Charlotte Lung and Health Center
1918 Randolph Road, Suite 440 Charlotte, NC 28207
Phone 704/342-8143 Fax 704/926-8044

Dear Patient:

Thank you for choosing Charlotte Lung and Health. Welcome to our practice!

Our first priority is you, our patient. We strive to provide you with excellent quality care and to exceed your expectations in a comfortable and convenient manner. Our highly trained physician and professional staff are always available to assist you with questions regarding your care, medications, insurance or billing.

The enclosed forms include a questionnaire to give your physician a clear picture of your medical history, office and financial policies, medication list, and our notice of privacy practices. Please complete all forms to the best of your knowledge and bring them in with you to your scheduled appointment. In addition, it is necessary that you also bring along the following items to your appointment. This ensures you get the most out of your consultation visit with us.

a) Photo ID
b) Insurance Card(s)
c) Pharmacy Information (name and phone number is sufficient)
d) Medication List (attached)
e) X-rays or CD's pertinent to the reason you are being referred
f) Medical Records to (including prior sleep studies, radiology reports, lab results, last chart notes, recent hospital records, and spirometer or complete pulmonary function tests. They can also be faxed to us at (704) 926-8044
g) If you are transferring your records from another physician's office, please do so as soon as possible so Dr. Spangenthal will have access to your prior medical records. You can send a request to your former physician to have your records sent to our office at the address above. This may also be faxed to us at (704) 926-8044

Your insurance requires that you pay your copay at the time of service.
If you have any questions regarding your appointment or the paperwork enclosed, please contact us at
(704) 342-8143 and one of our central scheduling staff members will gladly assist you.

We would like to thank you in advance for your cooperation with these issues, which will expedite registration. We are very pleased that you have chosen Charlotte Lung and Health Center for your health care needs and look forward to serving you.

Sincerely,

Charlotte Lung and Health Center
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PLEASE ANSWER ALL QUESTIONS

DATE_____

PATIENT NAME_____

DATE OF BIRTH_____ **SOCIAL SECURITY** _____

ADDRESS_____

CITY, STATE, ZIP_____

PHONE (H) _____ **(W)** _____**(C)**_____

PRIMARY CARE DR_____ **PHONE**_____

EMERGENCY CONTACT_____

RELATIONSHIP_____**PHONE**_____

NAME OF INSURANCE COMPANY_____

SIGNATURE_____DATE_____

_____Date _____
Signature of Patient or Personal Representative

_____
Print or Type Name of Patient or Personal Representative (attach authority of representative)

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Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____

_____

_____

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____ _____

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

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Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____
Address_____
City, State, Zip _____Phone _____

I authorize the practice below to release my health information:

_____
_____
_____

Please forward/release my health information to:

_____
_____

The information below is provided at the request of the patient. (Describe PHI needed)

_____
_____

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to _____

_____.

_____Date _____
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Epworth Sleepiness Scale

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 work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

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

Situation	*Chance of Dozing*
Sitting and reading ……	_____
Watching TV ……...	_____
Sitting, inactive, in a public place (e.g., a theater or a meeting)……	_____
As a passenger in a car for an hour without a break ……	_____
Lying down to rest in the afternoon when circumstances permit ……	_____
Sitting and talking with someone ……	_____
Sitting quietly after a lunch without alcohol ……	_____
In a car, while stopped for a few minutes in traffic ……	_____
Total	_____

Charlotte Lung and Health Center

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

NAME: _____

REASON FOR VISIT: _____ DATE OF BIRTH: _____ DATE: _____

_____ REFERRED BY: _____

SOCIAL HISTORY

☐ Married ☐ Divorced ☐ Separated ☐ Single Who lives with you? _____

Any pets? _____

Sexually active? ☐ Y ☐ N ☐ Men ☐ Women ☐ Both

Have you traveled recently? ☐ Yes ☐ No If yes, where? _____

Are you currently working? ☐ Yes ☐ No If yes, occupation? _____

☐ Retired ☐ Disabled

What are your daily activities? _____

NC Resident for how many years? _____

Do you smoke now? ☐ Yes ☐ No If no have you ever smoked? ☐ Yes ☐ No

If yes, year stopped smoking? _____ If yes, how long did you smoke? _____

If yes, how many packs per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, daily quantity? _____

Military Service? ☐ Yes ☐ No If yes, how many years? _____

OPERATIONS

Give approximate Date

Tonsillectomy _____ Hysterectomy _____

Gallbladder _____ Hernia Repair _____

Hemorrhoidectomy _____ Biopsy _____

Appendectomy _____ Ulcer Surgery _____

Joint Surgery _____ Other _____

Other Hospitalization or Accidents _____

_____

ALLERGIES

Drugs/Foods/Other _____

Asthma _____ Hay Fever _____

HABITS

Smokeless Tobacco _____

Caffeine (coffee, tea, cola) _____ Seat Belt Use _____

Daily Exercise _____

Name: _____ **Age:** _____

FAMILY HISTORY

Father: **Age** _____ **Health or cause of death** _____

Mother: **Age** _____ **Health or cause of death** _____

Number of Brothers _____ **Number of Sisters** _____

Age & Health of Spouse _____ **Occupation of Spouse** _____

Number of Children _____

Have any of your close relatives (parents, brothers, sisters) had:

Diabetes _____ **Tuberculosis** _____ **Cancer** _____

High Blood Pressure _____ **Heart Disease** _____

Do other diseases occur in your family? _____

IMMUNIZATIONS

Tetanus _____ **Flu** _____ **Pneumonia** _____ **Shingles** _____

TB Skin Test _____ **When** _____ **Results** _____

CONSTITUTIONAL

- ☐ Yes ☐ No **Feeling tired**
- ☐ Yes ☐ No **Fever**
- ☐ Yes ☐ No **History of sweating heavily at night**
- ☐ Yes ☐ No **Weight loss in last 3 months (lbs)** ____
- ☐ Yes ☐ No **Weight gain in last 3 months (lbs)** ____

CARDIAC

- ☐ Yes ☐ No **Chest pain, discomfort, pressure**
- ☐ Yes ☐ No **Palpitations**
- ☐ Yes ☐ No **Swelling right lower extremity**
- ☐ Yes ☐ No **Swelling left lower extremety**
- ☐ Yes ☐ No **Swelling both lower extremeties**

ALLERGY / IMMUNOLOGY

- ☐ Yes ☐ No **Seasonal allergies-when?**
- ☐ Yes ☐ No **Food allergies? What?**
- ☐ Yes ☐ No **Inhaled allergies? What?**

PULMONARY

- ☐ Yes ☐ No **Shortness of Breath**
- ☐ Yes ☐ No **Cough**
- ☐ Yes ☐ No **Coughing up Blood**
- ☐ Yes ☐ No **Chest Pain**
- ☐ Yes ☐ No **Chest tightness**
- ☐ Yes ☐ No **Wheezing**

Name: _____ Age: _____

HEENT

- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Sinus Pain
- ☐ Yes ☐ No Postnasal drip
- ☐ Yes ☐ No Hoarseness
- ☐ Yes ☐ No Trouble Swallowing

SLEEP

- ☐ Yes ☐ No Snoring witnessed
- ☐ Yes ☐ No Periods of not breathing while asleep
- ☐ Yes ☐ No Groggy for too long upon awakening
- ☐ Yes ☐ No Sleeping Too Much
- ☐ Yes ☐ No Suddenly Falling Asleep During the Day
- ☐ Yes ☐ No Waking at night with choking

NEURO / PSYCH

- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Fainting/Syncope
- ☐ Yes ☐ No Seizures? Last seizure, when?
- ☐ Yes ☐ No Headaches? Frequency?
- ☐ Yes ☐ No Anxiety/Depression?

SKIN / MUSCLE/ JOINT

- ☐ Yes ☐ No Skin lesions or rash, where?
- ☐ Yes ☐ No Backache, where? How long?
- ☐ Yes ☐ No Joint Pain. Which Joint(s)?

GU / GI

- ☐ Yes ☐ No Painful Urination
- ☐ Yes ☐ No Blood in Urine
- ☐ Yes ☐ No Incontinence (lack of bladder control)
- ☐ Yes ☐ No Frequent nighttime urination?
- ☐ Yes ☐ No Heartburn/Indigestion. How frequent?
- ☐ Yes ☐ No Nausea
- ☐ Yes ☐ No Vomiting
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Black or bloody bowel movements
- ☐ Yes ☐ No Constipation

DATE OF LAST TESTS

- EKG _____
- Rectal Exam _____
- Chest X-Ray _____
- Stool for Blood _____
- Colonoscopy _____
- Mammogram _____
- Pelvic Exam _____
- Bone Density Test _____
- Lab Tests (Blood Work) _____

Name: _____ **Age:** _____

Is there anything else we should know about your health?

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The undersigned agrees that the above information is true and accurate to the best of their knowledge:

_____ **DATE:** _____

SIGNATURE

_____

PRINT NAME