



Central Florida Pulmonary Group, P.A.

Board Certified in Internal Medicine,
Pulmonary Disease, Critical Care Medicine
and Sleep Medicine

Robert D. Bast, M.D.
1949 - 2002

Daniel Haim, M.D., F.C.C.P.

Daniel T. Layish, M.D., F.A.C.P., F.C.C.P.

Francisco J. Calimano, M.D., F.C.C.P.

Francisco J. Remy, M.D., F.C.C.P.

Ahmed Masood, M.D., F.C.C.P.

Syed Mobin, M.D., F.C.C.P.

Eugene Go, M.D.

Mahmood Ali, M.D., F.C.C.P.

Karem Y. Principe, M.D., F.C.C.P.

Steven Vu, M.D.

A.J. Iskandar, M.D.

Ruel B. Garcia, M.D.

Jose L. Martinez, M.D.

Tanarak Qureshi, M.D.

Kevin De Boer, D.O.

R. Milton Harris
Administrator

Downtown Orlando
326 North Mills Avenue
Orlando, Florida 32803

East Orlando
10916 Dylan Loren Circle
Orlando, Florida 32825

Altamonte Springs
610 Jasmine Road
Altamonte Springs, Florida 32701

(407) 841-1100 *phone*
(407) 843-7983 *fax*
www.cfpulmonary.com

Appointment Information:

Doctor:

Date:

Time: AM PM

Dear Patient,

Please complete all questions on the enclosed forms. Then bring these forms with you at the time of your office visit.

We will also need you to **bring** the following **if applicable**:

- **Chest X-ray Films and/or CAT-Scan Films and PET-Scan Films**
- **Pulmonary Function Testing (PFT) Reports**
- **Medical Records**
- **Please bring all medications with you**
- **Please bring all insurance cards with you**
- **Authorization or Referral**
- **Please sign Medical Release Form**

We do keep our office very cool; you may want to bring a sweater or jacket. Please note your appointment may last a minimum of (2-4 hours). You may visit our website at www.cfpulmonary.com.

Thank You,

{Select One}

Scheduling Department
407-841-1100 x{Select One}



Central Florida Pulmonary Group, P.A.

Board Certified in Internal Medicine,
Pulmonary Disease, Critical Care Medicine
and Sleep Medicine

Robert D. Bast, M.D.
1949 - 2002

Daniel Haim, M.D., F.C.C.P.
Daniel T. Layish, M.D., F.A.C.P., F.C.C.P.
Francisco J. Calimano, M.D., F.C.C.P.
Francisco J. Remy, M.D., F.C.C.P.
Ahmed Masood, M.D., F.C.C.P.
Syed Mobin, M.D., F.C.C.P.
Eugene Go, M.D.
Mahmood Ali, M.D., F.C.C.P.
Karem Y. Principe, M.D., F.C.C.P.
Steven Vu, M.D.
A.J. Iskandar, M.D.
Ruel B. Garcia, M.D.
Jose L. Martinez, M.D.
Tanarak Qureshi, M.D.
Kevin De Boer, D.O.

R. Milton Harris
Administrator

Downtown Orlando
326 North Mills Avenue
Orlando, Florida 32803

East Orlando
10916 Dylan Loren Circle
Orlando, Florida 32825

Altamonte Springs
610 Jasmine Road
Altamonte Springs, Florida 32701

(407) 841-1100 *phone*
(407) 843-7983 *fax*
www.cfpulmonary.com

Appointment Information:

Doctor:

Date:

Time: AM PM

Dear Patient,

Please complete all questions on the enclosed forms. Then bring these forms with you at the time of your office visit.

We will also need you to **bring** the following **if applicable**:

- CPAP/BiPAP Machine
- Sleep Study Reports
- Medical Records
- Please bring all medications with you
- Please bring all insurance cards with you
- Authorization or Referral
- Please sign Medical Release Form

We do keep our office very cool; you may want to bring a sweater or jacket. Please note your appointment may last a minimum of (2-4 hours). You may visit our website at www.cfpulmonary.com.

Thank You,

{Select One}

Scheduling Department
407-841-1100 x{Select One}

CENTRAL FLORIDA PULMONARY GROUP, P.A.

Patient Information For Authorization of Treatment

Office Use Only	
Account:	Date:
<input type="checkbox"/> Hospital <input type="checkbox"/> Mills <input type="checkbox"/> East <input type="checkbox"/> North	

Please Print

PATIENT INFORMATION

Patient Name		Evening Phone	Daytime Phone	Today's Date
Street Address	Apt. No.	City	State	Zip
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorce		Birth Date	Social Security Number	Gender

SPOUSE/GUARDIAN INFORMATION

Spouse/Guardian Name	Social Security Number	Relationship	Daytime Phone
----------------------	------------------------	--------------	---------------

EMERGENCY CONTACT

Emergency Contact Name (Not living at same address)	City/State	Relationship	Daytime Phone
---	------------	--------------	---------------

INSURANCE INFORMATION

Patient's Primary Care Physician (PCP)	PCP's Phone	Referring Physician	Referring Physician Phone	Is the patient retired? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	-------------	---------------------	---------------------------	---

If my insurance requires an authorization and it has NOT been obtained, I realize I may be responsible for services rendered. I understand that I am financially responsible for charges rendered and that filing my insurance is a courtesy performed by this office.

Primary Insurance Carrier	Policy Number	Group Number	Employer Name	Effective Date
Claims Address	City	State	Zip	Insurance Phone
Policy Holder's Name	Social Security Number	Birth Date	Relationship to Patient	Daytime Phone
Secondary Insurance Carrier	Policy Number	Group Number	Employer Name	Effective Date
Claims Address	City	State	Zip	Insurance Phone
Policy Holder's Name	Social Security Number	Birth Date	Relationship to Patient	Daytime Phone

Please continue authorization of treatment on the backside.

FOR MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to **Central Florida Pulmonary Group, P.A.**, for any services furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents, any information needed to determine these benefits or these benefits payable for related services. I also request that payment for authorized Medigap benefits be made on my behalf to **Central Florida Pulmonary Group, P.A.** for services provided. I authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine these benefits. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim because my signing this authorization will allow Medicare payment information to cross over automatically. This authorization serves as a lifetime authorization unless revoked in writing by me. A copy of this authorization may be used in place of the original.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

FOR NON-MEDICARE PATIENTS

I authorize release of any medical information necessary to process this claim and related claims. I request that payment of authorized benefits be made on my behalf to **Central Florida Pulmonary Group, P.A.** for any services furnished to me. This authorization serves as a lifetime authorization unless revoked in writing by me. A copy of this authorization may be used in place of the original.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

ALL PATIENTS

I agree to pay all balances owed, including, but not limited to, coinsurance, co-payments, deductible, and non-covered services promptly upon presentation thereof. Balances as shown by statements are agreed to be correct unless protested in writing within thirty days. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claim thereon. If your bill remains unpaid, you will be held responsible for all collection costs including collection agency fees. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

CONSENT FOR TREATMENT

The patient and/or authorized representative of the patient whose signature is affixed below does hereby consent to medical treatment which may be deemed advisable by my physician/provider. The intention, hereof, being to grant authority to administer and perform all examinations, treatment, and diagnostic procedures which may now or during the course of my care be deemed necessary.

Beneficiary Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

PATIENT PERMISSION TO COMMUNICATE MEDICAL INFORMATION

The patient and/or authorized representative of the patient whose signature is affixed below does hereby permit and does not object to the communication of medical information related to my care and condition to the following two individuals (e.g. spouse, son, daughter, friend, etc.)

Name of Individual _____ Relationship _____ Phone Number _____

Name of Individual _____ Relationship _____ Phone Number _____

Patient Signature _____ Date _____

Authorized Representative Signature (if applicable) _____ Date _____

Central Florida Pulmonary Group, P.A.

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name	Birth Date	Social Security Number
---------------------	-------------------	-------------------------------

By signing this authorization, I authorize *Central Florida Pulmonary Group, P.A.* to **obtain/release** certain protected health information (PHI) about me from/to: *(Name and address of entity being asked to release information or the entity to whom the information will be forwarded)*

The information requested to be obtained from the entity listed above should be sent to:

Attention: Medical Records, Central Florida Pulmonary Group, 326 North Mills Avenue, Orlando, Florida 32803

This authorization permits the following individually identifiable health information about me to be **obtained/released** for the specified date or period:

Records obtained/released are for the date(s) of _____ or the period from _____ to _____ (Date entry or period time **MUST** be entered)

- Visit services provided to me by any physician or other practitioner within the entity named above
- Visit services provided by only the following physician(s) or other practitioner(s) _____
- Office/Outpatient Diagnostic Testing Medication Lists Laboratory Results
- Psychiatric evaluation(s) and treatment Alcohol and/or drug abuse HIV testing/diagnosis
- Operative reports for surgical services Other _____
- My complete medical record _____

The information will be used or disclosed for the following purpose: _____ This authorization will expire: _____

I do not have to sign this authorization as a condition for receiving treatment from *Central Florida Pulmonary Group, P.A.* unless there is a specific rule under the federal Privacy Regulations where conditioning is permitted. If conditioning is permitted for this specific authorization, it is disclosed below including consequences that may apply. **Conditioning applies to this authorization: Yes No**

I understand that by refusing to sign this authorization, the following consequences may apply: *(This section is only completed when conditioning applies)*

When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the federal Privacy Rule.

I have the right to revoke this authorization, **in writing**, except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy Officer at:
Central Florida Pulmonary Group, P.A., 326 North Mills Avenue, Orlando, Florida 32803

I understand and agree that I am financially responsible for appropriate fees associated with my request in accordance with Florida Administrative Code, Rule 64B-10.003 which states that "(1) Any person licensed pursuant to Chapter 458, Florida Statutes, required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records. (2) Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: (a) For the first 25 pages, the cost shall be \$1.00 per page. (b) For each page in excess of 25 pages, the cost shall be 25 cents. (3) Reasonable costs of reproducing x-rays, and other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication."

The cost of postage related to mailing is a separate fee that may be charged and is unrelated to the costs of reproduction.

Signature of Patient : _____ Print Name: _____

Signed by Personal Representative/Guardian (if applicable): _____ Print Name: _____

Description of personal representative/guardian authority to act on behalf of the patient: _____

Witness Signature: _____ Print Name: _____ Date Signed: ____ day of _____, 20____

I Acknowledge Receiving a Copy of This Authorization: _____ (Patient or Personal Representative/Guardian)

For Internal Purposes Only

Completed by: _____ Date completed: _____ Fax Pick-up Mailed Other: _____

Central Florida Pulmonary Group, P.A.

326 North Mills Avenue Orlando, Florida 32803

Financial Policy

Welcome to our medical practice. We are committed to providing you with the best possible care and services. If you have insurance, we are anxious to help you to receive your maximum plan benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Balances owed for services rendered are due at the time of service and are rendered unless payment arrangements have been preapproved by our billing department. Copays will be collected the day of your appointment. We accept cash, checks, Visa, Mastercard and debit cards. We will file a claim for your primary insurance. Patient balances greater than 30-days old may be charged a monthly late fee of \$5.00 with each patient statement.

Please realize that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that specific contract.
2. We have established our charges based on the actual value of the services. We do, however, provided significant adjustments to those services with many insurance companies.
3. Not all services rendered are a covered benefit with all insurance company contracts that you or your employer may have chosen. It is important for you to have an understanding of the benefits and regulations associated with your health plan.

We must emphasize that as a health care provider, our relationship is with you, not your insurance company. Follow up on outstanding claims with your insurance company may require your intervention; and we appreciate your working with us in that regard. We realize that temporary financial problems may affect timely payment of your account. However, if such a problem should occur, we expect you to contact us promptly for assistance. If you have questions about the information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. WE ARE HERE TO TRY TO HELP YOU.

Policies Related To Medicare and Medicare Supplement Insurance

We are a participating provider with the Medicare Part B program; and as such are obligated to write off the difference between Medicare's allowed amount and our charge. Medicare pays 80% of that allowed amount to us directly. The 20% copay and annual deductible is the patient responsibility by federal law.

We do not manually file claims to your Medicare supplement. If Medicare transmits your supplemental information for payment to your insurance company, we will allow 30 days for payment. After 30 days, payment to our office and collection from your supplemental insurer will be your responsibility.

Policies of Contracted Managed Care Companies

In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to be able to provide this service to you, it is impossible for us to keep track of all the individual requirements of the many various plans. Each one has different stipulations regarding what services may be rendered and, even more importantly, where and who those services may be performed by. Even within the same insurance company, the plans differ depending upon what types of contracts you or your employer requested.

Providing quality medical care for our patients is our primary concern. We will provide that care within your contract guidelines, but we expect you to contact your plan and to actively participate in knowing your plan regulations as services are rendered. **If a treatment authorization is required by your plan, please be sure that our office is in receipt of that authorization PRIOR to your appointment or your appointment may require rescheduling.**

If you do not inform us of any special requirements in your contract, and we subsequently order services such as lab work, medical equipment, outpatient diagnostic services, hospitalization, or any other services recommended by your physician that are

not covered, we or the selected medical facility will have no alternative but to bill you directly for those charges. Payment for those charges is your responsibility.

With your cooperation and direction you should be able to receive all the benefits offered to you, and we will be able to concentrate on caring for your medical needs.

Central Florida Pulmonary Group, P.A.

Account

Patient's Name	Age	Martial Status S M D W	Today's Date
Current Occupation	Family Physician (PCP)	Phone	
If Retired, Previous Occupation	Referring Physician	Phone	

Main reason for today's visit, and when did you first notice this problem?

Please check any current problems you are having. If yes, please explain.

<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Hay fever (allergies)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Cough <input type="checkbox"/> with phlegm <input type="checkbox"/> with blood	<input type="checkbox"/> Yes <input type="checkbox"/> No	Color: _____
<input type="checkbox"/> Fevers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Recent weight change	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Sleeping disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

MEDICAL HISTORY FORM

ALLERGIES: Please check any current allergies you have.

___ Ace Inhibitors	___ Anesthesia	___ Antihistamines	___ Aspirin	___ Codeine
___ Dairy Products	___ Iodine	___ Latex	___ Mold	___ Penicillin
___ Pet Dander	___ Prednisone	___ Sulfa Drugs	___ X-ray Dye	___ No Known Allergies
___ Other: _____				

MEDICATION: Prescription and non-prescription medicines, vitamins, home remedies, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies or reactions to medications: _____

Date of your most recent IMMUNIZATION: Influenza (flu shot) _____ Pneumovax (pneumonia) _____ Other: _____

TESTING: Please check any recent testing you had.

Type of Test	When	Where	Results if known
TB Skin Test	_____	_____	_____
Chest X-ray/CT Scan	_____	_____	_____
Pulmonary Function Test (PFT)	_____	_____	_____

- OVER -

PAST SURGICAL/HOSPITALIZATION HISTORY: Please list all prior operations/hospitalization (with dates).

Type of Surgery/Hospitalization

Where (e.g. name of hospital or facility)

Date

PAST MEDICAL HISTORY: Please check if you have ever been diagnosed with any of the following.

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Anemia | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspirations | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchiectasis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> Cardiac Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Chronic Cough |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Fissure | <input type="checkbox"/> GERD/Heart Burn |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hodgkin's Disease |
| <input type="checkbox"/> Hyperactive Airway | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Non-Hodgkin's Lymphoma | <input type="checkbox"/> Obesity | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pneumothorax | <input type="checkbox"/> Pulmonary Emboli |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Raynaud's Phenomenon | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Condition |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Stridor | <input type="checkbox"/> Stroke, TIA, CVA | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Other: _____ | | | |

FAMILY HISTORY: Please indicate the current status of your immediate family members. Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions.

- | | | | |
|---------------------|-------|----------------------|-------|
| Addison's disease | _____ | High cholesterol | _____ |
| Alcoholism | _____ | Hypertension | _____ |
| Alzheimer's disease | _____ | Kidney disease | _____ |
| Asthma | _____ | Lupus | _____ |
| Autoimmune disorder | _____ | Obesity | _____ |
| Cancer (list type) | _____ | Osteoporosis | _____ |
| Cardiovascular | _____ | Respiratory disease | _____ |
| COPD | _____ | Rheumatoid arthritis | _____ |
| Cystic fibrosis | _____ | Schizophrenia | _____ |
| Diabetes | _____ | Sickle cell disease | _____ |
| Emphysema | _____ | Stroke | _____ |
| Fibromyalgia | _____ | Thyroid disease | _____ |
| Heart problems | _____ | Tuberculosis | _____ |
| Hepatitis | _____ | Other: | _____ |

SOCIAL HISTORY

Tobacco Use

- Cigarettes: Never Quit Date _____
 Current Smoker: packs/day _____ # of years _____
 Other tobacco: Pipe Cigar Snuff Chew
 Are you interested in quitting? Yes No

Alcohol Use

Do you drink alcohol? Yes # of drinks/week ____ No

Drug Use

Do you use recreational drugs? Yes No

Caffeine Use

Coffee/tea/soda _____ cups/day None

Exposures

- | | | |
|---|---|--|
| <input type="checkbox"/> asbestos while working in/as | <input type="checkbox"/> A/C | <input type="checkbox"/> construction, |
| | <input type="checkbox"/> a mechanic, | <input type="checkbox"/> a pipefitter |
| | <input type="checkbox"/> a shipyard | |
| <input type="checkbox"/> burns wood in home | <input type="checkbox"/> chemical/toxin | |
| <input type="checkbox"/> oil or kerosene burning heater in home | <input type="checkbox"/> radiation | |
| <input type="checkbox"/> dust | <input type="checkbox"/> coal dust | |
| <input type="checkbox"/> carpenter's wood dust | <input type="checkbox"/> ammonia | |
| <input type="checkbox"/> chemical fumes or gases | <input type="checkbox"/> silica | |
| <input type="checkbox"/> soldering/welding | <input type="checkbox"/> agent orange | |
| <input type="checkbox"/> UV overexposure | <input type="checkbox"/> chlorine | |
| <input type="checkbox"/> chemical fumes | <input type="checkbox"/> feathers | |
| <input type="checkbox"/> mold growing in house | <input type="checkbox"/> fiberglass | |
| <input type="checkbox"/> tobacco exposure | <input type="checkbox"/> Animals/Pets | |

Central Florida Pulmonary Group, P.A.

Sleep Questionnaire

Account

Patient's Name	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight	Height	Today's Date
----------------	-----	--	--------	--------	--------------

Part 1

Instructions: Please circle that one number following each statement that best describes how often you have had any of these experiences. Unless otherwise noted, the statements refer to what has been happening to you during the past six (6) months. Circling number "1" after a statement means that you have never had that experience, whereas circling number "5" means that you almost always have that experience.

Answer Key: 1 = Never 2 = Rarely 3 = Sometimes 4 = Usually 5 = Always

1. I have difficulty falling asleep _____ 1 2 3 4 5
2. When I awaken during the night I am unable to fall back to sleep _____ 1 2 3 4 5
3. At bedtime I am afraid of not being able to fall asleep _____ 1 2 3 4 5
4. I sleep better when sleeping away from my home _____ 1 2 3 4 5
5. Thoughts race through my mind when I am trying to go to sleep _____ 1 2 3 4 5
6. I use alcohol to help me get to sleep _____ 1 2 3 4 5
7. I use medications to help me get to sleep _____ 1 2 3 4 5
8. My sleep is disturbed because of pain _____ 1 2 3 4 5
9. I am anxious or depressed _____ 1 2 3 4 5
10. I have been told that I snore _____ 1 2 3 4 5
11. I have been told that my snoring can be heard in other rooms of the house _____ 1 2 3 4 5
12. I suddenly wake up gasping or choking _____ 1 2 3 4 5
13. I have been told I stop breathing at times during my sleep _____ 1 2 3 4 5
14. I have headaches when I wake up in the morning _____ 1 2 3 4 5
15. At times during the day I struggle to stay awake _____ 1 2 3 4 5
16. I have trouble at work or school because of sleepiness _____ 1 2 3 4 5
17. I have fallen asleep during the day involuntarily _____ 1 2 3 4 5
18. At times during the day I am so tired that I find myself doing things that make no sense _____ 1 2 3 4 5
19. I have been told that I kick my legs when I sleep _____ 1 2 3 4 5
20. My sleep is disturbed by aching or crawling sensations in my legs _____ 1 2 3 4 5
21. I get out of bed to walk and stretch my legs because of discomfort _____ 1 2 3 4 5
22. When awakening or falling asleep, I have been awake but felt paralyzed or unable to move _____ 1 2 3 4 5
23. When awakening or falling asleep, I have experienced vivid dreamlike visions or heard voices _____ 1 2 3 4 5
24. I have sudden attacks of muscular weakness when laughing, crying or otherwise very emotional _____ 1 2 3 4 5
25. I sleep walk at times _____ 1 2 3 4 5
26. I wake up screaming, confused or violent at times _____ 1 2 3 4 5

Please continue on the next page.

Part 2 – The 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:

Answer Key: 0 = Would never doze 1 = slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

- | | | | | |
|---|---|---|---|---|
| 1. Sitting and reading _____ | 0 | 1 | 2 | 3 |
| 2. Watching T.V. _____ | 0 | 1 | 2 | 3 |
| 3. Sitting inactive in a public place (i.e. a theatre, a meeting) _____ | 0 | 1 | 2 | 3 |
| 4. As a passenger in a car for an hour without a break _____ | 0 | 1 | 2 | 3 |
| 5. Lying down to rest in the afternoon when circumstances permit _____ | 0 | 1 | 2 | 3 |
| 6. Sitting and talking to someone _____ | 0 | 1 | 2 | 3 |
| 7. Sitting quietly after a lunch without alcohol _____ | 0 | 1 | 2 | 3 |
| 8. In a car, while stopped for a few minutes in traffic _____ | 0 | 1 | 2 | 3 |

Part 2

1. Do you work shifts or irregular hours? If so, please explain:
2. Is there a history for sleep problems in your family? If so, please explain:
3. Do you seem to sleep best at times different from most people you know? If so, please explain:
4. Did you have sleeping problems during childhood (i.e. sleep walking, night terrors, etc)? If so, please explain:
5. Do you drink caffeinated beverages (i.e. coffee, tea, colas)? If so, how many drinks per day?
6. Have you had any history for emotional or other psychiatric problems? If so, please explain:
7. Are there any other issues that you would like to bring to the doctors attention? If so, please explain:

Location: Downtown Orlando Office



Central Florida Pulmonary Group, P.A.
326 North Mills Avenue
Orlando, Florida 32803

Phone: 1 407-841-1100
Fax: 1 407-843-7983

Downtown Orlando Office

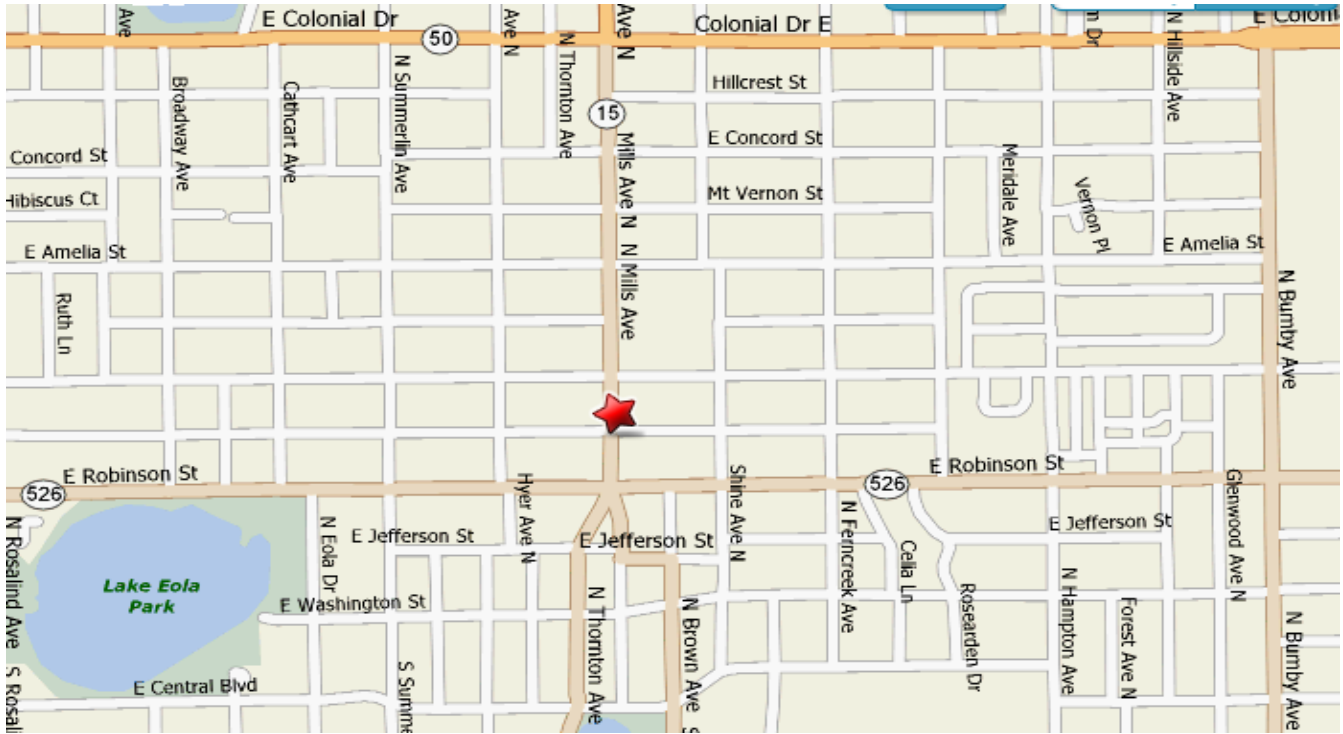
Directions and Map to Downtown Orlando Office

Coming from West I-4:

Exit Amelia St. exit (which is directly over downtown Orlando – after red light at Amelia go straight (this will be Arland St.) and veer to the far right lane – continue to Colonial Drive (aka State Road 50) – turn right onto Colonial Drive (which places you going east) follow approx 1 to 2 miles and you will come to red light at Mills Ave. – turn right and go 4 blocks – our office is on the corner of Livingston St. and Mills Ave. – we are directly across the street from the Girl Scout Council building – go past our office and turn right on Ridgewood St. then right into our parking lot.

Coming from East I-4:

Exit Colonial Dr. (aka State Road 50) which is directly over lake Ivanhoe – at red light turn left onto Colonial Drive (which places you going east) – follow approximately 1-2 miles to red light at Mills – turn right and go 4 blocks – our office is on the corner of Livingston St. and Mills Ave. – we are directly across the street from the Girl Scout Council building – go past our office and turn right on Ridgewood St. then right into our parking lot.



Location: East Orlando Office



Central Florida Pulmonary Group, P.A.
10916 Dylan Loren Circle
Orlando, FL 32825

Phone: 1 407-841-1100
Fax: 1 407-843-7983

Directions and Map to East Orlando Office

From the 408E

Take exit 20 (Rouse Rd).
Turn right onto Rouse Rd.
Turn right onto Lake Underhill.
Turn left at the next intersection (Cypress Hammock).
Take first right onto Dylan Loren Circle.

From West headed East on Lake Underhill

Cross Dean Rd.
Turn right at the next intersection (Cypress Hammock).
Take first right onto Dylan Loren Circle.

From East headed West on Lake Underhill

Cross Rouse Rd.
Turn left at the next intersection (Cypress Hammock).
Take first right onto Dylan Loren Circle.



Location: Altamonte Springs Office



Central Florida Pulmonary Group, P.A.
Altamonte Springs Office
610 Jasmine Road
Altamonte Springs, Florida 32701

Phone: 1-407-841-1100
Fax: 1-407-843-7983

Directions to Altamonte Springs Office

Coming from West I-4:

Exit SR-436 exit, towards Altamonte Springs/Apopka. Keep right at the fork to go on East Altamonte Drive/FL-436 East. Turn Right onto Boston Avenue. Turn Left onto Jasmine Road. 610 Jasmine Road is on the right.

Coming from East I-4:

Exit SR-436 exit, towards Altamonte Springs/Apopka. Take the ramp towards Altamonte Springs/Casselberry. Turn left onto FL-436 E/E Altamonte Drive/Semorán Blvd. Continue to follow FL-436 E/E Altamonte Drive. Turn Right onto Boston Avenue. Turn Left onto Jasmine Road. 610 Jasmine Road is on the right.

