Gwinnett
PULMONARY & SLEEP

Board Certified

Pulmonary Medicine
Critical Care
Sleep Medicine

Lawrence Kaplan, M.D.
Michael Sineway, M.D.
Paul Weinberg, M.D.
William McGann, M.D.
Rajesh Jasani, M.D.
Prasad Garimella, M.D.
Sarah Hayat, M.D.

Vosudesh Pai, M.D.
Susmita Rajanala, M.D.
Waqar Siddiqui, M.D.
Lynn Stewart, NP-C
Opal Blake, NP-C
Antonette Sanderson, NP-C

P: 770-995-0630
F: 770-995-1555

FULL NAME: **DOB:**

ADDRESS_____

(City) (State) (Zip)

HOME PHONE_____WORK PHONE_____

SS#_____CELL PHONE _____

E-MAIL ADDRESS _____ Who referred you to our office?_____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU (in case of emergency):_____

ADDRESS_____

(City) (State) (Zip)

PHONE_____ RELATIONSHIP TO PATIENT_____

Person Responsible For This Account

(if different from above)

NAME_____ DATE OF BIRTH_____

(First) (Middle) (Last)

ADDRESS_____

(City) (State) (Zip)

HOME PHONE_____WORK PHONE_____

SS#_____ RELATIONSHIP TO THE PATIENT_____

EMPLOYER_____ EMPLOYER PHONE_____

EMPLOYER ADDRESS_____

(City) (State) (Zip)

PLEASE FILL IN INSURANCE INFORMATION FOR PRIMARY INSURANCE COMPANY

PRIMARY INSURANCE COMPANY NAME	NAME OF INSURED	RELATIONSHIP TO PATIENT

PLEASE FILL IN INSURANCE INFORMATION FOR SECONDARY INSURANCE COMPANY

SECONDARY INSURANCE COMPANY NAME	NAME OF INSURED	RELATIONSHIP TO PATIENT

SHOULD THIS BE FILED UNDER WORKER'S COMPENSATION? _____

IF YES, PLEASE LIST THE DATE OF THE ACCIDENT _____

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FULL NAME: **DOB:**

Mail Order Pharmacy Name: _____

Local Pharmacy Name:_____

City Where Pharmacy Is Located: _____ Pharmacy #_____

Medication Allergies

Please list all medications that you are allergic to and the reaction you had when taking the medication.

Medication Allergies	Reaction
1._____	1. _____
2._____	2. _____
3._____	3. _____
4._____	4._____

Are you allergic to Albuterol and/or Xopenex nebulizer solution? Yes No

Have you had a flu shot?	_____	If so, when?	_____
Have you had a pneumonia shot?	_____	If so, when?	_____

Family Medical History

Has anyone in your **family** ever been diagnosed with any of the following health conditions?
Please indicate which family member was affected in the space provided.
Family Members Included: Mother, Father, Brother, Sister, Son, Daughter, Aunt, Uncle, and Grandparent

Health Condition	Family Member(s)
1. COPD	1.
2. Emphysema	2.
3. Asthma	3.
4. Pulmonary Fibrosis	4.
5. Pulmonary Hypertension	5.
6. Blood Clots	6.
7. Bleeding Disorders	7.
8. Sleep Apnea	8.
9. Narcolepsy	9.
10. Restless Leg Syndrome	10.
11. Alpha-1 Antitrypsin Deficiency	11.
12. Cancer (please indicate what type of cancer)	12.
13. Heart Attack	13.
14. Congestive Heart Failure	14.
15. Coronary Artery Disease	15.
16. High Cholesterol	16.
17. Stroke	17.
18. High Blood Pressure	18.
19. Diabetes	19.
20. Thyroid Problems	20.
21. Other	21.

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FULL NAME: **DOB:**

Past Medical History

What health condition(s) have **YOU** been diagnosed with?
Please indicate with a check mark beside the condition.

_____1. COPD
_____2. Emphysema
_____3. Asthma
_____4. Pulmonary Fibrosis
_____5. Pulmonary Hypertension
_____6. Blood Clots (when/where) _____
_____
_____7. Bleeding Disorders
_____8. Sleep Apnea
_____9. Narcolepsy
_____10. Restless Leg Syndrome
_____11. Alpha-1 Antitrypsin Deficiency
_____12. Other _____

_____13. Cancer (cancer type/when)
_____
_____
_____
_____14. Heart Attack (when) _____
_____15. Congestive Heart Failure
_____16. Coronary Artery Disease
_____17. High Cholesterol
_____18. Stroke (when) _____
_____19. High Blood Pressure
_____20. Diabetes
_____21. Thyroid Problems
_____22. Other _____

Please list all surgeries that you have had in the past.

Date	Procedure
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____
6._____	6._____

Do you currently have an Advanced Directive? _____ Yes _____No

Social History

1. Do you drink alcohol?

_____ no I do not drink alcohol

_____ no I do not drink alcohol now, but I did in the past

_____ yes I drink alcohol (circle one) occasionally, once weekly, once monthly, daily, other

Circle One: Beer Wine Hard Liquor Mixed Drinks

2. What is your living situation, or who do you live with?

_____ I live alone

_____ I live with: (circle one) spouse – parent(s) - son - daughter - domestic partner – roommate

Other _____

Name and daytime phone for this person: _____

Do you have any pets: _____

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FULL NAME: **DOB:**

Social History

3. Do you use tobacco/nicotine products?

_____yes, I smoke cigarettes. I started smoking at age _____. At most I smoke _____ packs per day and on average I smoke _____ packs per day.

_____yes, I use smokeless tobacco now and have for _____ years

_____Yes, I use a vape

_____No, I have never used tobacco products

_____No, I do not smoke cigarettes now. I started smoking at age _____. I quit smoking at age _____. In the past I smoked **at most** _____packs per day and **on average** _____ packs per day.

_____No, I have never used tobacco products, but I have lived with someone who smoked indoors (circle one) now / in the past

4. What is your occupation?

_____ I am currently retired. Prior to this, I worked as a _____
_____ I am currently working (circle one) full-time/part-time as a_____
_____ I am currently unemployed. Prior to this, I worked as a _____
_____ I am currently on disability. Prior to this, I worked as a _____

5. Please indicate if you have ever been exposed to smoke, fumes, dust, asbestos, etc in previous occupations:

_____

_____

Medications

Please list all medications including strength and how many times you take the medication daily (use back if needed)

1._____ 11._____

2._____ 12._____

3._____ 13._____

4._____ 14._____

5._____ 15._____

6._____ 16._____

7._____ 17._____

8._____ 18._____

9._____ 19._____

10._____ 20._____

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FULL NAME: **DOB:**

Please answer questions 1 - 8 using the scale below.
Please circle the number that applies for you in each situation.

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

Situation	Chance Of Dozing			
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place (meeting, movies, church)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down in the afternoon when circumstances permit	0	1	2	3
6. Sitting and talking with someone	0	1	2	3
7. Sitting quietly after lunch without alcohol	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

Total: _____

Please answer the following questions by circling yes or no.

1. Do you snore?	YES	NO
2. Do you feel sleepy during the daytime?	YES	NO
3. Do you **NOT** feel refreshed when you wake up in the morning?	YES	NO
4. Have you been in a car accident / or a near miss situation due to you falling asleep at the wheel?	YES	NO

If you answered yes to any question above, please explain:

I,_____ have answered all questions in this medical questionnaire to the best of my knowledge and agree for Gwinnett Pulmonary Group to use the information provided to aide in making informed medical treatment decisions.

Signature:_____ Date:_____

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FULL NAME: _____ **DOB:** _____

PAIN, NARCOTIC and SLEEP MEDICATION POLICY (Revised 7/2/2018)

Please read carefully and sign. A copy will be provided to you upon your request.

Gwinnett Pulmonary Group must comply with state laws and regulations and is registered with the Prescription Drug Monitoring Program (PDMP). We are required to review the PDMP prior to prescribing any controlled substance to ensure medication limits have not been exceeded.

Prescriptions for controlled substances will be limited to a 7-day prescription. If more than 7-day course is required, a prior authorization will most likely need to be done. GPG will NOT be doing these prior authorizations, however, you have the option to pay out of pocket for the medication.

1. I agree to take narcotic / controlled medication exactly as instructed. I am NOT allowed to change dosage amounts or alter the time schedule of taking the medication without first talking to my prescribing physician at a face to face visit.
2. Narcotics / controlled medication will NOT be phoned in after business hours or on the weekends. Please allow one week for a prescription to be authorized.
3. Only ONE pharmacy will be used for filling narcotics /controlled prescriptions.
4. Lost, misplaced, or stolen prescriptions will NOT be replaced.
5. I will be charged a $10.00 processing fee when I pick up a prescription for narcotic medications.
6. I am aware that the manufacturers of drugs used to treat chronic pain and sleep disorders recommend AGAINST the operation of equipment, which includes driving a motor vehicle. I am aware that if I choose to drive I could be charged with DUI.
7. I have been informed that the use of narcotics, tranquilizers or controlled medication may result in the development of tolerance, dependence, addiction, withdrawal, constipation, nausea, itching, harmful effects to an unborn child, urinary retention, impairment of reasoning and judgement, and depression of breathing.
8. I am aware that the use of narcotics and tranquilizers at the same time may worsen the side effects.
9. I will not combine any narcotic or controlled medications with the consumption of alcohol.
10. I will not give, trade or sell pain or controlled medications.
11. The following are conditions for immediate termination from the practice.
    A. Obtaining narcotics from any other physician while under our care without our knowledge.
    B. Altering or forging of a prescription is a felony and will be reported.
12. I will treat the office staff with respect. I understand that if I am disrespectful to staff or disrupt the care of other patients, I may be terminated from the GPG practice.
13. If you are currently receiving medication for chronic pain, you will be referred to a pain management clinic.
14. Medications referenced include, but are not limited to, Benzodiazepines, Cough syrup with codeine, Codeine, Hydrocodone, Oxycodone, Fentanyl, Methadone, Lunesta, Restoril, Zolpidem, Nuvigil or other amphetamine salts used to treat narcolepsy.

I have read and understand the above policy and agree to abide by its terms.

Patient Signature: _____ **Date:** _____

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FULL NAME: **DOB:**

Medical Records Request

I hereby grant permission to the following health care professional or facility to release my medical records

_____

_____

_____

_____

to Gwinnett Pulmonary Group and:

Lawrence Kaplan, M.D.
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Antonnette Sanderson, NP-C

Please mail or fax the following records:

Complete Record_____

X-Ray Report Only_____

Lab Report Only_____

X-Ray Films Only_____

Other_____

Thank you for your cooperation in this matter.

Patient / Guardian Signature _____ Date _____

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For **correspondence** of your medical information Gwinnett Pulmonary Group may **contact** you via: (please check all that apply)

Home Telephone #_____
_____OK to leave message with detailed information
_____Leave message with call back number only

Work Telephone #_____
_____OK to leave message with detailed information
_____Leave message with call-back number only

Written Communication
_____OK to mail to my home address
_____OK to mail to my work/office address
_____OK to fax to this number _____

Please list **relatives / friends** that you give Gwinnett Pulmonary Group permission to discuss your medical condition with. This includes but not limited to test or blood work results, physician's recommendations, etc.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

In case of emergency Gwinnett Pulmonary Group should contact:

Name: _____ Phone: _____

I, _____ give Gwinnett Pulmonary Group permission to discuss my medical condition with any person listed above.

Patient Signature: _____ Date: _____