Angsten
Center for Pulmonary
& Sleep Disorders, P.A.

New Patient Registration

Full Name _____ Nick Name if Applicable _____

If TriCare, SS# of Card Holder is needed _____ Email: _____

Date of Birth_____ Male_____ Female_____

Preferred Phone Number ( ) _____ Alternate ( ) _____

Address _____ City _____ St _____ Zip_____

Out of State Address if Applicable _____

City _____ State _____ Zip _____ Phone ( ) _____

Marital Status: □ Single □ Married □ Unmarried □ Widowed □ Divorced

Spouse's Name _____ Spouse's Date of Birth _____

Emergency Contact Person _____ Phone # _____

Relationship to you: _____

*Are you Hispanic or Latino? □Yes □No
*Primary Language Spoken: □ English □ Spanish □Other _____
*Please select the category with which you most closely identify: □ White □Black/African American
□ Asian □ Native Hawaiian/Other Pacific Islander □ American Indian/Alaska Native □ Other Race

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Primary Care Physician: _____Phone #_____

Pharmacy: _____Phone # _____Location_____

I hereby authorize my insurance benefits to be paid directly to Angsten Center for Pulmonary& Sleep Disorders, P.A. (and Dr. Angsten and/or his associates). I realize that I will be financially responsible to pay for any services not covered by my insurance plan. I hereby authorize the release of my medical information (insomuch as it pertains to the specific condition addressed) to my insurance company and consulting physicians.

Signature _____ Date _____

*Privacy Act Statement: Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your treatment, but in the instance of missing information, your medical practice will attempt to identify your race and ethnicity by visual observation.

Medication List

Patient Name:_____ Date of Birth: _____

Name of Medication	Strength/Dosage	How Often Taken
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

THE EPWORTH SLEEPINESS SCALE

PLEASE FILL OUT EVEN IF YOU ARE HERE FOR UNRELATED ISSUES.

Name: _____

Today's date:_____ Your age (years): _____

Your sex (male = M; female = F):_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation:

0 = would *never* doze

1 = *slight* chance of dozing

2 = *moderate* chance of dozing

3 = *high* chance of dozing

Situation	**Chance of Dozing (circle one)**
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting, inactive in a public place (e.g., a theater or a meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in the traffic	0 1 2 3

Thank you for your cooperation

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REVIEW OF SYSTEMS QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Review of Symptoms: (Please check any **current** symptoms you have.)

General:

☐ Weight Loss

☐ Fevers

☐ Chills

☐ Night Sweats

☐ Fatigue

Eyes:

☐ Glaucoma

☐ Wear contacts/glasses

☐ Blurred Vision

☐ Double Vision

Ears, Nose, Throat:

☐ Hard of Hearing or Deaf

☐ Ringing in Ears

☐ Enlarged Lymph Nodes

☐ Chronic Sinus Problems

☐ Sore Throat

☐ Mouth Pain/Sores

Cardiovascular:

☐ Chest Pain / Angina Pectoris

☐ Palpitations / Heart Murmur

☐ Irregular Heart Beat / Pressure

☐ Swelling in Feet / Ankles

Respiratory:

☐ Chronic or Frequent Cough

☐ Coughing up Blood

☐ Shortness of Breath

☐ Wheezing

☐ Snoring

Allergies / Immunology:

☐ History of Allergies

Skin:

☐ Rashes or Itching

☐ Change in Skin Color or Moles

☐ Varicose Veins

☐ Skin Cancer

Gastrointestinal:

☐ Difficult or Painful Swallowing

☐ Abdominal Pain

☐ Nausea / Vomiting

☐ Heartburn

☐ Indigestion

☐ Lump or Sensation in Throat

☐ Food Sticking

☐ Bloating

☐ Belching

☐ Diarrhea

☐ Constipation

☐ Rectal Bleeding

☐ Black or Tarry Stools

☐ **P**oor Appetite

☐ Jaundice

Genitourinary:

☐ Kidney Stones

☐ Pelvic Pain

☐ Incontinence

☐ Burning or Pain on Urination

☐ Blood in Urine

☐ Difficult Urination

☐ Men: Prostate Problems

Females: Past or Present:

☐ Abnormal Mammogram

☐ Abnormal Pap Smear

Musculoskeletal:

☐ Joint Pain / Arthritis

☐ Muscle or Joint Weakness

☐ Back Pain

☐ Bone Pain

☐ Muscle Aches

Neurological:

☐ Numbness / Tingling

☐ Arm / Leg Weakness

☐ Light-headedness / / Fainting Spells

☐ Tremors / Headaches

Psychiatric:

☐ Anxiety / Agitation

☐ Depression

☐ Crying for No Reason

☐ Insomnia

☐ Alcoholism

☐ Drug Problem

Hematologic:

Dizzy

☐ Easy Bruising

☐ Gum or Nose Bleeding

☐ Blood Transfusions

Endocrine:

☐ Heat or Cold Intolerance

☐ Excessive Skin Dryness

☐ Excessive Thirst

☐ Excessive Urination

☐ Weight Problem

☐ Hot Flashes