Thank you for choosing Birmingham Pulmonary Group for your healthcare needs. Please complete all of the forms and bring them with you when you come for your appointment.

Please arrive for your appointment 30 minutes before your appointment time. This allows for some necessary staff time to prepare your information and for the nurse to spend some time with you before you see the doctor.

Bring your insurance card, driver’s license and copayments for your visit. Payment is required at the time of visit.

There is a possibility that you will need to schedule a sleep study following your visit. Please check with your insurance company prior to your visit to see if your insurance covers sleep studies. The insurance company may ask what procedure you are having. The sleep study procedure code is 95810. If your insurance covers sleep studies, ask them the amount for which you are responsible. Also, ask the insurance company if a pre-authorization is required.

This appointment is to address any sleep disorders you may have. Any other healthcare needs should be addressed by your primary care doctor.

If you are unable to keep your appointment, please let us know 24 hours before your appointment time. There could be a charge for not cancelling.

We look forward to meeting you. Please call if you have any questions.
BIRMINGHAM PULMONARY GROUP, P.C.

Account# ____________________

BRUCE M. KEY, M.D.
JAMES H. STRICKLAND, JR., M.D.

WILLIAM C. HAYS, III, M.D.
PATRICIA E. PATTERSON, M.D.
NEAL D. DANIEL, M.D.

LARRY K. JACKSON, M.D.
JAY T. HEIDECKER, M.D.

DATE ____________________

Driver License # ____________________

DATE OF BIRTH ____________________

FULL NAME ____________________

SOCIAL SECURITY NUMBER ____________________

ADDRESS ____________________

CITY ____________________

STATE ____________________

ZIP CODE ____________________

HOME PHONE NUMBER ____________________

CELL OR PAGER NUMBER ____________________

WHERE EMPLOYED ____________________

WORK PHONE NUMBER (IF CALLS PERMITTED) ____________________

PRIMARY INSURANCE ____________________

POLICY OR I.D. NUMBER ____________________

GROUP# ____________________

POLICYHOLDER ____________________

SECONDARY INSURANCE ____________________

POLICY OR I.D. NUMBER ____________________

GROUP# ____________________

POLICYHOLDER ____________________

MARITAL STATUS ____________________

SPouse NAME ____________________

SPouse DATE OF BIRTH ____________________

SPouse EMPLOYER NAME AND TELEPHONE NUMBER ____________________

NAME AND TELEPHONE NUMBER OF PERSON TO NOTIFY IN CASE OF EMERGENCY (OTHER THAN SPOUSE) ____________________

REFERRED BY WHOM? ____________________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING ____________________

PLEASE LIST ANY KNOWN ALLERGIES ____________________

I hereby assign to and authorize payment of all benefits payable under the terms of my health insurance policy (policies) to Birmingham Pulmonary Group, P.C. I request payment of authorized Medicare benefits be made on my behalf to Dr. Key, Dr. Hays, Dr. Jackson, Dr. Strickland, Dr. Patterson, Dr. Heidecker or Dr. Daniel for any services furnished me by that physician. I authorize the release of any medical information needed to process claims. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits.

In carrying out my treatment, it might be necessary to FAX my records to the hospital or to another doctors group. By signing below I am authorizing the release of my records in this fashion.

It is the patient's responsibility to notify this office of any insurance changes.

I understand that I am responsible for any and all charges incurred by me and that I agree to pay any collection costs incurred including a reasonable attorneys fee.

SIGNATURE ____________________

DATE ____________________
Birmingham Pulmonary Group, P.C.

We use an automated phone system to call and remind patients of their appointments. It is very important that we have the best contact numbers on file for you. In the area below provide your phone numbers, listing first, the best number to reach you at all times. Then list any other numbers that might be helpful in reaching you. Please list any special instructions beside each number. (Example: Daytime numbers only, work nights, relative's number, etc.)

Name __________________________ DOB ____________

1. __________________________
   Home/Work/Cell (Best Number)

2. __________________________
   Home/Work/Cell

3. __________________________
   Home/Work/Cell

By signing this form, you are giving us permission to use an automated phone system to call you to remind you of your appointment.

__________________________
Signature

__________________________
Date

__________________________
Account #
SLEEP HISTORY / QUESTIONNAIRE

Birmingham Pulmonary Group, P.C.
2660 10th Ave. South - Suite 528
Birmingham, Alabama 35205
(205) 933-9258

Medical Staff:
Bruce M. Key, M.D.
William C. Hays, M.D.
Larry K. Jackson, M.D.
James H. Strickland, M.D.
Patricia E. Patterson, M.D.
Jay T. Heidecker, M.D.
Neal D. Daniel, M.D.

Date: ___________________ Name ___________________________ SS# ___________________________

Ht: __________ Wt: ______ Age: ______ Occupation: ____________________________

It is important for you to be as accurate as possible in answering the following questions.
The purpose of this questionnaire is to get a total picture of your background and the nature of your present
problem. Please complete these questions as thoroughly as you can.

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENTIALITY

1. Describe your main problem (s) in your own words, including when and how this began and what
treatment you have received for this in the past.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. How often does this problem occur?
   ( ) almost every night
   ( ) for periods of at least one week
   ( ) irregularly
   ( ) other ____________________________

3. How long has this problem bothered you?
   ( ) longer than 2 years
   ( ) 1 to 2 years
   ( ) several months
   ( ) within the last 3 months
   ( ) within the last month

4. How do you describe your sleep problem? Check all that apply to you.
   ( ) difficulty falling asleep
   ( ) wake up during the night
   ( ) wake up early in the morning
   ( ) Excessive daytime sleepiness
   ( ) difficulty awakening
5. Do any other members of your family have sleep problems? Please explain:

6. Have you had a weight change in the past 6 months?

7. How much have you gained or lost?

8. How many hours of sleep do you usually get per night?

9. What time do you usually go to bed on WEEKDAYS? WEEKENDS?

10. What time do you usually awaken in the morning on WEEKDAYS? WEEKENDS?

11. Are your sleep habits on weekends different from the rest of the week?
   ( ) No
   ( ) Yes- please describe

12. How long does it take for you to fall asleep?

13. How many times do you typically wake up at night?

14. If you wake up, on the average, how long do you stay awake?

15. If you do awaken during the night (after you fall asleep) which part(s) of your sleep period is it?

16. What do you usually do when you awaken during the night?

17. Is your sleep disturbed by:
   ( ) heat ( ) light ( ) need to eat
   ( ) cold ( ) bed partner
   ( ) noise ( ) not being in your usual bed
   ( ) bathroom ( ) need to smoke cigarettes
   ( ) other

18. Do you usually: (check all that apply to you)
   ( ) sleep with someone else in your bed
   ( ) sleep with someone else in your room
   ( ) provide assistance to someone during the night (child, invalid, bed partner, animal)

19. On the average, how long do you stay in bed after waking up in the morning?

20. Do you work split shifts or rotating (variable) shifts?

21. Do you:
    Feel afraid of going to sleep? Yes No
    Notice that parts of your body jerk or kick during the night? Yes No
    Experience crawling and aching feelings in your legs? Yes No
    Experience any type of leg pain during the night, including cramps? Yes No

Continued
Do you:

Usually drink coffee or tea within 2 hours before you go to bed?  Yes__No__
Do physical exercise before bedtime?  Yes__No__
Read before falling asleep?  Yes__No__
Watch TV in bed before falling asleep?  Yes__No__
Awaken from sleep short of breath?  Yes__No__
Awaken at night with heartburn, belching or coughing?  Yes__No__
Notice your heart pounding or beating irregularly during the night?  Yes__No__
Have morning jaw pain?  Yes__No__
Grind your teeth during sleep?  Yes__No__
Awaken with pain during the night?  Yes__No__
Snore loudly enough that others complain?  Yes__No__
Have periods where you stop breathing during sleep (observed by others)?  Yes__No__
Act out your dreams?  Yes__No__
Sleep walk?  Yes__No__
Sleep talk?  Yes__No__
Fall asleep during the day?  Yes__No__
Fall asleep involuntarily?  Yes__No__
Fall asleep while driving?  Yes__No__
Take naps during the afternoon or evening?  Yes__No__
Have trouble at school or work because of sleepiness?  Yes__No__
Fall asleep during physical effort, laughing or crying?  Yes__No__
Experience loss of muscle tone when extremely emotional?  Yes__No__
Feel unable to move (paralyzed) when waking or falling asleep?  Yes__No__
Have nightmares or experience vivid dreamlike scenes upon awakening or falling asleep?  Yes__No__
Feel sad, depressed, anxious or tense?  Yes__No__
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 estimate 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:**
- sitting and reading
- watching TV
- sitting, inactive in a public place (ex. theatre or meeting)
- as a passenger in a car for an hour without a break
- lying down to rest in the afternoon when circumstances permit
- sitting and talking with someone
- sitting quietly after lunch without alcohol
- in a car, while stopped for a few minutes in traffic

**Past Medical History**

Have you ever been diagnosed personally with any of the following illnesses or conditions?

<table>
<thead>
<tr>
<th>Illness</th>
<th>YES</th>
<th>NO</th>
<th>YEAR DIAGNOSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emphysema, COPD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Fibrosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phlebitis (clot in vein)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary Embolus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(clot traveled to lung)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Attack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
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<td></td>
<td></td>
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<tr>
<td>Stroke</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
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</tbody>
</table>

Specify type: _______________________

<table>
<thead>
<tr>
<th>Illness</th>
<th>YES</th>
<th>NO</th>
<th>YEAR DIAGNOSED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach ulcers / Heartburn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diverticulitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis / liver disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pancreatitis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gall bladder stones / infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney stones / infection</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gout</td>
<td></td>
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<tr>
<td>Arthritis</td>
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<td></td>
<td></td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td></td>
<td></td>
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</tbody>
</table>
Do you take any kind of medication?

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>How Often</th>
<th>Reason</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

Do you have any drug allergies? If so, what drugs?

Surgical History

Please list any operations and the years you had them:

<table>
<thead>
<tr>
<th>Operation</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Family Health History

<table>
<thead>
<tr>
<th>Age</th>
<th>Medical Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

Social History

Are you: Married_____ Single_____ Divorced_____ Widowed_____

List your consumption of the following per day:

<table>
<thead>
<tr>
<th>Consumption Type</th>
<th>Yes/No</th>
<th>Packs/Day</th>
<th>Never</th>
<th>Used to</th>
<th>Months/Years Ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cigarettes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
<td></td>
<td>Quantity (Beverages/Day)</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td>Quantity (Beverages/Day)</td>
<td></td>
</tr>
<tr>
<td>Recreational Drugs</td>
<td>Yes/No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Review of Systems

Mental Health:
(for example: depression, thoughts of suicide, alcoholism)

Nervous System:
(for example: strokes, seizures, diabetic nerve damage, history of concussion, loss of consciousness)

Ears, Eyes, Nose, Throat:
(for example: asthma allergies, polyps or tumors)

Breathing:
(for example: asthma, bronchitis, emphysema)

Stomach:
(for example: swallowing difficulties, heartburn, indigestion, hiatal hernia, ulcers)

Bowels:
(for example: diarrhea, constipation, cancer)

Urinary or Kidney:
(for example: infection with frequent nighttime urination or diuretics, stones, cancer)

Hormones:
(for example: high or low thyroid conditions, prescribed steroids such as prednisone or estrogen for menopause)

Blood:
(for example: "low blood" or anemia, thick blood, sickle cell disease, or HIV infection)

Chronic pain:
(for example: arthritis, broken hip, osteoporosis, fibromyalgia)