

## Columbus Sleep Consultants, Inc.

**Main Office–East:** 99 North Brice Road, Suite 300  
**Grove City Office:** 4191 Kelnor Drive, Suite 300  
**Westerville Office:** 477 Cooper Road, Suite 460

**Columbus Office:** 3650 Olentangy River Road, Suite 301  
**Newark Office:** 1900 Tamarack Road, Suite 1908  
**Lancaster Office:** 2405 Columbus Street, Suite 270

**Gautam Samadder, M.D.**  
**Rajib Saha, D.O., M.S.**  
**Manindar Kalra, M.D., M.S.**

Pulmonology & Sleep Medicine  
Neurology & Sleep Medicine  
Pediatrics & Sleep Medicine

**Telephone:** (614) 866-8200    **Toll Free:** 1-866-751-5411    **Fax:** (614) 866-9131

Dear \_\_\_\_\_:

Your consultation has been scheduled for \_\_\_\_\_, at the \_\_\_\_\_ office, at \_\_\_\_\_ Dr. Samadder / Dr. Saha / Dr. Kalra.

### **Please call us to confirm your appointment.**

Because we are a leader in the field of Sleep Medicine and put our patient's needs first, our new patient appointments are very valuable to the community we serve. Therefore, we ask that you make every effort to keep your appointment. We understand that emergencies arise, so if you find that you can not keep your appointment, **please call us as soon as possible to reschedule** so that other patients may have the opportunity to use that vacated appointment time slot.

Please **complete all of the enclosed forms and bring them to your appointment along with copies of any medical records** necessary for the doctor to better serve your health needs. **In order for the information to be processed before you see the doctor, we ask that you arrive 15 minutes before your appointment time.** If you do not arrive in enough time, you may be asked to reschedule.

Enclosed you will find a map and directions to the facility you are scheduled. **At the time of every appointment, you will need your photo identification, insurance card, and your co-pay.**

If a doctor's office has scheduled your appointment with us, please call us to confirm we have your current insurance information so we may verify your coverage. **You are required to acquire an annual referral from your PCP or referring physician if your insurance policy requires one.**

Please call the office if you have questions, comments, or concerns. We look forward to serving you and your health needs.

Sincerely,  
Gautam Samadder, M.D.

Sincerely,  
Rajib Saha, D.O.

Sincerely,  
Maninder Kalra, M.D.

**Columbus Sleep Consultants, Inc.  
PATIENT INFORMATION SHEET**

**Patient Information: (Please Print)**

**(Use legal name and indicate any nickname in "quotation marks" after your first name)**

Name: \_\_\_\_\_ Previous Name: \_\_\_\_\_  
(Last) (First) (Middle) (Last) (First) (Middle)

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: S M W D SEP OTHER Gender: M F

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Referring Physician: NAME & phone number: \_\_\_\_\_

Primary Care Physician: NAME & phone number: \_\_\_\_\_

**Next of Kin/Spouse/Parent and/or Responsible Party Information:  
(Give spouse/parent information even if you are not covered under their insurance)**

Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Relationship to You: \_\_\_\_\_ SS#: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
(Street Address) (City) (State) (Zip)

**PRIMARY INSURANCE:**

Policyholder: (please circle) Self Spouse Parent Other

Insurance Company Name: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY INSURANCE:**

Policyholder: (please circle) Self Spouse Parent Other

Insurance Company Name: \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group #: \_\_\_\_\_

**EMERGENCY CONTACT: (Not living with you)**

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
(Street Address) (City) (State) (Zip) Work Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Patient or Guardian Signature Date

**Columbus Sleep Consultants, Inc.  
NON COVERED SERVICE WAIVER**

Medicare, Medicaid and private insurers or payers set various benefit limits based upon the plan selected by government agencies, employers, and individuals. Your physician may determine that certain services, supplies and/or tests are useful, and consequently may provide or order one or more of these items to provide you with the degree of medical care he or she believes is necessary to protect your health. In addition, due to the benefit limits in the plan, Medicare, Medicaid and private insurers may not cover some services for payment without corresponding medical diagnoses or condition. Columbus Sleep Consultants, Inc. will bill your insurance carrier for these procedures. If the service is denied, the billing will be forwarded to you for payment. By signing this form below you are agreeing to be fully responsible for payment of any services not covered under your health care contract by your insurance carrier. I have read and understand the above information and I agree to be personally and fully responsible as indicated if my insurance carrier or payer denies payment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ANNUAL ASSIGNMENT AND RELEASE**

**Patient's or Authorized Persons Signature:**

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Insured or Authorized Person's Signature:**

I authorize payment of medical benefits to the undersigned physician or supplier for services provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# ANNUAL REFERRAL ACKNOWLEDGMENT

It is YOUR RESPONSIBILITY to acquire an annual referral from your Primary Care Physician or your Referring Physician if your insurance policy requires one. You must contact your insurance company and your primary care or referring physician to learn the guidelines regarding your policy. If you do not have a valid referral or do not comply with the guidelines your insurance company has established, YOU WILL BE RESPONSIBLE FOR ALL CHARGES ACCRUED.

I, \_\_\_\_\_, have read the above notice and understand  
Print Patient Name

that I will be responsible for payment of any and all charges that are not paid by my insurance provider due to lack of a valid annual referral from my primary care doctor or referring physician.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Columbus Sleep Consultants, Inc.**  
**FINANCIAL POLICY**

We are committed to providing you with the best possible medical care. If you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our practice participates with a variety of insurance plans. It is your responsibility to:
  - ❖ **Bring your current insurance card at every visit.** We consider an insurance card similar to a credit card because you are asking us to bill another party for charges for the services you have been provided. If you do not bring your insurance card, you should be prepared to pay for your services in full on that date.
  - ❖ **Be prepared to pay your co-pay each visit.** We are required by your insurance plan to collect co-pays on the date of service. Payment can be made by cash, check, or credit card. If you do not bring proper payment to your visit, you will need to reschedule your appointment except in the case of a medical emergency.
  - ❖ **For medical care not covered by your insurance or for patients that have no insurance, payment in full is due at the time of the visit.**
  - ❖ **THERE WILL BE A \$25 REBILLING CHARGE if the insurance card and registration information provided at each visit is not correct.**
2. If you have insurance that we do not participate in, upon request our billing company will provide you with a form with itemized charges that you can use to file to that plan for reimbursement. However, payment in full is expected on the date of service.
3. Referrals: It is your responsibility to bring any required referrals for treatment at, or prior to the visit. If you do not have the referral, your visit may be rescheduled, or you may be financially responsible.
4. If the patient is a minor (under 18 years of age), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, bringing the necessary referrals, and insurance cards.
5. If you have any questions about insurance, we are happy to help you. However, specific coverage issues should be directed to your insurance company customer service department (the telephone number is on your insurance card).
6. If you fail to make payment in full for the services that are rendered to you, your outstanding balance will be sent to a collections agency. You will be responsible for the fees assessed by the collections agency.
7. Due to the length of wait and the urgency that some patients require to have their sleep study performed, cancellations and no shows for sleep study appointments has become a problem. All patients are required to give at least a 48 hour notice if cancelling for a sleep study appointment. Cancellations must be called directly to the location for which the study has been scheduled. **Failure to follow the 48 hour cancellation procedure will result in a cancellation fee of \$125. Columbus Sleep Consultants is aware that there are some extenuation circumstances that may affect your ability to cancel within the 48 hour window (i.e. work related accident, automobile accident, family emergency, death in the family, serious illness, etc.) and patients who legitimately experience one of these issues or a similar issue may qualify to have this fee waived after review by the physician. We would like to thank you in advance for your attention to this matter.**

Our practice believed that a good physician-patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the office where you regularly receive services. Please sign that you have read and agree to the Financial Policy.

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Signature of Patient or Responsible Party

Date

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Signature of Co-Responsible Party

Date

Columbus Sleep Consultants, Inc.

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**Your Legal Rights**

The federal privacy regulations give you the right to make certain requests regarding health information about you. You may ask us to:

- Communicate with you in a certain way or at a certain location. For example, you might want us to send health information to a different address from that of the person who subscribes to your insurance. We will accommodate reasonable written requests.
- Restrict the way we use or disclose health information about you in connection with health care operations, payment and treatment. We will consider, but may not agree to, such requests which must be in writing. You also have the right to ask us to restrict disclosures to persons involved in your health care which must be in writing.
- Amend health information that is in a "designated record set." Your request must be in writing and must include the reason for the request. If we deny the request, you may file a written statement of disagreement which we will include in your health information.

We will respond to your request as quickly as possible, but cannot assure you that our response will be ready before five business days after our receipt of your written request.

- Provide you physical access to your health information, which you must request in writing. Your physical access may be denied in certain limited circumstances. If your request is granted, your access and inspection must be during our normal daytime business hours, and we may require your inspection to be accompanied by one of our employees or representatives.
- Provide a list of certain disclosures we have made about you, such as disclosures of health information to government agencies that license us. Your request must be in writing. We will respond to your request as quickly as possible, but cannot assure you that our response will be ready before five business days after our receipt of your written request.

You also have the right to file a complaint if you think your privacy rights have been violated. To do so, please write to our Practice Administrator/Privacy Officer. You also may write to the Secretary of U.S. Department of Health and Human Services. You will not be penalized and we will not retaliate against you for filing a complaint.

### **Our Legal Obligations**

The federal privacy regulations require us to keep personal information about you private, to give you notice of our legal duties and privacy practices, and to follow the terms of the notice currently in effect.

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### **This Notice Is Subject To Change**

We are required to abide by our currently in effect privacy practices described herein; however, we reserve the right to change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of the information that we already have about you, as well as any information that we may receive or hold in the future. The changes will be effective when they are posted to our current or future website (currently, [www.columbussleepconsultants.com](http://www.columbussleepconsultants.com)).

Please note that we do not destroy personal information about you when you terminate your relationship with us or otherwise cease to be our patient. It may be necessary to use and disclose this information for the purposes described above even after your status as an active patient ends, although policies and procedures will remain in place to protect against inappropriate use or disclosure.

If you have questions regarding this notice, please contact our Practice Administrator/Privacy Officer at: Practice Administrator/Privacy Officer, Columbus Sleep Consultants, 99 North Brice Road, Suite 300, Columbus, Ohio 43213; by phone at (614) 866-8200; or by fax at (614) 866-9131. Please include your name, address, e- mail address and fax number.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Columbus Sleep Consultants, Inc.**  
**Gautam Samadder, M.D   Rajib Saha, D.O., M.S.   Maninder Kalra, M.D.**  
99 North Brice Road, Suite 300, Columbus, OH 43213  
Phone (614) 866-8200   Fax (614) 866-9131

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Phone Number

**AUTHORIZATION TO RELEASE INFORMATION FROM COLUMBUS SLEEP CONSULTANTS**

I, the undersigned, hereby authorize Columbus Sleep Consultants, Inc. to release the following information from my medical record:  
\_\_\_\_\_ Sleep Studies   \_\_\_\_\_ Office Notes   \_\_\_\_\_ All Records and/or Test Results

**This information is to be forwarded to:**

\_\_\_\_\_  
Name of Agency

\_\_\_\_\_  
Attention

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip

\_\_\_\_\_  
Agency Phone Number

\_\_\_\_\_  
Agency Fax Number

**AUTHORIZATION TO RELEASE INFORMATION TO COLUMBUS SLEEP CONSULTANTS**

I, the undersigned, hereby authorize you to release the following information to Columbus Sleep Consultants, Inc.:  
\_\_\_\_\_ Sleep Studies   \_\_\_\_\_ Office Notes   \_\_\_\_\_ All Records and/or Test Results

**TO:**

\_\_\_\_\_  
Name of Agency

\_\_\_\_\_  
Attention

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip

\_\_\_\_\_  
Agency Phone Number

\_\_\_\_\_  
Agency Fax Number

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**The patient is unable to sign and I do hereby sign in legal representation of the above named patient.**

\_\_\_\_\_  
Print Representative's Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**PROHIBITION OF REDISCLOSURE:** This information is being disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information except with the specific written consent of the person to whom it pertains.

**STATEMENT OF AUTHORIZATION AND REVOCATION:** This statement must be signed and dated, and may be revoked at any time except to the extent action had been taken prior to revocation. This consent will expire sixty (60) days after the date below, or sooner by choice, in which case this consent will expire on \_\_\_\_\_. I hereby state that I have read and fully understand the above statements as they apply to me I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

**NOTICE OF POTENTIAL COST:** Please note that there may be a charge to copy records that are not being sent to a physician, or health care facility for continued medical care. This charge must be paid in full before records are released.

**Columbus Sleep Consultants, Inc.**  
**Notice of Privacy Practices**

This Notice of Privacy Practices applies to the medical practice of Gautam Samadder, M.D., Rajib Saha, D.O., M.S., Maninder Kalra, M.D., and the services provided by Gautam Samadder, M.D., Inc. (doing business as Columbus Sleep Consultants, Inc.) and their current, past, and future affiliates, including Eastside Sleep Diagnostic Center, Grove City Sleep Diagnostic Center, Knightsbridge Sleep Diagnostic Center, Newark Sleep Diagnostic Center, Lancaster Sleep Diagnostic Center, any physician or physician's assistant-certified practicing herein.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We<sup>1</sup> consider your personal information to be confidential. We are required by law to protect the privacy of that information in accordance with federal and state privacy laws, as well as our own company privacy policies. We are required by law to provide you with this Notice of Privacy Practices in which we describe our legal duties and privacy practices with respect to your personal information.

This notice describes how we may use and disclose information about you in providing health care services, and it explains your legal rights regarding the information.

When we use the term "personal information", we mean financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with health care services. By "health information", we mean information that identifies you and relates to your medical history (i.e., the health care you receive or the amounts paid for that care.)

*This notice will become effective on April 14, 2003.*

**How We Use and Disclose Personal Information**

In order to provide you with health care services, we need personal information about you, and we obtain that information from many different sources – particularly your Patient Registration Form (and other paperwork you fill out when you visit us), your insurer(s), HMOs or third-party administrators (TPAs), and your other health care providers. In the course of providing health care services, we may use and disclose personal information about you in various ways, including:

**Health Care Operations:** We may use and disclose information during the course of running our medical practice and sleep diagnostic and consulting services – that is, during operational activities such as quality assessment and improvement; health services research and preventative health, disease management, case management and care coordination. For example, we may use the information to provide sleep programs for patients with specific conditions, such as insomnia, snoring, sleep apnea and narcolepsy. Other operational activities requiring use and disclosure include transfers of personal information between our affiliates to facilitate billing and the scheduling of appointments, and other general administrative activities, including data and information systems management.

**Payment:** To help pay for your health care services, we may use and disclose personal information in a number of ways – in submission of claims for insurance and in answering insurers' questions for determining eligibility. For example, we may submit your medical history and other health information about you to your insurer to allow it to determine whether treatment is medically necessary and what the payment should be. We may then discuss your medical history with your insurer to assist in the payment of your account by your insurer – we would answer specific questions about your diagnosis, medical history, and other health information to allow your insurer to determine coverage.

**Treatment:** We may disclose information to other doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, we may disclose all or a portion of your medical history to a pharmacy when we prescribe medication for you. We may provide all or a portion of your medical history to another doctor with whom we are consulting in your medical care. Other doctors involved in your care may request medical information from us to supplement their records.

**Appointment Reminders:** We may contact you at the locations you specify in your Patient Registration Form or otherwise provide to us to provide appointment reminders. We will limit oral messages at these locations to the date and time of the appointment and other information you may need to identify that the messages are from us (such as the sleep diagnostic center name and contact information). We will not disclose additional health information in these messages.

**Disclosures to Other Covered Entities:** We may disclose personal information to other covered entities, or business associates of those entities for treatment, payment and certain health care operations purposes. For example, we may disclose personal information to other health plans maintained by your employer if it has been arranged for us to do so in order to have certain expenses reimbursed.

**Additional Reasons for Disclosure**

We may use or disclose health information about you in providing you with treatment alternatives, treatment reminders, or other health-related benefits and services. We also may disclose such information in support of:

- **Plan Administration** – to your employer, when we have been informed that appropriate language has been included in your health plan documents.
- **Research** – to researchers, provided measures are taken to protect your privacy.
- **Business Associates** – to persons who provide services to us and assure us they will protect the information.
- **Industry Regulation** – to state insurance departments, boards of pharmacy, U.S. Food and Drug Administration, U.S. Department of Labor and other government agencies that regulate us.
- **Law Enforcement** – to federal, state and local law enforcement officials.
- **Legal Proceedings** – in response to a court order or other lawful process.
- **Public Welfare** – to address matters of public interest as required or permitted by law (e.g., child abuse and neglect, threats to public health and safety, and national security).

**Disclosure to Others Involved in Your Health Care**

We may disclose health information about you to a relative, a friend, the subscriber of your health benefits plan, or any other person you identify on your Patient Registration Form, provided the information is directly relevant to that person's involvement with your health care or payment for that care. For example, if a family member or a caregiver specifically listed and authorized on your Patient Registration Form calls us with prior knowledge of your medical history, we may discuss aspects of your personal information. You have the right to stop or limit this kind of disclosure by providing written notice to us.

**Uses and Disclosures Requiring Your Written Authorization**

In all situations other than those described above, we will ask you for your written authorization before using or disclosing personal information about you. If you have given us authorization, you may revoke it at any time, if we have not already acted on it. If you have questions regarding authorization, please contact our Practice Administrator/Privacy Officer.

<sup>1</sup>For the purpose of this notice, "Columbus Sleep Consultants" and the pronouns "we", "us" and "our" refer to the medical practice of Gautam Samadder, M.D., Rajib Saha, D.O., M.S., Maninder Kalra, M.D., and the services provided by Gautam Samadder, M.D., Inc. (doing business as Columbus Sleep Consultants, Inc.) and their current, past, and future affiliates, including Eastside Sleep Diagnostic Center, Grove City Sleep Diagnostic Center, Knightsbridge Sleep Diagnostic Center, Newark Sleep Diagnostic Center, Lancaster Sleep Diagnostic Center, any physician, physician assistant-certified practicing herein. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**SURGICAL AND PROCEDURAL HISTORY**

Please check YES if YOU have had any of the following procedures:

| YES | NO | <b>Auditory (Ear)</b>                             | YES | NO | <b>Respiratory (Lungs-Throat)</b>             |
|-----|----|---|-----|----|---|
|     |    | Tympanoplasty (repair of middle ear)              |     |    | Laryngectomy (surgery to throat)              |
|     |    | Other   |     |    | Laryngotracheotomy (surgery to throat)        |
| YES | NO | <b>Cardiovascular (Heart)</b>                     |     |    | Lobectomy (removal of part of lung)           |
|     |    | Angioplasty (repair of blood vessel)              |     |    | Rhinoplasty (surgery to nose)                 |
|     |    | Cardiac Catheterization                           |     |    | Septoplasty (surgery to nasal septum)         |
|     |    | Pacemaker   |     |    | Septotomy (surgery to nasal septum)           |
|     |    | Stent Placement                                   |     |    | Uvulectomy (removal of uvula)                 |
|     |    | Other   |     |    | Uvulopalatopharyngoplasty (UPPP)              |
| YES | NO | <b>Gastrointestinal (Esophagus-Stomach-Colon)</b> |     |    | Other   |
|     |    | Abdominoplasty (repair of abdomen)                | YES | NO | <b>Visual (Eyes)</b>                          |
|     |    | Appendectomy (removal of appendix)                |     |    | Cataract removal                              |
|     |    | Cholecystectomy (removal of gall bladder)         |     |    | Artificial lens placement                     |
|     |    | Colectomy (removal of colon)                      |     |    | Iridectomy (removal of part of eye)           |
|     |    | Colonoscopy (scope of colon)                      |     |    | LASIK surgery (vision correction)             |
|     |    | Endoscopy (scope of upper or lower GI tract)      |     |    | RK surgery (vision correction)                |
|     |    | Gastrectomy (removal of stomach)                  |     |    | Sclerotomy (surgery-outside of eyeball)       |
|     |    | Hemorrhoidectomy (removal of hemorrhoids)         |     |    | Other   |
|     |    | Splenectomy (removal of spleen)                   | YES | NO | <b>Musculoskeletal (Bones-Joints-Muscles)</b> |
|     |    | Other   |     |    | Arthroplasty (joint replacement)              |
| YES | NO | <b>Genitourinary (Bladder-Genitals-Kidneys)</b>   |     |    | Arthroscopy (surgery or scope of joint)       |
|     |    | Cervicectomy (removal of cervix)                  |     |    | Other   |
|     |    | Cystectomy (removal of bladder)                   | YES | NO | <b>General Surgeries or Procedures</b>        |
|     |    | Cystolithotomy (removal-bladder-remove stone)     |     |    | Adenoidectomy (removal of Adenoids)           |
|     |    | Hysterectomy (removal of uterus)                  |     |    | Mastectomy (removal of breast)                |
|     |    | Lithotripsy (crushing of kidney stone)            |     |    | Mastoidectomy (removal-mastoid bone)          |
|     |    | Oophorectomy (removal of ovaries)                 |     |    | Thyroidectomy (removal of thyroid)            |
|     |    | Prostatectomy (removal of Prostate)               |     |    | Tonsillectomy (removal of tonsils)            |
|     |    | Salpingectomy (removal of fallopian tubes)        |     |    | Other   |
|     |    | Vasectomy (cutting of Vas Deferens)               | YES | NO | <b>Others Not Listed Above</b>                |
|     |    | Other   |     |    |   |
| YES | NO | <b>Others Not Listed Above</b>                    |     |    |   |
|     |    |   |     |    |   |
|     |    |   |     |    |   |

**DRUG OR MEDICATION ALLERGIES**

Medication Name

Reaction to this Medication

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**OTHER ALLERGIES**

Reaction

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please mark **YES** if **YOU** have any of the following:

| YES        | NO        | Cardiovascular (Heart-Blood Vessels)            | YES        | NO        | Immunologic (Blood Disorder-Rejection)       |
|------------|-----------|---|------------|-----------|--|
|            |           | Angina  |            |           | Anemia                                       |
|            |           | Coronary artery disease                         |            |           | B12 deficiency                               |
|            |           | Heart attack                                    |            |           | Hemophilia                                   |
|            |           | Heart failure                                   |            |           | HIV or AIDS                                  |
|            |           | Hypertension/High blood pressure                |            |           | Organ Transplant/Rejection Therapy           |
|            |           | Hypotension/Low blood pressure                  |            |           | Vitamin Deficiency                           |
|            |           | Irregular heartbeat                             |            |           | Other  |
|            |           | Other   | <b>YES</b> | <b>NO</b> | <b>Musculoskeletal (Muscles-Bones)</b>       |
| <b>YES</b> | <b>NO</b> | <b>Central Nervous (Brain-Spinal Cord)</b>      |            |           | Carpal Tunnel Syndrome/CTS                   |
|            |           | Alzheimer's Disease                             |            |           | Facial injury (broken cheek, etc.)           |
|            |           | Aneurysm  |            |           | Fibromyalgia                                 |
|            |           | Bell's palsy                                    |            |           | Nasal injury (broken nose, etc)              |
|            |           | Brain damage or injury                          |            |           | Neck Injury-Significant                      |
|            |           | Cerebral Palsy                                  |            |           | Head Injury-Significant                      |
|            |           | Epilepsy, seizures or convulsions               |            |           | Osteoporosis                                 |
|            |           | Major Infections (Meningitis-encephalitis-etc.) |            |           | Paralysis                                    |
|            |           | Migraine headaches                              |            |           | Rheumatoid Arthritis                         |
|            |           | Multiple Sclerosis                              |            |           | Scoliosis                                    |
|            |           | Parkinson's Disease                             |            |           | Other  |
|            |           | Stroke or CVA                                   | <b>YES</b> | <b>NO</b> | <b>Psychological/Psychiatric (Emotional)</b> |
|            |           | Other   |            |           | Anxiety/Panic Attacks                        |
| <b>YES</b> | <b>NO</b> | <b>Congenital Defects (Birth Defects)</b>       |            |           | Bi-Polar Disorder                            |
|            |           | Down's Syndrome                                 |            |           | Depression-Chronic                           |
|            |           | Major Birth Defect                              |            |           | Schizophrenia                                |
|            |           | Other   |            |           | Other  |
| <b>YES</b> | <b>NO</b> | <b>Endocrine (Glands)</b>                       | <b>YES</b> | <b>NO</b> | <b>Respiratory (Lungs-Throat-Nose)</b>       |
|            |           | Adrenal disease                                 |            |           | Asthma                                       |
|            |           | Calcium disorders                               |            |           | Deviated nasal septum                        |
|            |           | Goiter  |            |           | Emphysema                                    |
|            |           | Hyperthyroidism/overactive thyroid              |            |           | Chronic bronchitis                           |
|            |           | Hypothyroidism/under active thyroid             |            |           | COPD   |
|            |           | Hypothalamic disorders                          |            |           | Inability to breathe through nose            |
|            |           | Parathyroid disorders                           |            |           | Nasal polyps                                 |
|            |           | Pituitary disorders                             |            |           | Pneumonia                                    |
|            |           | Other   |            |           | Pulmonary or Cystic fibrosis                 |
| <b>YES</b> | <b>NO</b> | <b>Gastrointestinal (Stomach-Colon)</b>         |            |           | Sinusitis, chronic sinus condition           |
|            |           | Cirrhosis of liver                              |            |           | Other  |
|            |           | Crohn's Disease                                 | <b>YES</b> | <b>NO</b> | <b>General Disorders/Major Treatments</b>    |
|            |           | Diabetes/hyperglycemia/high blood sugar         |            |           | Cancer or On Chemotherapy                    |
|            |           | Diverticulitis                                  |            |           | Kidney Failure or On Dialysis                |
|            |           | Gastric Ulcer                                   |            |           | Enlarged Adenoids                            |
|            |           | GERD/Reflux/chronic heartburn                   |            |           | Enlarged Tonsils                             |
|            |           | Hepatitis                                       |            |           | Occupational Disease (black lung, silicosis) |
|            |           | Hiatal hernia                                   |            |           | Hyperactivity or Attention Deficit Disorder  |
|            |           | Hypoglycemia/low blood sugar                    |            |           | Problems with vocal cords or voice box       |
|            |           | Irritable bowel syndrome                        |            |           | TMJ/lock jaw                                 |
|            |           | Pancreatitis                                    |            |           | Toxins (exposure to poisons-lead-etc.)       |
|            |           | Other   |            |           | Other  |
| <b>YES</b> | <b>NO</b> | <b>Others Not Listed Above</b>                  | <b>YES</b> | <b>NO</b> | <b>Others Not Listed Above</b>               |
|            |           |   |            |           |  |
|            |           |   |            |           |  |

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### EPWORTH SLEEPINESS SCALE

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 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 |        |          |      |
|--|------------------|--------|----------|------|
|  | Never            | Slight | Moderate | High |
| Sitting and reading-----   | 0                | 1      | 2        | 3    |
| Watching television-----   | 0                | 1      | 2        | 3    |
| Sitting inactive, in a public place-----<br>e.g. in a theatre or meeting | 0                | 1      | 2        | 3    |
| As a passenger in a car for an hour<br>without a break-----              | 0                | 1      | 2        | 3    |
| Lying down in the afternoon when<br>circumstances permit-----            | 0                | 1      | 2        | 3    |
| Sitting and talking to someone-----                                      | 0                | 1      | 2        | 3    |
| Sitting quietly after lunch without<br>alcohol -----                     | 0                | 1      | 2        | 3    |
| In a car while stopped for a few<br>minutes in traffic-----              | 0                | 1      | 2        | 3    |

**Total Score** \_\_\_\_\_

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

**GENERAL REVIEW OF BODY SYSTEMS**

Please mark **YES** if ***YOU*** have any of the following:

|     |    |                         |     |    |  |
|-----|----|-------------------------|-----|----|--|
| YES | NO | <b>CARDIOVASCULAR</b>   | YES | NO | <b>GENITOURINARY</b>                   |
|     |    | Cardiac Arrest          |     |    | Blood in Urine                         |
|     |    | Chest Pain              |     |    | Difficulty Urinating-stopping/starting |
|     |    | Dizziness               |     |    | Kidney Problems                        |
|     |    | Heart Murmur            |     |    | Kidney Stones                          |
|     |    | Palpitation             |     |    | Loss of Bladder Control                |
|     |    | Rhythm Problems         |     |    | Menopause                              |
| YES | NO | <b>DERMATOLOGICAL</b>   |     |    | Painful Urination                      |
|     |    | Excessive Dry Skin      |     |    | Pregnancy                              |
|     |    | Itching                 |     |    | Prostate Problems                      |
|     |    | Non-healing Sores       |     |    | Recurrent Urinary Infections           |
|     |    | Rashes                  |     |    | Urinary Frequency at night             |
|     |    | Skin Changes            | YES | NO | <b>IMMUNOLOGIC</b>                     |
|     |    | Skin Lesions            |     |    | Environmental Allergies                |
| YES | NO | <b>GASTROINTESTINAL</b> |     |    | Frequent Nasal Congestion              |
|     |    | Abdominal Cramping      |     |    | Seasonal Allergies                     |
|     |    | Blood in Stool          | YES | NO | <b>MUSCULOSKELETAL</b>                 |
|     |    | Constipation            |     |    | Back Pain                              |
|     |    | Diarrhea                |     |    | Difficulty Walking                     |
|     |    | Nausea                  |     |    | Joint Pain                             |
|     |    | Reflux/Heartburn        |     |    | Joint Swelling                         |
|     |    | Vomiting                |     |    | Leg/Buttock Pain                       |
| YES | NO | <b>GENERAL</b>          |     |    | Muscle Soreness                        |
|     |    | Anemia                  |     |    | Swelling                               |
|     |    | Appetite Changes        | YES | NO | <b>NEUROLOGICAL</b>                    |
|     |    | Bleeding disorder       |     |    | Confusion                              |
|     |    | Blood Clots             |     |    | Headaches                              |
|     |    | Depression/Anxiety      |     |    | Numbness                               |
|     |    | Difficulty Swallowing   |     |    | Seizures                               |
|     |    | Fatigue                 |     |    | Tingling                               |
|     |    | Fever/Chills            |     |    | Weakness                               |
|     |    | Hearing Problems        | YES | NO | <b>RESPIRATORY</b>                     |
|     |    | Hot Flashes             |     |    | Chronic Lung Disease                   |
|     |    | Infections              |     |    | Cough <b>with</b> Phlegm/Sputum        |
|     |    | Liver Problems          |     |    | Cough <b>without</b> Phlegm/Sputum     |
|     |    | Night Sweats            |     |    | Shortness of Breath                    |
|     |    | Nose Problems           |     |    | Wheezing                               |
|     |    | Serious Eye Problems    | YES | NO | <b>OTHERS NOT LISTED ABOVE</b>         |
|     |    | Throat Problems         |     |    |  |
|     |    | Thyroid Problems        |     |    |  |
|     |    | Trouble Sleeping        |     |    |  |
|     |    | Weight Changes          |     |    |  |

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**CURRENT MEDICATIONS**

Medication

Reason You're Taking This Medication

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
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 \_\_\_\_\_

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**OTHER FAMILY MEDICAL HISTORY**

Please mark **YES** if anyone in ***YOUR IMMEDIATE FAMILY (parent, sibling, grandparent)*** have any of the following:

| YES | NO | Cardiovascular (Heart-Blood Vessels) | YES | NO | Immunologic (Blood Disorders)             |
|-----|----|--------------------------------------|-----|----|---|
|     |    | Angina                               |     |    | Anemia                                    |
|     |    | Coronary disease                     |     |    | Hemophilia                                |
|     |    | Heart attack                         |     |    | HIV or AIDS                               |
|     |    | Heart failure                        | YES | NO | <b>Musculoskeletal (Muscles-Bones)</b>    |
|     |    | Hypertension/High blood pressure     |     |    | Fibromyalgia                              |
|     |    | Hypotension/Low blood pressure       |     |    | Osteoporosis                              |
|     |    | Irregular heartbeat                  |     |    | Rheumatoid Arthritis                      |
| YES | NO | Central Nervous (Brain-Spinal Cord)  | YES | NO | Psychological/Psychiatric (Emotional)     |
|     |    | Alzheimer's Disease                  |     |    | Anxiety Attacks                           |
|     |    | Aneurism                             |     |    | Bi-Polar Disorder                         |
|     |    | Bell's palsy                         |     |    | Depression-Chronic                        |
|     |    | Cerebral Palsy                       |     |    | Psychiatric illness (Schizophrenia, etc.) |
|     |    | Epilepsy, seizures or convulsions    | YES | NO | <b>Respiratory (Lungs-Throat-Nose)</b>    |
|     |    | Migraine headaches                   |     |    | Asthma                                    |
|     |    | Multiple Sclerosis                   |     |    | Emphysema                                 |
|     |    | Parkinson's Disease                  |     |    | Chronic bronchitis                        |
|     |    | Stroke or CVA                        |     |    | COPD                                      |
| YES | NO | Gastrointestinal (Stomach-Colon)     |     |    | Pulmonary or Cystic fibrosis              |
|     |    | Diabetes                             | YES | NO | <b>Major Medical Disorders</b>            |
|     |    | Gastric Ulcer                        |     |    | Cancer Where?                             |
|     |    | GERD/Reflux/chronic heartburn        |     |    | Organ Failure What?                       |
|     |    | Hypoglycemia/low blood sugar         | YES | NO | <b>Others Not Listed Above</b>            |
|     |    | Irritable bowel syndrome             |     |    |   |
| YES | NO | Others Not Listed Above              |     |    |   |
|     |    |                                      |     |    |   |

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

I have reviewed the preceding History and Physical information on the above named patient on the date of this patient's initial consultation. My physical examination and recommendations will follow.

\_\_\_\_\_  
Gautam Samadder, M.D.

\_\_\_\_\_  
Rajib Saha, D.O., M.S.

\_\_\_\_\_  
Maninder Kalra, M.D.

\_\_\_\_\_  
Julia Kopcak, PA-C