USF HEALTH

WELCOME TO USF HEALTH

We appreciate you choosing USF Health for your healthcare needs. When you come to see a new healthcare provider, you may have questions about what to expect at your first visit. We hope this letter will prepare you.

USF Health has multiple locations throughout the Tampa Bay area so please reference the location for your appointment time. As a new patient, please plan on arriving at least 30 minutes prior to your appointment. All of our locations have handicap accessible parking available for vehicles that display the appropriate State issued handicap tag. All locations offer general patient parking as well as valet services available at the Morsani Center (for a nominal fee of $2) and the South Tampa Center (provided by Tampa General Hospital for a fee of $5). Additional information on our locations, including maps, may be found on our website: www.myhealthcare.usf.edu

At the time of your appointment, you may be asked for any of the following information: insurance card, physician referral, name and address of referring physician, completed health history form, copies of medical records, current prescription bottles and appropriate co-payment. Your name and insurance information will be verified at each subsequent office visit. As a result of Federal Law, we are required to ask for your race and ethnicity at the registration or check-in desk. Please note that you have the option of indicating "declined" if you so desire.

We are an academic institution where future healthcare providers are trained. We use a team approach for your best medical and surgical care so don't hesitate to ask your caregivers their name or the role they have in your care. Although your Attending Physician is responsible for overseeing your healthcare team, the following explains the types of Providers that you might see during your visit:

- Attending Physician – has completed medical school, a residency program, and is fully licensed. The Attending Physician is directly responsible for your medical and surgical care and will answer questions about your diagnosis and treatment plan.
- Nurse Practitioner (NP), Physician Assistant (PA), or Certified Nurse Midwife (CNM) – is a fully licensed, advanced practice healthcare professional, trained to care for you in our clinic setting.
- Fellow – has completed medical school, has completed residency training, and is now concentrating on his/her sub-specialty.
- Resident – is a physician who has completed medical school and is in training focusing on his/her specialty of interest.
- Medical Student – is in medical school learning how to care for patients under the direct supervision of USF Physicians.

Our team is devoted to providing you with the highest quality of care. Let us know if we do not meet your expectations so we can address your concerns promptly. If you think we can improve our care in any way, feel free to make suggestions in person, by phone, in writing, or via our patient satisfaction kiosks.

Thank you for choosing USF Health for all your healthcare needs.

8/17/2011

Department of Pulmonology

USF HEALTH

Dr. _____

Date of Appointment _____

Time _____

Dear Patient:

Please complete the enclosed questionnaire and bring it with you on the day of your office visit. Please bring all chest x-ray and CT scan films with you along with all medical records that pertain to this appointment.

If you have any questions, please feel free to contact us at (813) 974-2920.

Thank you for choosing us to serve your healthcare needs.

Department of Internal Medicine
Pulmonary, Critical Care and Sleep Disorders Medicine

Patient Name: _____ Medical Record# _____
Last First MI

Age: _____ Date of Birth: _____ Sex: M F (circle)

PHYSICIAN INFORMATION

Primary Care Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Name of Person Referring You to the Sleep Center: _____

Would you like your records to go to any other physician? ☐ Yes ☐ No

Other Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

1. **Briefly describe your sleep problem:** _____

_____

At what age did this problem begin? _____

How does this affect your life and daily activities? _____

_____

How serious a problem is this for you on a scale of 1 to 10? (1 is not serious and 10 is very serious) _____

2. Have you had any previous evaluations (exam or sleep study)? ☐ Yes ☐ No
When: _____ Where: _____ Results _____

3. Have you had any previous treatment? ☐ Yes ☐ No
When: _____ Where: _____ What type: (i.e., CP AP) _____

4. Please list any medications (prescribed or otherwise) that you have used to help your sleep problem:

DRUG	AMOUNT	FREQUENCY	HOW LONG?	HOW USEFUL?	PHYSICIAN

CHECK CLINIC SITE: ☐ Medical Clinic MDC 33 ☐ Ent Clinic MDC 73

SLEEP HABITS

5. If employed, what are your usual working hours?
Start: _____ am / pm Stop: _____ am / pm

6. Do you ever change work shifts? ☐ Never ☐ Infrequently ☐ Regularly

7. Write in the time you usually go to bed and get up on weekdays.
Go to bed_____ am / pm Get up _____ am / pm

8. Write in the time you usually go to bed and get up on weekends.
Go to bed_____ am / pm Get up _____ am / pm

9. Do you have a regular sleep partner? ☐ Yes ☐ No

10. On the average, how long does it take you to fall asleep? _____ Minutes

11. What do you ordinarily do just prior to going to sleep? (e.g. reading, TV, bath, etc)
☐ Reading ☐ TV ☐ Bath ☐ Exercise ☐ Eat
Other: _____

12. On the average, how often do you wake up during the night? _____ Times

13. Do you ever wake up too early in the morning and then are unable to return to sleep? ☐ Yes ☐ No

14. On the average, how long are you actually asleep at night? _____ hours _____ minutes

15. How do you ordinarily awaken? ☐ Spontaneously ☐ Alarm Clock ☐ Other

16. How difficult is it for you to awaken and get out of bed after sleeping?
☐ Very Difficult ☐ Difficult ☐ Sometimes Difficult ☐ No Problem

17. How long does it take for you to be alert and functioning after sleeping? _____ hours _____ minutes

18. Do you nap or return to bed after arising? ☐ Yes ☐ No ☐ Sometimes
If yes, how many times per day? _____ Average length of nap: _____ hours _____ minutes

19. Are you bothered by sleepiness during the day? ☐ Yes ☐ No

20. Do you feel you get too much sleep at night? ☐ Yes ☐ No

21. Do you feel you get too little sleep at night? ☐ Yes ☐ No

22. Do you usually feel tired during the day? ☐ Yes ☐ No
If yes, what do you attribute this to? _____
_____

23. Do you find yourself falling asleep when you don't mean to? ☐ Yes ☐ No
If yes, describe: _____
_____

How long does the sleep episode last?_____ hours _____ minutes
Do you feel rested or refreshed after the sleep episode? ☐ Yes ☐ No

24. Have you ever suddenly fallen? ☐ Yes ☐ No

25. Have you ever experienced sudden bodily weakness (jaw, head, shoulders, arms, legs)? ☐ Yes ☐ No

If you have suddenly fallen or experienced weakness, were you aware of things around you? ☐ Yes ☐ No
Was the fall or weakness brought on by any particular event or feeling (laughter, fear, sadness, etc.)? ☐ Yes ☐ No
If so, briefly describe: _____

_____

26. Have you ever experienced muscle weakness or paralysis upon:
Going to sleep? ☐ Yes ☐ No

Awakening from sleep? ☐ Yes ☐ No

How often does this occur? _____ Times/Week

27. Have you experienced seeing things or hearing voices that weren't real?
On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

28. Have you experienced a feeling like falling or the bed moving?
On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

29. Do you have difficulty breathing at night?
If so, briefly describe: _____

_____

_____

How often? _____ Times/Night When did this first occur? _____ (Age)

30. Have you been told you snore when you sleep? ☐ Yes ☐ No
Does the snoring disturb:
A bed partner (or someone in the same bedroom)? ☐ Yes ☐ No
Someone in the next room? ☐ Yes ☐ No

31. Have you been told you stop breathing when you sleep? ☐ Yes ☐ No

32. Have you ever experienced, upon lying in bed, before sleep, or on awakening from sleep, a restlessness of legs, "nervous legs," a creeping crawling sensation of legs or twitching? ☐ Yes ☐ No

How often does this occur? _____ times/week
How long does the sensation last? _____ Minutes

Does anything relieve the sensation (e.g. getting out of bed, a massage, medication, etc)? _____

_____

When did you first experience this? _____ (age) ☐ Yes ☐ No

33. Has anyone ever told you that your arms or legs jerk or twitch while you are asleep? ☐ Yes ☐ No

If yes, how often during the night does this occur?_____ times/night
How many nights per week does this happen? _____ times/week
At what age did this come to your attention? _____

Does this seem to awaken you from sleep? ☐ Yes ☐ No

34. Have you ever experienced doing something without being aware at the time of the action? ☐ Yes ☐ No

If so, briefly describe: _____

_____

_____

How often does this occur?_____ times/week

35. Do you know or do others tell you that you:

			Treatment
Talk while apparently asleep?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Walk while apparently asleep?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Grit teeth while apparently asleep?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Wet the bed during sleep?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Wake up screaming or seemingly afraid?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Have disturbing dreams?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Have unusual movements?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Awake during the night with headaches?	☐ Yes ☐ No	_____ times/week	_____ age started _____
Have erections while asleep (males)?	☐ Yes ☐ No	_____ times/week	_____ age started _____

ALLERGIES *(Specify drug and reaction)*

_____ _____
_____ _____
_____ _____
_____ _____

MEDICATIONS

Do you use any prescribed medications either regularly or occasionally? ☐ **Yes** ☐ **No**

If so, please list by name below (include over the counter medications, herbal products, supplements, and vitamins):

Name of Medication	Amount	How Often	Reason Used	How Long Used	Prescribing Physician

Give the year of your last physical examination _____

Results of this exam _____

Height: _____ inches Weight: _____ pounds Neck Size: _____ inches

Have you now or ever in the past experienced any health problems or had surgery associated with the below listed areas?

	Yes	Type of Problem	Dates	Physician, Clinic or Hospital
A - mental health				
B - head or nervous system				
C - eyes, ears, nose, mouth, throat				
D - heart, circulation				
E - breathing (lungs)				
F - stomach, digestive				
G - urine, kidney				
H - sexual				
I - bones, joints, arms, legs				
J - diabetes, glands				
K - blood pressure				
L - weight problems				
M - other				

SOCIAL HISTORY (tobacco, caffeine, alcohol, drug use)

Do you currently smoke cigarettes? ☐ Yes ☐ No How many years? _____ # packs per day _____

Have you used tobacco products like cigars, pipes, or smokeless tobacco? ☐ Yes ☐ No

How many years? _____ # per day _____

Do you currently consume alcohol? ☐ Yes ☐ No

How many years? _____ What type? _____ Amount per day _____

On the average, how many alcoholic beverages do you drink on weekdays? _____ Drinks/day

On the average, how many alcoholic beverages to you drink on weekends? _____ Drinks/day

Have you received treatment for substance abuse? ☐ Yes ☐ No

On average, how much do you drink of the following beverages?

Coffee _____ cups/day

Tea _____ cups/day

Carbonated or other soft drinks _____ bottles/day

OCCUPATIONAL HISTORY

Current job _____ Year started _____

Previous positions _____

FAMILY HISTORY

Marital Status _____ Number of Children _____ Ages _____

Family Member	Age	Living	Deceased	Illnesses*	Cause of Death	List Sleep Problems
Father						
Mother						
Brothers						
Sisters						
Children (indicate sex)						

**Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses.*

REVIEW OF SYSTEMS

Check all responses that apply.

General	Yes	No
Weight gain/loss	☐	☐
Difficulty falling asleep	☐	☐
Need to cut down alcohol consumption	☐	☐
Fever	☐	☐
Change in appetite	☐	☐

Skin	Yes	No
Rash, sore, or excessive bruising	☐	☐
Lump or growth on skin	☐	☐

Eyes	Yes	No
Wear glasses	☐	☐
Decreased vision	☐	☐
Pain in eyes	☐	☐

Ears, Nose, Throat, Mouth	Yes	No
Difficulty or changes in hearing	☐	☐
Earaches	☐	☐
Discharge from ears	☐	☐
Buzzing or ringing in ears	☐	☐
Frequent sneezing	☐	☐
Nose stuffiness or running	☐	☐
Recurrent sore throat	☐	☐
Persistent hoarseness	☐	☐
Dental problems	☐	☐
Sinus problems	☐	☐
Lymph glands or nodes	☐	☐
Frequent nose bleeds	☐	☐

Genitourinary	Yes	No
Painful urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Difficulty emptying bladder	☐	☐

Musculoskeletal	Yes	No
Painful joints	☐	☐
Sore muscles	☐	☐
Back pain	☐	☐
Pain in calves of legs	☐	☐
Weakness in extremities	☐	☐
Numbness in extremities	☐	☐

Neuropsychiatric	Yes	No
Anxiety	☐	☐
Depression	☐	☐
Frequent or severe headaches	☐	☐
Dizziness or faintness	☐	☐
More nervous than average person	☐	☐
Dizziness or faintness	☐	☐

Cardiovascular	Yes	No
Chest pain	☐	☐
Shortness of breath	☐	☐
Abnormal swelling in legs/feet	☐	☐
Fatigue or tire easily	☐	☐

Respiratory	Yes	No
Cough	☐	☐
Blood in sputum	☐	☐
Wheezing	☐	☐

Endocrine	Yes	No
Excessive thirst or urination	☐	☐
Change in sexual drive/performance	☐	☐
Change in heat or cold tolerance	☐	☐

Gastrointestinal	Yes	No
Frequent heartburn/indigestion	☐	☐
Nauseas or vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Ulcers	☐	☐

For Women Only	Yes	No
Irregular periods	☐	☐
Bleeding between periods	☐	☐
Are you pregnant	☐	☐
Date of last menstrual period	__/__/__	
Ever have an abnormal Pap smear	☐	☐
Lump or growth on breast	☐	☐

Allergic/Immunologic	Yes	No
Hayfever	☐	☐
Hives	☐	☐
Immunodeficiency	☐	☐

Hematologic/Lymphatic	Yes	No
Anemia	☐	☐
Excessive bleeding or bruising	☐	☐
Blood Transfusion	☐	☐

Reviewed by:

_____MD _____ Date

_____RN _____ Date

USF HEALTH

MINI SCREEN

PATIENT NAME: _____ DATE OF BIRTH: _____

DATE OF INTERVIEW: _____ If **YES,** go to the corresponding M.I.N.I. module ↓

- Have you been **consistently** depressed or down, **most of the day, nearly every day**, for the past two weeks? NO YES → A
- In the past two weeks, have you been much less interested in most things or much less able to enjoy the things you used to enjoy **most of the time?** NO YES → A
- Have you felt sad, low or depressed **most of the time** for the last two years? NO YES → B
- In the past month did you think that you would be better off dead or wish you were dead? NO YES → C
- Have you **ever** had a period of time when you were feeling 'up' or 'high' or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol). NO YES → D
- Have you **ever** been persistently irritable, for several days, so that you had arguments or verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or over reacted, compared to other people, even in situations that you felt were justified? NO YES → D
- Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? NO YES → E
  CODE YES ONLY IF THE SPELLS PEAK WITHIN 10 MINUTES.
- Do you feel anxious or uneasy in places or situations where you might have a panic attack or panic-like symptoms, or where help might not be available or escape might be difficult: like being in a crowd, standing in a line (queue), when you are away from home or alone at home, or when crossing a bridge, traveling in a bus, train or car? NO YES → F
- In the past **month** were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches, or being in social situations. NO YES → G
- In the past **month** have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (e.g., the idea that you were dirty, contaminated **or** had germs, or fear of contaminating others, **or** fear of harming someone even though you didn't want to, **or** fearing you would act on some impulse, **or** fear or superstitions that you would be responsible for things going wrong, **or** obsessions with sexual thoughts, images or impulses, **or** hoarding, collecting, **or** religious obsessions.) NO YES → H

Turn Page

If **YES,** go to the corresponding M.I.N.I. module ↓

- In the past **month,** did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, or arranging things, or other superstitious rituals? NO YES → H

- Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?
  EXAMPLES OF TRAUMATIC EVENTS INCLUDE SERIOUS ACCIDENTS, SEXUAL OR PHYSICAL ASSAULT, A TERRORIST ATTACK, BEING HELD HOSTAGE, KIDNAPPING, FIRE, DISCOVERING A BODY, SUDDEN DEATH OF SOMEONE CLOSE TO YOU, WAR, OR NATURAL DISASTER. NO YES → I

- Did you respond to the trauma with intense fear, helplessness, or horror? NO YES → I

- During the past month, have you re-experienced the event in a distressing way (such as, dreams, intense recollections, flashbacks or physical reactions)? NO YES → I

- In the past **12 months,** have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions? NO YES → J

- Now I am going to show you / **READ THE LIST BELOW** of street drugs or medicines. In the past **12 months,** did you take any of these drugs more than once, to get high, to feel better, or to change your mood? NO YES → K

Amphetamines	Speed	Crylstal Meth	Dexedrine	Ritalin, Diet Pills
Cocaine	Crack	Freebase		
Heroin	Morphine, Methadone	Opium	Demerol	Codeine, Percodan, Oxycontin
LSD	Mescaline	PCP	MDMA	Ecstasy
Inhalants	Glue	Ether	GHB	Steroids
THC, Marijuana	Cannabis, Hashish	Grass		Barbiturates, Valium, Xanax, Ativan

- How tall are you? |__|__|__| inches

- What was your lowest weight in the past 3 months? |__|__|__| lbs

IS PATIENT'S WEIGHT LOWER THAN THE THRESHOLD CORRESPONDING TO HIS / HER HEIGHT? NO YES → M
SEE TABLE BELOW

FEMALES	4'10	4'11	5'0	5'1	5'3	5'4	5'5	5'6	5'7	5'8	5'9
Weight (lbs)	85	86	87	89	94	97	99	102	104	107	110
MALES	5'3	5'4	5'5	5'6	5'7	5'8	5'9	5'10	5'11	6'	6'1
Weight (lbs)	108	110	111	113	115	115	118	120	122	125	127

- In the past **three months,** did you have eating binges or times when you ate a very large amount of food within a **2-hour** period? NO YES → N

- In the last **3 months,** did you have eating binges as often as twice a week? NO YES → N

- Have you worried **excessively** or been anxious about several things over the past 6 months? NO YES → O

THE EPWORTH SLEEPINESS SCALE

Name: _____

Date: _____ Your Age: _____

Sex (male=M, female=F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = would ***never*** dose
1 = ***slight*** chance of dosing
2 = ***moderate*** chance of dosing
3 = ***high*** chance of dosing

Situation:	**Chance of Dosing:**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation. Total: _____

USF Physicians Group

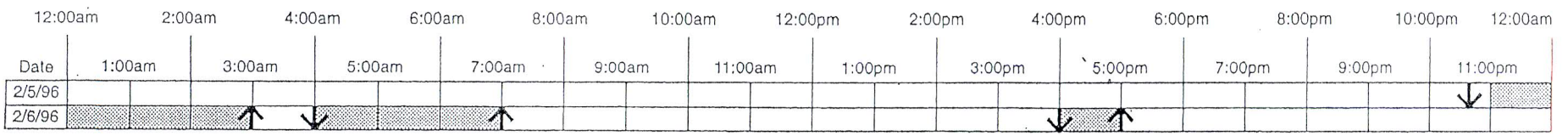
University of South Florida College of Medicine

Sleep Diary

Patient ID/Stamp

Instructions: Mark any time you lay down with an arrow pointing down. Mark any time you get up from lying down with an arrow pointing up. Shade in times when you are asleep, including nap times. Shade 1/2 of a box for half an hour, 1/4 of a box for 15 minutes, etc. Leave blank the hours you are awake.

Example: (below) On February 5th the patient went to bed at 10:30pm, fell asleep at 11:00pm and woke up again at 3am (now the morning of the 6th). The patient fell back asleep at 4am and woke up for the day at 7am. The patient took a nap between 4 and 5pm.



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Form # 2018-011

USF HEALTH

USF Physicians Group

UNIVERSITY OF SOUTH FLORIDA

Authorization to Records Custodian

RELEASE OF INFORMATION

Patient's Name_____ Date of birth_____

Patient's Social Security No. _____ Medical Record No. _____

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as described below to the following person(s) or organization(s)

Release to: _____

_____
Name

_____
Street Address

_____
City, State, Zip Code

Obtain from: _____

_____
Name

_____
Street Address

_____
City, State, Zip Code

Purpose: _____

I specifically authorize the use and disclosure of the following PHI: (Please provide a detailed description of the particular data and period of time you are requesting) Initial next to A, B, or C

A. _____ALL records in the custody of USF/USF Physicians Group

B. _____ALL records in the custody of _____

C. _____ONLY the following: (Check records being requested)

_____Records of the treating physician _____only

_____Evaluation Initial

_____Follow Up Notes

_____Medication Report

_____Most Recent Discharge Status

_____Other_____

_____Discharge Summary

_____Hospital Admission History and Physical

_____X-rays

_____Lab Results

I understand that I may be charged for the copying of these patient records and payment is expected at the time the copies are received from the University of South Florida/USF Physicians Group.

If requesting information relating to: (1) Acquired immunodeficiency syndrome ("AIDS") or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; (3) mental or behavioral health or psychiatric care, excluding psychotherapy notes or (4) genetic testing, specific authorization on this form or a court order is required since this information is privileged. A separate authorization is required for psychotherapy session notes. Psychotherapy session notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. 45 CFR 164.501.

I may revoke this authorization form at any time by notifying the above-referenced records custodian at the location listed above, of my intent to revoke this authorization. Returning this form, signed, dated and with the words "authorization revoked" is sufficient notice. However, I understand that such revocation will not have any effect on any information already used or disclosed by the University of South Florida before the University received my written notice of revocation.

This authorization form expires on _____ or when _____ occurs.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.

I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from the University of South Florida or _____. I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form.

I understand that I may refuse to sign this form.

There is a potential that the PHI may be re-disclosed by the recipient and no longer protected by federal or state privacy laws.

_____
Signature of patient or personal representative

_____
Date

_____
Printed name of patient or personal representative

_____
Relationship to patient giving representative authority to act for patient