



# Charlotte Lung and Health Center

8045 Providence Road, Suite 200 Charlotte NC 28277

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

1918 Randolph Road, Suite 440 Charlotte, NC 28207

Phone 704/342-8143 Fax 704/926-8044

## **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 \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

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

Acknowledgement of Receipt  
Of Notice of Privacy Practices

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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

'HVFULSWLRQ RI 3HUVRQDO 5HSUHVHQWDWLYH¶V \$XWKRULV

# 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

<i>Situation</i>	<i>Chance of Dozing</i>
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 .....	_____
<i>Total</i>	_____



NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

REASON FOR VISIT: \_\_\_\_\_

NAME: \_\_\_\_\_

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 extremity  
 Yes  No Swelling both lower extremities

**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:*

\_\_\_\_\_  
SIGNATURE

DATE: \_\_\_\_\_

\_\_\_\_\_  
PRINT NAME