Heart Disease?	Yes	No	Relationship:
Psychiatric Illness?	Yes	No	Relationship:
Other Disorder: _____________________	Yes	No	Relationship:

MEDICATIONS

Please list your medications. Attach a separate sheet if necessary.

Medication	Dose	Times /Day	Medication	Dose	Times/ Day

I verify all information provided on these forms is completely accurate to the best of my knowledge.

Patient or Responsible Party Signature ____________________________________ Date ___________________

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AUTHORIZED DELEGATE(S) FOR MEDICAL INFORMATION

Patient Name ________________________________ Date of Birth ________________________________

Please list the person(s) with whom we may discuss your medical information. If your patient is a minor, list the names of both parents.

Authorized Delegate(s) Name	Relationship to Patient

This authorization will remain in effect unless revoked by the patient or responsible party.

Patient Signature ____ Date ___________________

Parent or Guardian Signature (if applicable) ___________________________ Date ___________________

RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED

As a patient at Capitol Area Pulmonary Associates, I understand that I am here willingly and that my responsibilities as a patient include, but are not limited to, schedule and comply with all recommended follow up appointments, testing including but not limited to labs, diagnostic imaging and pulmonary function tests, any fees not covered by my insured, and discussing any concerns I have with my provider.

Patient Signature ____ Date _____________________

I agree to be responsible for payment of all services rendered including any deductible amount, co-insurance or any other balance not paid for by the insurance company. I understand that the insurance company may pay less than the actual bill for services and that not all services are a covered benefit. I understand that payment is due at the time of service or within 30 days of receiving a bill statement.

Patient Signature ____ Date _____________________

APPOINTMENT & CONTACT AGREEMENT

I understand that if I have scheduled an appointment, I must show up to the appointment. If an appointment is not canceled 24 hours in advance, I understand that I will be charged a $50 no show fee.

I, _______________________________________(print name), give permission to Capitol Area Pulmonary Associates to contact me using the telephone numbers that I have provided regarding my appointments.

Patient Signature ____ Date _____________________