Accredited by AASM

American Academy of Sleep Medicine

ARIZONA PREMIER PULMONARY & SLEEP SPECIALISTS

www.azpremierpass.com

Phone: (602) 978-6100 **Fax :(602)978-6555**

Asthma Clinic	Pulmonary Function Test
Shortness of breath	Cardiopulmonary Exercise Test
Chronic Cough	Arterial Blood Gas
Lung Nodule Clinic	Bronchoscopy
Valley Fever Clinic	Sleep Study
Pneumonia	COPD

MANJIT S. BHAMRAH, M.D., F.C.C.P.

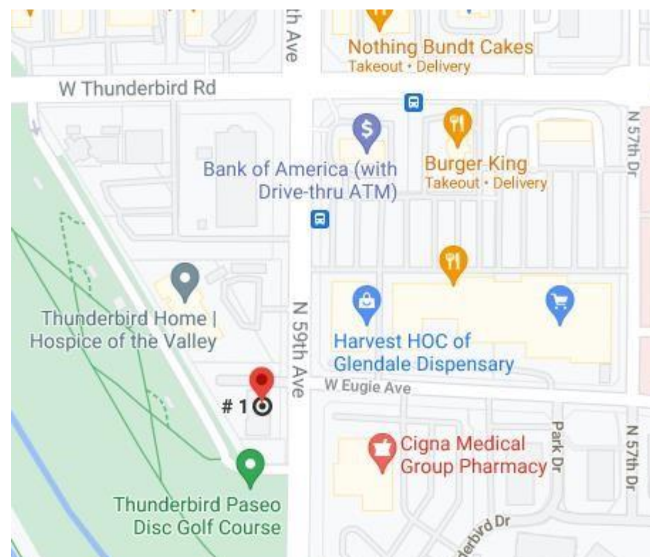
Diplomate of American Board of Pulmonary & Sleep Medicine
Clinical Assistant Professor, Division of Clinical Education, Midwestern University, Glendale, AZ
Teaching Attending Abrazo Health Network Internal Medicine Residency Program Director
Sleep Lab Arizona Premier Pulmonary and Sleep Specialists

RACHEL JACOB, FNP-C

RONALYN BARICEVIC, FNP-C

OUR LOCATION:

13606 N. 59TH AVENUE, Suite #1, GLENDALE, AZ 85304



LOCATED 1 BLOCK SOUTH OF THUNDERBIRD RD ON THE SOUTHWEST CORNER OF 59th AVENUE & EUGIE

ARIZONA PREMIER PULMONARY & SLEEP SPECIALISTS PATIENT REGISTRATION

Responsible Person's Information:

Last Name: First Name: Middle Initial: Name you prefer to be called:
Mailing Address: City: State: Zip Code:
Street Address: City: State: Zip Code:
Home Phone#: Cell Phone#: Work Phone#:
Birth Date: Social Security#: Sex: ☐M ☐F
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Disabled ☐ Student
Race: ☐ White ☐ Hispanic Black ☐ Native American ☐ Asian ☐ Other:
Primary Language Spoken:
Primary Care Physician: Referred by: E-Mail Address:
PRIMARY CONTACT ☐PATIENT ☐OTHER Name of contact:
First Name: MI: Last Name: Sex: ☐ M ☐ F
Birth Date: Social Security#: Relation to Patient:

Insurance Information: *PLEASE DO NOT LEAVE BLANK*

Primary Insurance: ID#: Group#:
Policyholders Name: Sex: ☐M ☐F DOB: Relation to Patient:
Secondary Insurance: ID#: Group#:
Policyholders Name: Sex: ☐M ☐F DOB: Relation to Patient:
Emergency Contact: Name Phone #

Advanced Directive:

Do you have a living will? ☐ YES ☐ NO
If not, would you like information about a living will? ☐YES ☐NO
If you have a living will, may we have a copy for your chart? ☐YES ☐ NO (Staff Initials________)
PRIMARY CONTACT: ☐HOME PHONE ☐WORK PHONE ☐MOBILE ☐OTHER
DO YOU GIVE US PERMISSION TO LEAVE MESSAGES AND SEND TEXTS REMINDERS? ☐ YES ☐NO

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NAME:(First, Last) ____ **DOB**: _____________ **Age:**_______ **Sex**:_____

MAIN HEALTH REASON (s) for **TODAY'S VISIT**: _________________________________ Date: ______________

Referring Provider: ____________________________________ **MD/DO/NP/PA Phone Number**: ______________

Names of Specialists that you see: 1. _____________________________ 2. _________________________

PHARMACY Name: _________________________________ **CROSS STREETS:** _____________________

CURRENT ACTIVE MEDICATIONS: (PLEASE LIST EACH) ▢ SEE SEPARATE LIST MADE

PULMONARY MEDICATIONS **(LIKE INHALERS-PUT ON TOP)**	**DOSE**	**HOW OFTEN PER DAY**	**REASON FOR TAKING**
OTHER MEDICATIONS (LIKE FOR DM, HTN, ARTHRITS)	**DOSE**	**HOW OFTEN PER DAY**	**REASON FOR TAKING**

DRUG ALLERGIES: (PLEASE LIST REACTION TYPE AND SEVERITY)

NAME OF DRUG	**REACTION TYPE** (RASH, HIVE, ITCHING, BREATHING DIFFCULTY, ANAPHYLAXIS	**SEVERITY: MILD/MODERATE/SEVER**

Are you allergic to any of the following? _______Contrast dye _______Iodine _______Shellfish

1. **COUGH:** ________Yes ______No
   - Duration? _____# Days _____#weeks _____#months _____#years
   - What time of the day: ______ Morning _______evening/night _____throughout the day
   - Severity: _____Mild ______Moderate ______severe to the point of passing out
   - Character: _____Dry _____Productive ________color of expectoration
   - Treatment received: ______None ______antibiotics _____steroids _____inhalers
   - Impact of tx: ______getting better ______getting worse _______No change
   - Prior diagnosis given: ____
   - Any recent travels: ______No ______Yes, Any Sick contact: ______No _______Yes
2. **SHORTNESS OF BREATH**: ______Yes ______No
   - Duration? _____#Days _____#Weeks ______#Months _____#Years
   - Severity? _____Mild ______Moderate _____Severe
   - Does anything help? _____Rest ______Inhalers ____Medication (sub-lingual)
   - Course: ______Getting better _____Getting worse _____Unchanged
   - Worsens during sleep ____Yes ____No
   - Head pillows used during sleep? _____One _____Two _____ Use recliner

Describe your shortness of Breath: ***Mark One Box Only***

☐ Grade 0: I only get breathless with **strenuous exercise**.

☐ Grade 1: I get short of breath **when hurrying** on a level or **walking up a slight hill**.

☐ Grade 2: I walk **slower than people of the same age** on a level because of breathlessness/I have to **stop for breath when walking at my own pace** on a level

☐ Grade 3. I stop for breath **after walking about 100 meters (**one block) on or after a **few minutes on** a level

☐ Grade 4. I am too **breathless to leave the house** or I am breathless when dressing or undressing

3. **HEMOPTYSIS: Are you COUGHING UP BLOOD?** _____No ____Yes
   - Amount: _______Streaky _____Teaspoon ______ Tablespoon
   - How long ago: _____First time ______ Last time

4. **Do You Wheeze?** _______No ________Yes

5. **CHEST PAIN:** ______No _____Yes
   - Location: ____Left ____Right ____Front ____Back ____Center of chest
   - Quality: _____Sharp ____Dull Worsens with breathing? _ ____No _____Yes
   - Duration: ____#Sec ____#Minutes ____#Hours Severity Scale (1 to 10) _____
   - What relieves it? __________ What worsens it? ___________
6. **ASTHMA:** ______No _______Yes
   - What age it started: ___________ what age it stopped: ___________
   - What are your main asthma symptoms: _______cough ______shortness in breath _____wheezing?
   - When was the last hospitalization: _____None _____yes, when? _______
   - Any history of intubation for asthma? ______None _______yes, when? ______
   - When was the last Urgent care visit for asthma? _____None ______Yes, When? _______
   - Did you receive allergy shot? ____never _____ yes, when _________
   - What are your triggers for asthma? _______________________
   - How many Puffs of rescue inhaler taken **during the day** in last **one week**? _____________
   - How many puffs of rescue inhaler taken **during the night** in **one month**? ______________

7. **COPD**: _________No _________Yes
   - When were you told to have COPD ______#years ago?
   - Hospitalized for COPD? _____No _____yes, when? _______
   - History of intubation due to COPD? _______None _______yes, when? ________
   - What brought your COPD? ________smoking ________family history ________air pollution
   - Did you receive Antibiotics and or Steroid taper in the past year; ______No ______yes, when______
   - Are you on Oxygen therapy: _______no _______yes, since when_________
   - Last CT chest done? ______None _______yes, when? __________

ROS: (Please circle ***POSITIVE SYMPTOMS BELOW***)

CONSTITUTIONAL: fever chills major weight changes
EYES: red eyes dry eyes
EARS: ear pain ear discharge
NOSE: nasal congestion runny nose nasal itching sneezing nasal polyp's postnasal drip
THROAT: Sore throat feeling of lump in throat hoarseness
CARDIOVASCULAR: Chest pain palpitations swelling of feet
RESPIRATORY: OTHER SYMPTOMS
GASTROINTESTINAL: Difficulty swallowing heartburn abdominal pain diarrhea
GENITO URINARY: Blood in urine kidney stone
MUSCULOSKELETAL: Pain/swelling in bone muscle pain joint pain
INTEGUMENTARY/SKIN: Skin rash skin lesion needing biopsy Urticaria
NEUROLOGICAL: Headache's numbness in fingers or feet seizure stroke
HEMATOLOGIC/LYMPHATIC: Anemia easy bruising lumps in necks axilla groin
ENDOCRINE: Excessive thirst heat/cold intolerance
ALLERGIC/IMMUNOLOGIC: Allergies to pollens trees grasses animal dander
PSYCHIATRIC: Anxiety depression panic attacks
TRAUMA: Traumatic brain injury chest trauma
SLEEP HISTORY: Snoring gasping choking daytime sleepiness chronic fatigue insomnia restless legs

PAST MEDICAL HISTORY (Please put check mark (√) all that apply ___________NONE

√	**MEDICAL CONDITION**	√	**MEDICAL CONDITION**
	ANXIETY		LUPUS
	ATRIAL FIBRILATION		RHEUMATOID ARTHRITID
	CANCER, WHICH ORGAN------------------		SJOGREN SYNDROME
	CHRONIC KIDNEY DISEASE		THYROID DISORDER
	CHRONIC PAIN AT-------------------------		MULTIPLE SCLEROSIS
	CORONARY ARTERY DISEASE/CHF		NEUROMUSCULAR DISEASE/MYOPATHY
	DEPRESSION		PARKINSON'S DISEASE
	DEMENTIA/ COGNITIVE DYSFUNCTION		SEIZURE DIORDER
	DIABETES MELLITUS		STROKE
	GERD		TRAUMATIC BRAIN INJURY
	HYPERTENSION		**OTHER:**

PAST PULMONARY HISTORY (Please put check mark (√) all that apply __________NONE

√	**PULMONARY CONDITIONS**	√	**PULMONARY CONDITIONS**	√	**PULMONARY CONDITIONS**
	Asthma		Blood clot-DVT/PE		QuantiFERON assay positive
	Bronchitis, chronic, 3mo/yr x 2 yr		Coccidiomycosis/Valley fever		Pleural effusion
	Bronchiectasis		COPD		Pleurisy
	Chest procedure-bronchoscopy		Diaphragmatic disorder		Pneumonia
	Chest procedure-lung biopsy		Emphysema		Pneumothorax
	Chest procedure for lung cancer		Nasal polyp		Pulmonary hypertension
	Sarcoidosis		Sinusitis		Rib fracture
	Whooping cough		Tuberculosis exposure		Other
	Oxygen therapy-how long		+COVID 19		

PAST SURGICAL HISTORY (Please put check mark (√) all that applies): _____________NO SURGERY

SURGERY AND PROCEDURES	YEAR		YEAR
BRONCHOSCOPY		NASAL POLYP SURGERY	
CABG, CORONARY ARTERY BYPASGRAFT SURGERY		SINUS SURGERY	
LUNG RESECTION SURGERY		THYROID GLAND RESECTION SURGERY	
THORACOTOMY FOR EMPYEMA		UVULO PALATO PHAYNGOPLASTY/UPPP	
TRACHEOSTOMY		OTHER:	

PERSONAL AND SOCIAL HISTORY:

Place of birth: ________________________ how long living in Arizona? __________________

Marital status: _____Married _____Single _____Widowed _____Divorced ______Separated

Last menstrual period (IF APPLICABLE) __________

Do you currently use Tobacco: ____________Yes ___________No

Have you ever used Tobacco: ____________Yes ____________No

Age began: _______ Age Quit ______ Total years smoked _______ Average # Pack/day_________

What products tried to quit: _____Gum ______Patches ______Chantix

Do you Vape? _____Yes _____No **Do you smoke Hookah**? _____Yes ____No

Have you used street drugs: _______Yes ______No

________Marijuana ________Cocaine ________Heroin ______Methamphetamine ______ others

Current Occupation: ________________________________ **Past Occupation**: ________________

Any history of Exposure to: ________Yes ________ No

Asbestos: ______No ______Yes, which years____________________________

Beryllium: ______No ______Yes, which years____________________________

Coal work: _______No ______Yes, which years____________________________

Silica dust: _______No _______Yes, which years____________________________

Radon/Uranium: _______No ______Yes, which years__________________________

Fumes/Dust/ Chemicals: _____No _____ Yes, which years __________

Other: ____________________

ENVIRONMENTAL EXPOSURE HISTORY:

Pets at home: **Dogs** _______ No _______ Yes **Cats** _______No _______Yes other, explain __________

Birds Exposure: _________ No ______ Yes, which year's __________________

Black Mold exposure: _________ No ______ Yes, which year's __________________

Hot Tub Exposure: _________ No ______ Yes, which year's ________________ ___ Other: ___________

FAMILY HISTORY:	MOTHER	FATHER	BROTHER	SISTER
ASTHMA				
COPD				
EMPHYSEMA				
BLOOD CLOTS DVT/PE				
LUNG CANCER				
TUBERCULOSIS				
PULMONARY FIBROSIS				
AUTOIMMUNE DISEASE				
OTHER				

Sleep Questionnaire

SLEEP COMPLAINT(S)

❑ Trouble falling asleep ❑ Trouble remaining asleep ❑ **Excessive Daytime Sleepiness** ❑ Snoring ❑ insufficient quantity of sleep ❑ Unwanted behaviors during sleep ❑ Other, Explain___________________ ❑ **how long**? ___________

PRIOR SLEEP DISORDER DIAGNOSIS OR STUDIES: ❑ NONE

❑ I have a **prior sleep diagnosis** of ________________________ Prior sleep studies (where, when) __________________

I am currently prescribed ❑ **CPAP** or ❑ **Bi-level** pressure. Settings ______________________

❑ Yes ❑ No------- I have **had surgery** for a sleep disorder ❑ UPPP ❑ Tonsillectomy.

❑ Yes ❑ No------ I use a **dental device** for sleep disordered breathing.

ANY WEIGHT CHANGE IN THE PAST YEAR ❑ **gained** _________ **#**pounds ❑ **lost** ______**#** pounds ❑ **No change**

BREATHING DURING SLEEP:

❑ Yes ❑ No -----I have been told that I **snore** ❑ loudly.

❑ Yes ❑ No -----I have been told that I **stop breathing** while asleep.

❑ Yes ❑ No------ I have **awakened by** my own **snoring**.

❑ Yes ❑ No------ I awaken at night **choking or gasping** for air.

❑ Yes ❑ No------ I have **morning headaches.**

❑ Yes ❑ No------ I **sweat** a great deal **at night**.

DAYTIME IMPAIRMENT(S):

❑ Yes ❑ No---------I often **feel drowsy** during the day, more than I expect is normal.

❑ Yes ❑ No-------- I feel **un-refreshed or tired in the morning** despite sleeping at night.

❑ Yes ❑ No-------- I take **daytime naps**. How many? ________

❑ Yes ❑ No-------- I have **uncontrollable urges to fall asleep** during the day.

❑ Yes ❑ No-------- I have **fallen asleep while driving**.

❑ Yes ❑ No-------- I **performed poorly in school or work** because of sleepiness

❑ Yes ❑ No---------I have an impairment **in Attention**, concentration, memory

❑ Yes ❑ No--------I have **Mood disturbances** or irritability

❑ Yes ❑ No--------I have **reduction in Motivation, or energy**

❑ Yes ❑ No ------- I have constant **Concerns or worries** about sleep

❑ Yes ❑ No ------- I have **Tension headaches** in response to sleep loss

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the **following situations** in contrast to feeling just tired?
(0 = would never doze, **1 = slight chance of dozing**, **2 = moderate chance**, **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 (ex: movie theatre or 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, if circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE: _______ /24

RLS/PLMD:

❑ Yes ❑ No---------I **kick or jerk my legs** excessively during sleep. ❑ **bothers my bed partner**.

❑ Yes ❑ No-------- I experience a **creeping-crawling or tingling sensation in my legs in evening** when I **try to fall asleep** that can be **relieved by** walking or movement.

❑ Yes ❑ No------ I have ***restless leg syndrome that have not responded to treatment.***

OREXIN RELATED:

❑ Yes ❑ No----- I experience **sudden muscle weakness** in response to emotions such as laughter, anger or surprise.

❑ Yes ❑ No------I experience an **inability to move** while falling asleep or when waking up.

❑ Yes ❑ No------ I have experienced **hallucinations or dreamlike images** when falling asleep or waking up.

❑ Yes ❑ No------I have frequent **uncontrollable bouts of sleep** during the day.

PARASOMNIAS:

❑ Yes ❑ No----- I **act on my dreams** while asleep ***with injury to self or others***. (Hitting, kicking, fallen out of bed, without memory or recall).

❑ Yes ❑ No----- I have frequent **nightmares**.

❑ Yes ❑ No----- I **talk** in my sleep.

❑ Yes ❑ No----- I have **sleepwalked** as an adult

(**If yes,** when was **first** Episode, _______when was the **last** episode **_______**, **how often** in one month_______
When does it occur in sleep: _______beginning ______first half of night **______**_second half of night _____end of sleep)

MISCELLANEOUS (CIRCADIAN, GERD, DEPRESSION, BRUXISM, PAIN)

❑ Yes ❑ No----- I frequently **travel across two or mor**e time zones.

❑ Yes ❑ No------- I awaken alert in the morning earlier than it is time to get up.

❑ Yes ❑ No------- I regularly **work night shifts.**

❑ Yes ❑ No------- I work **rotating shifts**, including night shift work.

❑ Yes ❑ No------- I frequently have **heartburn or acid reflux at** night.

❑ Yes ❑ No------- I feel **depressed**.

❑ Yes ❑ No ------- **Chronic pain** interferes with my sleep.

❑ Yes ❑ No--------- The need to **urinate frequently** interrupts my sleep.

❑ Yes ❑ No-------- I **grind my teeth** in my sleep.

SLEEP WAKE PATTERN

Typical bedtime: __________ weekday __________ on weekend

Typical awakening time: __________ weekday __________ on weekend
Typica**l TOTAL hours** in **bed**: __________ hours. Typical **TOTAL hours** of **sleep**: __________ hours
Typical amount of **time it takes to fall** asleep __________
Typical **number of awakenings** per night_____ **Time it takes to fall back** asleep after awakening
____ ❑ Yes ❑ No------ My sleep **pattern is irregular**.

What best describes sleep difficulty?

❑Inability to fall sleep

❑Difficulty in maintaining sleep due to frequent awakenings and inability to fall sleep

❑Early awakening or

❑Insufficient quantity of sleep

SLEEP ENVIRONMENT HABITS, SLEEP MEDICATIONS, SLEEP FAMILY HISTORY

Typical **sleep position**(s) ❑ back ❑ side ❑ stomach ❑ head elevated ❑ in a chair
❑ I sleep alone ❑ I share a bed with someone.
My **bedroom** is ❑ comfortable ❑ noisy ❑ too warm ❑ too cold
❑ Yes ❑No-------- I have **pets in the bedroom.**
❑Yes ❑No--------- I **watch TV** in bed prior to sleep
❑Yes ❑ No -------- I **read in bed** prior to sleep.
❑ Yes ❑ No ------- I **work or study** in bed
❑Yes ❑No --------- I **drink alcohol prior to bedtime**
❑ Yes ❑ No -------- I **smoke prior to bedtime** or **when awaken** during the night
❑ Yes ❑ No ------- --I eat a **snack at bedtime**
❑ Yes ❑ No --------- I **eat if I awaken** during the night
❑ Yes ❑No --------- I **drink caffeinated beverages** _____ cups/bottles/cans ❑Tea ❑ Coffee ❑ soda per day
❑ Yes ❑ No --------- I have interruption in sleep from **unusual sounds** in the home or outside
❑ Yes ❑ No --------- I get **racing thoughts** prior to sleep
❑ Yes ❑ No -------- I sleep better when on vacation
❑ Yes ❑ No---------- **I take prescribed medications** for sleep. Name: ___________________________
❑Yes ❑No --------- I take **herbal or over the counter medications** for sleep. Name: _________________________
❑Yes ❑No---------- I have history **of brain injury or concussion, meningitis, nocturnal seizures**
❑Yes ❑ No--------- I have **family history of ___________ sleep apnea ____________Insomnia ____________ Narcolepsy**

Paseo Medical Specialists

Consent for Treatment, Financial Policies, and HIPAA Notice

Consent for Treatment

I consent to the use or disclosure of my protected health information by Paseo Medical Specialists, dba Arizona Premier Pulmonary & Sleep Specialists, for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills, or to conduct healthcare operations. I understand that the diagnosis or treatment of me by and provider of Arizona Premier Pulmonary & Sleep Specialists, may be conditioned upon my consent as evidenced by my signature on this document.

I understand that it is my responsibility to follow the medical advice of my provider, including taking medications as prescribed and making and keeping appointments with my provider.

Use and Disclosure of Protected Health Information

By signing this form, I give Paseo Medical Specialists, dba Arizona Premier Pulmonary & Sleep Specialists permission to use and disclose protected health information (PHI) of individually identifiable health information (IHI) to carry out treatment, payment, and healthcare operations. I have read or have been provided the opportunity to read the privacy practices prior to signing this release.

I also understand that my protected health information (PHI) will not be released in any form without my written consent, as described in this office's privacy and confidentiality policy. I understand that I have a right to a copy of this policy at any time, and that any requests for access to or copies of my PHI must be made in writing. I also understand that it is the policy of this office to give at least 72 hours' notice prior to receiving requested PHI information, and that I may be charged a nominal copying fee for any records requested for my personal use. Please refer to the Notice of Privacy Practices provided by the practice for more complete information.

I authorize information about my medical care to be disclosed to the following individual(s):

Name: _______________________________ Relationship to patient: _________________________

Name: _______________________________ Relationship to Patient: _________________________

Financial Policies

I hereby assign my insurance benefits to be paid directly to the physician for services rendered. I understand that I am financially responsible for any non-covered services, co-insurances, or deductibles, including any balance of my account until the insurance pays their portion. If my insurance pays me directly for services provided by the physician, I agree to forward such payments to Paseo Medical Specialists, dba Arizona Premier Pulmonary & Sleep Specialists. I understand that it is my responsibility to notify this office of any changes in my information including my insurance eligibility.

I understand that am responsible for obtaining any referral or authorization required by my insurance company and failure to do so may make me liable for costs associated with the denial of coverage for my received services.

I understand that all copays and associated coinsurance and deductibles are due at the time of service.

If any unpaid balance should be forwarded to a collection agency, I understand that I am responsible for all costs associated with the collection of my unpaid balance.

Cancellation Policy

I understand that if I fail to show for an appointment without 24 hours' notice that I may be charged a cancellation fee.

____ _________________

Signature Date

____

Printed Name

Rev. 2/2022