Pulmonary Associates of Saint Augustine, P.A.

300 HEALTH PARK BLVD., SUITE 4000, SAINT AUGUSTINE, FL 32086
PHONE: (904)824-8666 / FAX: (904)824-8933
CUSTOMERSERVICE@PASADOCS.COM

KISHWAR HUSAIN MD	JAVIER ADUEN MD	FAISAL USMAN MD	BRANDON BRADDOCK PA-C
NPI #: 1912000696	NPI #: 1699762641	NPI #: 1194011908	NPI #: 1336536697

INTAKE AND CONSENT

DATE: _____ FULL NAME: _____ DOB: _____

SS #: _____ SEX: M / F EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SINGLE MARRIED SEPARATED DIVORCED WIDOWED

EMPLOYED / STUDENT / RETIRED EMPLOYER: _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE #: _____

INSURANCE INFORMATION

NAME OF INSURED: _____ RELATION TO PATIENT: _____

DOB: _____ SS #: _____ EMPLOYER: _____

INSURNACE NAME: _____ MEMBER #: _____ GROUP #: _____

SECONDARY INSURANCE? _____ IF YES:

NAME OF INSURED: _____ RELATION TO PATIENT: _____

DOB: _____ SS #: _____ EMPLOYER: _____

INSURNACE NAME: _____ MEMBER #: _____ GROUP #: _____

AUTHORIZATIONS AND RELEASES

I HEREBY AUTHORIZE PAYMENT OF ALL INSURANCE BENEFITS DIRECTLY TO PULMONARY ASSOCIATES OF SAINT AUGUSTINE. ANY AND ALL COPAYS AND COINSURANCES FOLLOWING INSURANCE PAYMENTS ARE DUE AND PAYABLE BY MYSELF.

SIGNATURE OF PATIENT OR GUARDIAN: _____ RELATION: _____ DATE: _____

I AUTHORIZE OF ANY INFORMATION CONCERNING MY HEALTHCARE AND ANY MEDICAL RECORDS REQUESTED BY PHYSICIANS PROVIDING MY HEALTH ADVICE, AND TREATMENT FOR THE PURPOSE OF CONTINUING CARE.

SIGNATURE OF PATIENT OR GUARDIAN: _____ RELATION: _____ DATE: _____

I HAVE RECEIVED AND ACKNOWLEDGE HIPAA AND PRIVACY PRACTICES INFORMATION.

SIGNATURE OF PATIENT OR GUARDIAN: _____ RELATION: _____ DATE: _____

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CLINICAL INTAKE

DATE: _____ FULL NAME: _____ SEX: M / F AGE: _____

REFERRED BY: _____ YOUR PRIMARY PHYSICIAN: _____

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT: _____

_____

SYMPTOMS

DO YOU HAVE ANY SHORTNESS OF BREATH (SOB)? YES / NO IF YES, HOW LONG? _____

ARE YOU SHORT OF BREATH AT REST? YES / NO WITH EXERTION? YES / NO

HOW FAR CAN YOU WALK BEFORE GETTING SOB? _____

IS THERE ANYTHING THAT TRIGGERS YOUR SOB? _____

DID YOU HAVE ANY BREATHING PROBLEMS AS CHILD, TEENAGER, OR ADULT? _____

HAVE YOU EVER TAKEN MEDICATIONS TO HELP YOUR BREATHING? YES / NO

IF YES, PLEASE LIST: _____

_____

ARE YOU ON HOME OXYGEN? YES / NO IF YES, HOW LONG? _____ HOW MANY LITERS/MIN? _____

HOW MANY PILLOWS DO YOU USE UNDER YOUR HEAD WHILE SLEEPING? _____ DO YOU HAVE SWELLING IN FEET/ANKLES? _____

DO YOU WAKE UP AT NIGHT SOB? YES / NO OR CHOKING? YES / NO

DO YOU HAVE A COUGH? YES / NO IF YES, HOW LONG? _____ DRY / PRODUCTIVE SPUTUM COLOR? _____

HAVE YOU EVER COUGHED UP BLOOD? YES / NO IF YES, WHEN AND FOR HOW LONG? _____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE EXPERIENCED: WHEEZING / CHEST PAINS / HEARTBURN / RUNNY NOSE / CHOKING ON FOOD / POST-NASAL DRIP / FREQUENT THROAT CLEARING / NOSEBLEEDS / WEIGHT LOSS / WEIGHT GAIN

SLEEP HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE EXPERIENCED: SLEEP APNEA / RESTLESS LEG SYNDROME / SNORING / DAYTIME SLEEPINESS / DAYTIME FATIGUE/TIREDNESS

PAST MEDICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH? PLEASE CIRCLE ALL THAT APPLY AND FILL IN HOW LONG AGO DIAGNOSED.

ASTHMA _____ COPD _____ EMPHYSEMA _____

CHRONIC BRONCHITIS _____ BRONCHIECTASIS _____ BLOOD CLOTS _____

CYSTIC FIBROSIS _____ PNEUMONIA (HOSPITALIZED? YES / NO) _____

TUBERCULOSIS (TB) _____ HAVE YOU EVER HAD A POSITIVE TB SKIN TEST? YES / NO WHEN? _____

HIGH BLOOD PRESSURE _____ DIABETES _____ STOMACH ULCER _____

LUNG CANCER _____ IF YES, TREATMENTS? _____

OTHER CANCERS _____

HEART ATTACK _____ WHEN? _____ CONGESTIVE HEART FAILURE _____

PAST SURGICAL HISTORY

HAVE YOU EVER BEEN DIAGNOSED WITH? PLEASE CIRCLE ALL THAT APPLY AND FILL IN HOW LONG AGO PERFORMED.

CHEST OR LUNG SURGERY _____ IF YES, WHAT KIND: _____

TONSILS REMOVED _____ SINUS _____ UTERUS OR OVARIES REMOVED _____

GALL BLADDER REMOVED _____ APPENDIX REMOVED _____ COLON SURGERY _____

ANY OTHER SURGERIES? _____

_____

FAMILY HISTORY

PLEASE CHOOSE FROM THE FOLLOWING PROBLEM LIST IF YOUR BLOOD RELATIVES HAVE BEEN DIAGNOSED WITH:

(ASTHMA, COPD, EMPHYSEMA, CYSTIC FIBROSIS, END-STAGE CANCER, DVT (BLOOD CLOTS IN LEGS), PULMONARY EMBOLISM, OSA)

MOTHER: PROBLEM(S) _____ LIVING / DECEASED

FATHER: PROBLEM(S) _____ LIVING / DECEASED

BROTHER/SISTER: PROBLEM(S) _____ LIVING / DECEASED

CHILDREN: PROBLEM(S) _____ LIVING / DECEASED

VACCINATION HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING VACCINATIONS? PLEASE CIRCLE ALL THAT APPLY AND FILL IN HOW LONG AGO VACCINATED.

FLU SHOT _____ PNEUMONIA VACCINE _____ COVID-19 VACCINE _____

OCCUPATIONAL HISTORY

WHAT TYPES OF WORK DID YOU DO MOST OF YOUR LIFE? _____

HAVE YOU EVER HAD EXPOSURE TO ANY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY AND SPECIFY LENGTH OF EXPOSURE.

ASBESTOS _____ SAND/SILICA/DUST _____ SMOKE INHALATION _____

METAL PARTICLES _____ FARM WORK _____ BIOLOGICAL AGENTS _____

MILITARY CONFLICT _____ VETERANARIAN WORK _____ OTHER _____

SOCIAL HISTORY

DO YOU SMOKE? YES / NO HAVE YOU EVER SMOKED? YES / NO IF YOU QUIT, HOW LONG AGO? _____

WHAT DO YOU/HAVE YOU SMOKED? _____

HOW MANY YEARS TOTAL HAVE YOU SMOKED? _____ HOW MANY PACKS PER DAY ON AVERAGE OVER THAT TIME? _____

HOW MAY CUPS PER DAY OF CAFFEINATED BEVERAGES DO YOU DRINK? _____

DO YOU USE ANY ILLICIT DRUGS LIKE MARIJUANA, PLEASE SPECIFY: _____

IF YES, HOW OFTEN? _____

DO YOU DRINK ALCOHOL? YES / NO IF YES, HOW OFTEN AND HOW MUCH? _____

DID YOU EVER DRINK ALCOHOL? YES / NO IF YES, HOW OFTEN AND HOW MUCH? _____

ENVIRONMENTAL HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE REGULAR CONTACT WITH: PETS / HVAC / DUST

IF YES, PLEASE ELABORATE: _____

TRAVEL HISTORY

PLEASE CIRCLE ANY OF THE FOLLOWING LOCATIONS THAT YOU HAVE TRAVELED TO:

SOUTH/MID-WEST / FAR EAST COUNTRIES / SOUTH AMERICA/HAITI

IF YES, PLEASE ELABORATE: _____

_____

ALLERGIES

PLEASE CIRCLE ANY OF THE FOLLOWING THAT APPLY: FOOD ALLERGY / MEDICATION ALLERGY / ENVIRONMENTAL ALLERGY

IF YES, PLEASE ELABORATE: _____

_____

HAVE YOU EVER SEEN AN ALLERGY SPECIALIST? YES / NO HAD ALLERGY TESTING? YES / NO ALLERGY SHOTS? YES / NO

MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY	ROUTE
PHARMACY LOCAL:		**PHARMACY MAIL:**	

STOP-BANG QUESTIONAIRE

DO YOU SNORE LOUDLY?	**YES**	**NO**
DO YOU OFTEN FEEL TIRED?	**YES**	**NO**
HAVE YOU BEEN OBSERVED CHOKING OR GASPING WHILE SLEEPING?	**YES**	**NO**
DO YOU HAVE OR ARE YOU BEING TREATED FOR HIGH BLOOD PRESSURE?	**YES**	**NO**
IS YOUR BODY MASS INDEX (BMI) GREATER THAN 35?	**YES**	**NO**
ARE YOU OLDER THAN 50?	**YES**	**NO**
IS YOUR NECK 17 INCHES OR GREATER (MALE) OR 16 INCHES OR GREATER (FEMALE)?	**YES**	**NO**
IS YOUR GENDER MALE?	**YES**	**NO**
TOTAL YES ANSWERS: (0-2 LOW RISK / 3-4 MODERATE RISK / 5-8 HIGH RISK)		

EPWORTH SLEEPINESS SCALE

HOW LIKLEY ARE YOU TO DOZE OFF IN THE FOLLOWING SITUATIONS	NO CHANCE	SLIGHT	MODERATE	HIGH
SITTING AND READING	**0**	**1**	**2**	**3**
WATHCING TELEVISION	**0**	**1**	**2**	**3**
SITTING INACTIVE, IN A PUBLIC SPACE	**0**	**1**	**2**	**3**
LYING DOWN TO REST IN THE AFTERNOON WHEN POSSIBLE	**0**	**1**	**2**	**3**
SITTING AND TALKING TO SOMEONE	**0**	**1**	**2**	**3**
SITTING QUIETLY AFTER LUNCH, WITHOUT ALCOHOL	**0**	**1**	**2**	**3**
AS A PASSENGER IN A CAR FOR AN HOUR, WITHOUT A BREAK	**0**	**1**	**2**	**3**
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC	**0**	**1**	**2**	**3**
TOTAL SCORE:				

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MEDICAL INFORMATION RELEASE

PATIENT FULL LEGAL NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ TELEPHONE #: _____

ADDRESS: _____

_____

_____

RELEASE MY INFORMATION TO / FROM :

PROVIDERS NAME: _____

PROVIDERS ADDRESS: _____

FAX #: _____ TELEPHONE #: _____

THE PURPOSE OF THIS DISCLOSURE IS: _____

THE INFORMATION TO BE DISCLOSED INCLUDES THE FOLLOWING (CHECK ALL THAT APPLY):

_____PROGRESS NOTES _____HOSPITAL RECORDS _____CONSULTATION REPORTS

_____LABORATORY RESULTS _____RADIOLOGY REPORTS _____CARDIOPULMONARY

_____SUBSTANCE ABUSE _____MENTAL HEALTH/PSYCH HISTORY

_____HIV/AIDS RELATED INFO _____Other: _____

PATIENT OR GUARDIAN SIGNATURE: _____ RELATION: _____ DATE: _____