



North Point Pulmonary Associates

3400-C Old Milton Parkway
Suite 425
Alpharetta, GA 30005

1505 Northside Forsyth Drive
Suite 3400
Cumming, GA 30042

Phone: 770-343-8760 Fax: 770-664-2101

Welcome to our practice!

On behalf of North Point Pulmonary Associates, we welcome and thank you for choosing our practice. It is our desire to make your visit a pleasant one and to work with you to establish a positive treatment plan.

Please help us provide the best medical care by bringing the following items:

- **All of your medications.** If you are unable to bring the bottles, please bring a list of medications, the dosage, and the number of times taken daily, including all over-the-counter medications.
- **Previous sleep study records** (If you have had a sleep study previously)
- If you are currently on CPAP or BiPAP, please bring your machine.
- **Completed History and Demographic forms**
- **Insurance Card**
- **Photo Identification**
- **Insurance Referral from your primary care physician**

We request all History and Demographic documents be completed prior to your appointment and ask that you arrive 30 minutes early. If documents aren't completed, we will need to reschedule your appointment.

Thank you for your assistance and we look forward to meeting you!

Dr. Daniel Callahan
Dr. Gayle Mason
Michael Rayburn, PA-C

Patient Name _____ Date of Birth _____

Past Medical History

Please list any medical conditions that you have been diagnosed with:

MEDICAL CONDITION	DATE DIAGNOSED	TREATING PHYSICIAN

Please list any Surgeries and hospitalizations you've ever had.

Surgery	Hospitalization/Reason	Date(s)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Family History

Please check all that apply:

	MOTHER	FATHER	SIBLING	GRANDPARENT	AUNT/UNCLE
Cancer (Indicate Type)					
Respiratory Disease					
Mental Illness					
High Blood Pressure					
Kidney Disease					
Diabetes					
Heart Disease					
Blood Clot					
Tuberculosis					
Other:					
Other:					

AGE OF DEATH:

Mother _____ Father _____ Siblings _____ Grandparents _____

Social History (please check one)

____ Single ____ Married ____ Divorced ____ Widowed ____ Domestic Partner

Have you ever had x-ray dye? YES/NO

Allergic to x-ray dye? YES/NO

Have you ever smoked? YES/NO

How many packs per day? _____

For how many years? _____

If you no longer smoke, when did you quit? _____

Do you consume alcohol? ____ Currently ____ In the past ____ Never

If currently how much? _____

Do you or have you ever used recreational drugs? _____

Do you exercise? _____

How often? _____

Have you ever used diet pills? _____

Medication _____

Last time taken: _____

Patient Name _____ Date of Birth _____

Are you exposed to any pets? dogs, cats, birds, rodents or wild animals YES/NO

Describe _____

Have you ever worked in/with?

__ MINE __ BRICK PLANT __ FOUNDRY __ QUARRY __ POTTERY __ COTTON/FLAX/HEMP/MILL __ NONE

Have you ever been exposed to?

__ ASBESTOS __ BERYLLIUM __ ACIDS __ LEAD __ SOLVENTS __ COAL DUST __ GRINDING DUST __ NONE

Have you ever served in the military? YES/NO

What Branch? _____

Dates of Service? _____

Have you ever lived in any of the following areas? (please circle)

ARIZONA, CALIFORNIA, OHIO VALLEY any other SOUTHERN STATES



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PATIENT HEALTH SUMMARY

Patient Name: _____	Patient DOB: _____
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VACCINE INFORMATION

Date of last Flu Vaccine: _____	Date of last Pneumonia Vaccine: _____
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ALLERGIES:

DATE <small>(diagnosed)</small>	PAST MEDICAL HISTORY	DATE <small>(surgery date)</small>	PAST SURGICAL HISTORY	STAFF INITIALS

INITIALLY COMPLETED BY:

Employee _____ Date _____

_____	_____	_____	_____	_____
<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>
_____	_____	_____	_____	_____
<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>
_____	_____	_____	_____	_____
<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>
_____	_____	_____	_____	_____
<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>	<small>Updated Initial/Date</small>

Review of Systems

Welcome, so that we may provide you with the best care possible, please assist us by completing the following form. Remember — always bring an updated list of all your medications including inhalers.

Please mark all that apply:

GENERAL NONE

- Fevers
- Night Sweats
- Fatigue
- Appetite Loss
- Recent weight Changes

EYES NONE

- Glaucoma
- Cataracts
- Macular Degeneration

EAR/NOSE/THROAT NONE

- Nasal Congestion
- Postnasal Drip
- Voice Hoarseness
- Sinus Disease
- Seasonal Allergies

CARDIAC NONE

- Heart Attack (MI)
- Valvular Heart Disease
- Heart Murmur
- Rheumatic Fever
- Abnormal Cholesterol
- Congenital Heart Defect
- Hypertension
- Palpitations
- Heart Rhythm Disorder
- Pacemaker or Cardiac Defibrillator (ICD)
- Claudication/Leg Pains
- Passing out/Syncope

RESPIRATORY NONE

- Dry Cough
- Cough with phlegm
- Coughing up blood
- Shortness of breath at rest
- Shortness of breath with activity
- Wheezing
- Chest Tightness

SLEEP NONE

- Morning Headaches

- Excessive Daytime Sleepiness
- Excessive Snoring
- Restless Sleep
- Sleep Disturbance Secondary to Breathing
- CPAP/BiPAP use

GASTROINTESTINAL NONE

- Heartburn/Reflux
- Difficulty/Painful Swallowing
- Abdominal Pain
- Blood in Stool or Vomit
- Nausea/Vomiting
- Colostomy/Ileostomy
- Hepatitis or Jaundice

GENITOURINARY NONE

- Painful Urination
- Frequent Urination
- Blood in Urine
- Incontinence/loss of bowel or bladder function
- Frequent bladder/Kidney infections
- Enlarged Prostate

GYNECOLOGICAL NONE

- Are you presently or could you be pregnant? Y N
- Abnormal Mammogram
 - Abnormal Pap smear
 - Hysterectomy

Present or past history of cancer:

Breast Y N
Please describe: _____

Ovarian Y N
Please describe: _____

Uterine Y N
Please describe: _____

MUSCULOSKELETAL: NONE

- Last DEXA: _____
- Osteoarthritis
 - Osteopenia/Osteoporosis
 - Rheumatoid Arthritis
 - Fibromyalgia

- Gout
- Disc Problems
- Back Pain
- Trouble Walking
- Frequent Falls
- Pain in Legs with Walking
- Joint Pain (other than arthritis)
- Bone Pain

NEUROLOGICAL NONE

- Fainting Spells
- Balance Problems
- Tremors
- Dizziness
- Seizures
- Mini strokes/TIA
- Stroke
- Headaches/Migraines
- Muscle Weakness
- Memory Problems
- Difficulty Swallowing
- History of Polio

BLOOD DISORDERS NONE

- Anemia
- Impaired Immune System
- Low Platelets
- Unusual Bleeding
- Blood Clots (in legs or lungs)

ENDOCRINE NONE

- Thyroid Problems
- Goiter
- Graves Disease
- Diabetes

MENTAL/EMOTIONAL NONE

- Excessive Stress
- Anxiety
- Depression
- Suicidal Thoughts
- Sleeping Difficulty
- Phobias (i.e. claustrophobia)



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MEDICATIONS SUMMARY

Please list ALL current medications below:

Allergies:

Medication	Strength	Dosage

Pharmacy Information:

Pharmacy Name _____
Pharmacy Address _____
Pharmacy Phone Number _____



NH
NORTHSIDE HOSPITAL
SLEEP DISORDERS CENTER

AFFIX PATIENT LABELS OVER THIS BOX
 ↓ BAR CODE MUST FALL BETWEEN THESE LINES ↑

Patient Name: _____

Gender (circle one): Male Female Age: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 decide how you would react to these situations. Use the following scale to choose the most appropriate number for each one.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

<u>SITUATION</u>	<u>CHANCE OF DOZING (circle one)</u>			
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting, inactive in a public place (e.g., theater or meeting).	0	1	2	3
As a passenger in a car for an hour without a break.	0	1	2	3
Lying down to rest in the afternoon when circumstances permit.	0	1	2	3
Sitting and talking to someone.	0	1	2	3
Sitting quietly after lunch without alcohol.	0	1	2	3
In a car, while stopped for a few minutes in traffic.	0	1	2	3

TOTAL SCORE: _____

AVERAGE AMOUNT OF SLEEP PER NIGHT: _____

SIGN HERE: Completed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____