

LONE STAR PULMONARY AND SLEEP SPECIALISTS

Faisal Saeed, MD (Pulmonologist) * Sidra Saeed, MD (Sleep Medicine Specialist) * Sonam Balani, FNP

Policies & Consents

Please read and review carefully, then sign and date

Thank you for selecting Lone Star Pulmonary and Sleep Specialists for your healthcare needs. We understand that you have a choice when it comes to healthcare providers, and we are glad you chose us. This office policy was developed to help us make your experience in our office as pleasant as possible.

OFFICE INFORMATION: Our office hours are Monday through Thursday, 9:00 am – 5:00 pm and Friday, 9:00 am – 3:00 pm. The office phone number is (940) 381-0971 and the fax is (940) 387-2563. We are currently doing in-person consultations, as well as telemedicine visits, as long as insurance will approve the telemedicine visit for payment. If you need an appointment, please contact the office to schedule.

FINANCIAL POLICY: As a courtesy to you, Lone Star Pulmonary and Sleep Specialists will file all insurance claims for you. **It is your responsibility to present us with your most current insurance card and information.** Failure to do so may cause you to be responsible for the entire bill, if your failure to inform us of these changes causes your insurance company to deny payment. If your insurance requires a referral, you must obtain one from your primary care provider (PCP) prior to your appointment. Referrals can be faxed to (940) 387-2563.

FORM FEE: There is a \$15.00 fee for processing forms which require more than a physician signature. Some forms may have a higher fee. This is billable directly to you (not your insurance company) and should be paid prior to the completion of the forms.

LABS: All tests and procedures are ordered for your benefit, and we are not liable for any costs your insurance may not cover. There will be no refunds after services are performed. If you have blood drawn or any other type of tests done in our office that needs to be sent to a lab for processing, please allow at least 48-hours before contacting our office for results. If we receive any **abnormal** results, the nurse will contact you after they have been reviewed by the physician. Copies of labs will be released by request only.

APPOINTMENTS: Please arrive on time. If for some reason you are going to be more than 15 minutes late, please call ahead to see if we can still accommodate you. There will be a **\$25.00 charge** to existing patients for same day cancellations and a **\$50.00 fee** for all new patients who fail to attend their scheduled appointment.

INSURANCE AND PERSONAL INFORMATION CHANGES: It is your responsibility to notify our office immediately if your insurance or personal information has changed. You will be held financially liable for charges incurred while you are not covered.

NEW PATIENTS: We request that you provide us with your completed new patient paperwork before your scheduled appointment. This will give us enough time to enter your information into the computer system to create your chart. If you are unable to provide your paperwork prior to your appointment, we will have to reschedule you.

PRESCRIPTION REFILLS: Please call your pharmacy and ask them to fax us a refill request. If you contact the office for a prescription refill, we will advise you to contact the pharmacy. Our fax number is (940) 387-2563.

PRIVACY POLICY: You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review our Notice of Privacy Practices carefully. It provides more details on how Lone Star Pulmonary and Sleep Specialists may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested from our office.

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Printed patient name

Patient signature/responsible party

Date

Confidential Communication Compliance

In effort to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including Protected Health Information (PHI), Lone Star Pulmonary and Sleep Specialists would like to ensure the privacy of your medical information when using alternative types of communication.

These types of communications may include the following:

- Voice: messages left with spouse/significant other, family members, friends, and/or coworkers
- Voicemails: recorded messages left on home, work, or cell phones
- Electronic communication: email or online patient portal

Please answer the following questions:

May we leave a message on a home, cell, or work voicemail or send you an email regarding an appointment, referral, or test results? Yes No N/A

May we discuss your appointments and/or treatment with your spouse or with the person who may answer your phone? Yes No N/A

May we leave messages concerning your appointments with a coworker, receptionist, or secretary, who regularly answers your calls? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your appointments and/or treatment with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may be discuss your appointment and/or treatment with your children? Yes No N/A

If we may discuss your care with someone other than yourself, please indicate below:

_____ I do not wish for my medical care to be discussed with anyone other than myself

_____ You have my permission to discuss my medical care with the following individual(s):

Name: _____

Relation: _____

Name: _____

Relation: _____

Name: _____

Relation: _____

You must inform us, in writing, of any changes to your directives. This will be kept in your file, along with your acknowledgement of receipt of your Notice of Privacy Practices.

Printed patient name

Patient signature/responsible party

Date

Staff printed name

Staff signature

Date

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Consent for AI-Assisted Documentation

Purpose of Use:

To ensure the most accurate and thorough medical record possible, our practice uses Artificial Intelligence (AI) technology to assist with clinical documentation. This technology acts as a "digital scribe," allowing your healthcare provider to focus entirely on you during your visit rather than typing on a computer.

How it Works:

Audio Recording: During your consultation, a secure device will record the conversation between you and your provider.

Transcription & Summarization: The AI processes the audio to generate a clinical summary and draft a progress note for your medical record.

Provider Review:

Your healthcare provider reviews, edits, and approves every note generated by the AI to ensure total accuracy before it becomes a permanent part of your file.

Privacy and Security:

Data Protection: All audio and text data are encrypted and handled in compliance with HIPAA (Health Insurance Portability and Accountability Act) regulations.

Storage: In most cases, the raw audio recording is deleted immediately after the clinical note is finalized.

Non-Disclosure: Your data will not be sold to third parties or used for advertising.

Your Rights:

Voluntary Participation:

Your consent is entirely voluntary. Your quality of care will not be affected if you choose not to participate.

Right to Revoke:

You may ask your provider to turn off the AI recording at any time during your visit.

Access to Records:

You retain the right to review your medical notes at any time, just as you would with traditional documentation.

Acknowledgement and Signature:

By signing below, I acknowledge that I have read the information above and consent to the use of AI-assisted technology for the documentation of my medical visits.

Printed patient/guardian name

Patient/guardian signature

Date

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Medical Office Privacy and Communication Policy

Purpose

This policy explains how our office collects, uses, and protects your personal and medical information and describes our communications practices (phone, voicemail, email, patient portal, and SMS/text messaging). It also contains the SMS Terms & Conditions that govern text communications between you and Lone Star Pulmonary and Sleep Specialists PLLC.

1. Confidentiality and Protected Health Information (PHI)

We are committed to protecting your privacy consistent with HIPAA. PHI includes any information that identifies you and relates to your health, healthcare services, or payment. We will only use or disclose PHI as permitted or required by law.

2. Types of Information We Collect

We collect the minimum information necessary to provide care, bill for services, and communicate with patients. This may include:

Personal & Contact Information

- Full name, date of birth, gender
- Home, mailing, and email addresses
- Phone numbers (home, work, mobile)
- Emergency contact information

Medical Information

- Medical history, diagnoses, medications, allergies
- Laboratory and imaging results, clinical notes, treatment plans
- Referrals, care coordination records

Administrative & Billing Information

- Insurance provider and policy numbers
- Payment history and billing statements
- Appointment history, scheduling preferences
- Signed consent forms and communication preferences

Other Data Collected for Communications / SMS

- Mobile phone number(s) provided for SMS and voice messaging
- Device or carrier metadata necessary to deliver messages (e.g., routing info)
- (If applicable and only with consent) location data limited to what you provide or permit

3. How We Use Collected Information

We use collected information for legitimate healthcare purposes including, but not limited to:

- Providing medical treatment and coordinating care
- Processing claims and billing (treatment, payment, healthcare operations)
- Scheduling, appointment reminders, and administrative communications
- Improving patient service and office operations (e.g., quality improvement, patient outreach)
- Complying with legal, regulatory, or public health reporting requirements

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- Communicating about services related to your care (with your authorization for sensitive info)
We do not use or process more information than is reasonably necessary for these purposes.

4. Practices for Sharing Information (Third-Party Sharing)

We respect your privacy and limit disclosure of your information as follows:

No marketing resale or sharing:

- We will not sell, rent, or share your phone number or other personal information with third parties for marketing or promotional purposes.

Permitted disclosures:

- We may disclose necessary information to:
 - Your insurance company for claims processing and payment
 - Other healthcare providers involved in your care (e.g., labs, specialists) to coordinate treatment
 - Business associates and service providers who perform services on our behalf (e.g., secure SMS providers, billing processors, EHR vendors)
 - Authorities when required by law (e.g., court orders, mandatory public health reporting)

What we share and why:

- When sharing with service providers we limit the information to what is necessary for them to perform their function
- We require Business Associate Agreements and other safeguards to ensure HIPAA-level protections where applicable.

5. Communication Methods We Use

We may contact you by phone, voicemail, email, patient portal, postal mail, or SMS/text messaging as described in this policy.

6. Text Messaging (SMS) Policy — Overview

Text messaging is convenient but is not considered fully secure. By providing your mobile number, you authorize Lone Star Pulmonary and Sleep Specialists PLLC to send you SMS messages regarding appointment reminders, administrative notices, billing reminders, etc. under the terms below. We will not transmit sensitive medical details via SMS unless you explicitly authorize such transmissions in writing.

7. SMS Terms & Conditions

These SMS Terms & Conditions should be included either in your Privacy Policy or as a stand-alone SMS Terms & Conditions document.

1. SMS Consent Communication

Phone numbers and information obtained as part of the SMS consent process will not be shared with third parties for marketing purposes.

2. Types of SMS Communications

If you consent to receive text messages from Lone Star Pulmonary and Sleep Specialists PLLC, you may receive messages related to:

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- Appointment reminders and confirmations
- Scheduling changes or cancellations
- Patient care and follow-up reminders
- Billing, payment reminders, and insurance notifications
- Office announcements (e.g., closures, urgent notices)

3. Message Frequency

Message frequency may vary depending on your interactions with our office. For example, you may receive up to 1-2 SMS messages per week related to customer care, appointment reminders, billing, etc.

4. Potential Fees for SMS Messaging

Standard message and data rates from your wireless carrier may apply.

5. Opt-In Method

You may opt in by:

- Checking the SMS consent box on an online or paper form
- Providing your mobile number verbally and confirming consent
- Submitting an online form explicitly consenting to SMS communications

6. Opt-Out

You may opt out at any time by replying STOP to any SMS message you receive from us. You may also opt out by contacting our office directly.

7. Help

For assistance, reply HELP to any message, or contact our office at 940-381-0971.

8. Standard Messaging Disclosures

- Message & data rates may apply.
- Reply STOP to opt out.
- Reply HELP for assistance
- Message frequency may vary

8. SMS Privacy Policy Statement

SMS opt-in phone numbers are not shared with third parties or affiliate companies for marketing purposes. Phone numbers and SMS data are only used to provide communications described in this policy or through vetted service providers under contract and subject to privacy safeguards.

9. Security Measures

We maintain administrative, physical, and technical safeguards to protect PHI and communication data. SMS vendors are under contractual safeguards consistent with HIPAA standards.

10. Patient Responsibilities & Limits of SMS

Keep your contact info up to date. Avoid sending sensitive health details via text unless specifically authorized. Notify the office if your phone is lost or stolen.

11. Opting Out & Changing Preferences

You can opt out of SMS or email anytime (see "Opt-Out" above). Changes may take effect within a short processing period.

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12. Contact & Privacy Officer

Lone Star Pulmonary and Sleep Specialists PLLC

Privacy Officer: Ben Doroodchi

Address: 3200 Colorado Blvd #200, Denton, TX 76210

Phone: 940-381-0971

Email: clinic@lonestarpulmonarysleep.com

I have read and understand the Medical Office Privacy and Communication Policy and the SMS Terms & Conditions. I consent to receive communications as indicated below:

Patient Name: _____

Mobile Phone: _____

SMS Consent: I consent to receive SMS communications from Lone Star Pulmonary and Sleep Specialists PLLC.

Signature: _____

Date: _____

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New Patient Information

Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Alternate phone: _____

Email address: _____ Last 4 #'s of SS#: _____

Preferred name: _____ Height: ___ft___inch Weight: _____lbs Neck: ___inch

Gender at birth: Male Female Gender you identify as: Male Female

Marital status: Single Married Divorced Widowed Other

Preferred Language: English Spanish Other: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino Prefer not to answer

Race: White Black/African American American Indian Other: _____ Prefer not to answer

Emergency contact: _____ Relation: _____

Phone: _____

Employer: _____ Occupation: _____ Retired

Address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ SS#: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to patient: _____ Employer: _____ Phone: _____

Primary Insurance: _____ Phone: _____

ID #: _____ Group #: _____

Secondary Insurance: _____ Phone: _____

ID #: _____ Group #: _____

Referred by: _____ Reason for visit: _____

Primary care physician: _____

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Patient name: _____ DOB: _____

Please explain the reason for your visit today: _____

Patient Health Questionnaire Please answer the following questions

Little interest or pleasure in doing things?

Not at all Several days More than half of days Nearly everyday

Feeling down, depressed, or hopeless?

Not at all Several days More than half of days Nearly everyday

Trouble falling asleep, staying asleep, or sleeping too much

Not at all Several days More than half of days Nearly everyday

Feeling tired, or having little energy?

Not at all Several days More than half of days Nearly everyday

Poor appetite or overeating?

Not at all Several days More than half of days Nearly everyday

Feeling bad about yourself, or that you are a failure, or have let yourself or your family down?

Not at all Several days More than half of days Nearly everyday

Trouble concentrating on things, such as reading the newspaper, or watching television?

Not at all Several days More than half of days Nearly everyday

Moving or speaking so slowly that other people could have noticed or the opposite – being so fidgety or restless that you have not been moving?

Not at all Several days More than half of days Nearly everyday

Thoughts that you would be better off dead or hurting yourself in some way?

Not at all Several days More than half of days Nearly everyday

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Patient name: _____

DOB: _____

Generalized Anxiety Disorder Please answer the following questions

Feeling nervous, anxious, or on edge?

Not at all Several days More than half of days Nearly everyday

Not being able to stop or control worrying?

Not at all Several days More than half of days Nearly everyday

Worrying too much about different things?

Not at all Several days More than half of days Nearly everyday

Trouble relaxing?

Not at all Several days More than half of days Nearly everyday

Being so restless that it's hard to sit still?

Not at all Several days More than half of days Nearly everyday

Becoming easily annoyed or irritated?

Not at all Several days More than half of days Nearly everyday

Feeling afraid, as if something awful might happen?

Not at all Several days More than half of days Nearly everyday

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Patient name: _____

DOB: _____

Other symptoms we need to know about Please mark all that apply

General

- | | | |
|--|--|--|
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Loss of or excessive appetite | <input type="checkbox"/> Weight loss or gain |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Fevers or chills | <input type="checkbox"/> Trouble speaking |

Sleep history

- | | | |
|---|---|---|
| <input type="checkbox"/> Prior diagnosis of sleep apnea | <input type="checkbox"/> Stop breathing while asleep | <input type="checkbox"/> Working nights/swing shift |
| <input type="checkbox"/> Using PAP therapy | <input type="checkbox"/> Waking up choking/gasping | <input type="checkbox"/> Narcolepsy / cataplexy / sleep paralysis |
| <input type="checkbox"/> Using Inspire/Genio therapy | <input type="checkbox"/> Waking up repeatedly at night | <input type="checkbox"/> Talking while asleep |
| <input type="checkbox"/> Using oral appliance therapy | <input type="checkbox"/> Waking up tired in the morning | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> PAP device 5+ years old | <input type="checkbox"/> Frequent bathroom trips at night | <input type="checkbox"/> Night terrors |
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Restless leg/limb movements | <input type="checkbox"/> Acting out dreams |
| <input type="checkbox"/> Snoring/observed snoring | <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Use of sleep nightly sleep medication |

Environmental exposure

- | | | |
|--|--|---|
| <input type="checkbox"/> Animal contact | <input type="checkbox"/> Contact with anyone with TB | <input type="checkbox"/> Exposure to asbestos |
| <input type="checkbox"/> Exposure to fiberglass | <input type="checkbox"/> Exposure to chemicals | <input type="checkbox"/> Exposure to military service chemicals |
| <input type="checkbox"/> Exposure to secondhand smoke | <input type="checkbox"/> Recent travel | <input type="checkbox"/> Exposure to mold |
| <input type="checkbox"/> Exposure to anyone with COVID | <input type="checkbox"/> Positive for COVID | <input type="checkbox"/> Prior diagnosis of COVID |

Skin

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Lumps | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Color changes | <input type="checkbox"/> Hair and/or nail changes (dry/weak, etc.) |

Headache

- | | | |
|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Migraines | <input type="checkbox"/> Head injury |
|-----------------------------------|------------------------------------|--------------------------------------|

EENT

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Nasal or sinus congestion | <input type="checkbox"/> Post-nasal drainage |
| <input type="checkbox"/> Deviated septum | <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Frequent sneezing | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Ear pain or drainage |
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Ringing in the ears (tinnitus) | <input type="checkbox"/> Change in vision |
| <input type="checkbox"/> Blurry or double vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Watery, itchy, or red eyes | <input type="checkbox"/> Flashing lights, specks, floaters | <input type="checkbox"/> Sore mouth or tongue |
| <input type="checkbox"/> Mouth dryness | <input type="checkbox"/> Thrush | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Neck lymph node swelling/lumps | |

Lungs

- | | | |
|---|--|--|
| <input type="checkbox"/> Cough (dry or wet, productive) | <input type="checkbox"/> Coughing up blood (hemoptysis) | <input type="checkbox"/> Phlegm: color _____ |
| <input type="checkbox"/> Shortness of breath, resting | <input type="checkbox"/> Shortness of breath, movement | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Using inhalers or nebulizer | <input type="checkbox"/> On supplemental oxygen at night | <input type="checkbox"/> On supplemental oxygen 24/7 |

Heart

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest tightness and/or pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diagnosis of congestive heart failure |
| <input type="checkbox"/> Stents | <input type="checkbox"/> Bypass surgery | <input type="checkbox"/> Atrial fibrillation |

Blood

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Spontaneous bruising | <input type="checkbox"/> High blood sugar |
| <input type="checkbox"/> History of blood clots/DVT | | |

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Patient name: _____ DOB: _____

Gastrointestinal

- | | | |
|--|---|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Dark, tarry stools with or without food |
| <input type="checkbox"/> Fresh blood in the stools | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Loose stools or diarrhea |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Reflux/heartburn | <input type="checkbox"/> Choking on food/drink, trouble swallowing |

Urinary

- | | | |
|---|---|---|
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urinary dribbling |
| <input type="checkbox"/> Frequent nighttime urination | <input type="checkbox"/> Burning on urination | <input type="checkbox"/> Blood in the urine |

Musculoskeletal

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Muscle aches or pains | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Joint pain |
|--|--|-------------------------------------|

Neurological

- | | | |
|--|---|---|
| <input type="checkbox"/> History of stroke | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Numbness in the limbs | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Gait disturbance |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Using a cane or walker | <input type="checkbox"/> Using a wheelchair |

If you are seeing any specialists, please list their name and city below and the reason:

Cardiologist: _____

Neurologist: _____

Endocrinologist: _____

Infectious disease: _____

Oncologist: _____

Nephrologist: _____

Other: _____

If applicable, name of your current medical equipment (DME) provider: _____

Have you had any of the following immunizations/boosters?

Flu shot? No Yes Date: _____ Location: _____

Pneumovax shot? No Yes Date: _____ Location: _____

Prevnar shot? No Yes Date: _____ Location: _____

RSV shot? No Yes Date: _____ Location: _____

COVID shot? No Yes Date: _____ Location: _____

Shingles shot? No Yes Date: _____ Location: _____

Any other information we need to know regarding this visit? No If yes, please explain: _____

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Patient name: _____ DOB: _____

Medical History Please mark all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> COPD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Pulmonary embolism or DVT | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Testosterone replacement (males) |
| <input type="checkbox"/> Pulmonary fibrosis | <input type="checkbox"/> Restless legs | <input type="checkbox"/> Hormone replacement (females) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Polycythemia/high blood count | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Diabetes, type 1 | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes, type 2 | <input type="checkbox"/> Sexual dysfunction |

Other medical history: _____

Medical Tests

If you have had any of the following tests performed, please list the date and location performed

- | | |
|--|--|
| <input type="checkbox"/> Pulmonary function: _____ | <input type="checkbox"/> Mammogram: _____ |
| <input type="checkbox"/> Sleep study: _____ | <input type="checkbox"/> Bone density: _____ |
| <input type="checkbox"/> Chest x-ray: _____ | <input type="checkbox"/> Colonoscopy: _____ |
| <input type="checkbox"/> CT chest: _____ | <input type="checkbox"/> Other: _____ |

Have you been hospitalized recently? If yes, please list the location, dates, and reason for hospitalization:

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Patient name: _____ DOB: _____

Surgical History Please mark all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Nasal surgery (deviated septum/polyps/sinus) | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Gastric surgery (lap band/bypass/sleeve) | <input type="checkbox"/> Colon surgery |
| <input type="checkbox"/> Thoracentesis | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Thyroid surgery |
| <input type="checkbox"/> Lung biopsy | <input type="checkbox"/> Gallbladder surgery | <input type="checkbox"/> Cataract removal |
| <input type="checkbox"/> UPPP / palate surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Fracture repair |
| <input type="checkbox"/> Inspire surgery | <input type="checkbox"/> Ovaries removed | <input type="checkbox"/> Hip replacement |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> C-section | <input type="checkbox"/> Knee replacement |

Other surgical history: _____

Social History

- Never smoked Former smoker Smoker Dates of smoking (years or ages): _____
- Cigarettes – packs per day: _____ Tobacco pipe – times per day: _____
- Vaping/e-cigs – times per day: _____ Chewing tobacco – cans per day: _____
- Marijuana – times per day: _____ Illicit drug use: _____
- Cigars – times per day: _____ Other: _____

Are you interested in quitting smoking? Yes No

Do you drink alcohol? Yes No If yes, what do you drink & how often do you drink: _____

Do you have pets? Yes No If yes, what kind of pets: _____

Occupational History Please check all that apply

Have you ever worked in or with any of the following or have you been exposed to any of the following:

- | | | | |
|-----------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Chemicals/chemical smells | <input type="checkbox"/> Foundry | <input type="checkbox"/> Welding |
| <input type="checkbox"/> Mold | <input type="checkbox"/> Paint/paint fumes | <input type="checkbox"/> Sand blasting | <input type="checkbox"/> Quarry |

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Faisal Saeed, MD (Pulmonologist) * Sidra Saeed, MD (Sleep Medicine Specialist) * Sonam Balani, FNP

Patient name: _____ DOB: _____

Family History

Biological father: Alive Deceased Age: _____

Medical conditions: _____

Biological mother: Alive Deceased Age: _____

Medical conditions: _____

Siblings:

Brothers (how many) _____ Sisters (how many) _____

Any medical conditions of brothers: _____

Any medical conditions of sisters: _____

Sleep History

What time to you go to bed: _____ What time do you wake up in the morning: _____

Have you ever been diagnosed with sleep apnea? Yes No

If yes, date of testing and where your study was done: _____

If yes, what treatment are you using? Untreated PAP therapy Oral appliance Inspire/Genio

If using PAP therapy, is your device 5+ years old and you need replacement therapy? Yes No

Do you have difficulty falling asleep at night? Yes No

Do you experience excessive daytime sleepiness? Yes No

Do you snore or have you been observed snoring? Yes No

Have you been told that you stop breathing in your sleep? Yes No

Have you woken up gasping or choking for air? Yes No

Do you wake up tired after a full night's sleep? Yes No

Do you wake up repeatedly throughout the night? Yes No If yes, number of awakenings: _____

Do you take naps during the day? Yes No If yes, how many: _____

Do you have a history of increased limb movements at bedtime? Yes No

Do you have a history of 'creepy crawly' sensations in your legs at bedtime? Yes No

Do you have a history of restless leg syndrome or periodic limb movements? Yes No

Do you have a history of narcolepsy? Yes No

Do you have a history of sleep walking? Yes No

Are you on any sleep medications? Yes No If yes, what are you taking: _____

Are you on any pain medications? Yes No If yes, what are you taking: _____

LONE STAR PULMONARY AND SLEEP SPECIALISTS

Faisal Saeed, MD (Pulmonologist) * Sidra Saeed, MD (Sleep Medicine Specialist) * Sonam Balani, FNP

Patient name: _____ DOB: _____

Sleep Questionnaire

Please answer the following questions to better assess your signs, symptoms, and possible diagnostic and treatment options.

Have you had a sleep problem diagnosed before? Yes No **If yes, please answer the following questions:**

When/where was your prior study performed? _____

What was the diagnosis? _____

Do you currently use PAP therapy? Yes No If yes, at what pressure(s): _____

Do you currently use an oral appliance? Yes No

If you are using an oral appliance, is this referral to evaluate the effectiveness of treatment? Yes No

Do you currently use home oxygen? Yes No If yes, do you use it: while sleeping continuously

Have you had a weight loss of 10% or greater since your previous study? Yes No

Are you being considered for bariatric surgery? Yes No

Are you being tested for sleep apnea because of a scheduled surgery? Yes No

Are you being tested for CDL, DOT or FAA purposes? Yes No

Do you snore? Never Sometimes Often Always

Do you ever awaken yourself snoring? Never Sometimes Often Always

Do you or has anyone observed you not breathing in your sleep? Never Sometimes Often Always

Do you awaken at night due to snorting/gasping or wake up short of breath? Never Sometimes Often Always

How long have your sleep symptoms been present (months/years)? _____

Over the past year, have the symptoms: Improved Remained the same Worsened

What time do you typically go to bed? _____ What time do you typically wake up? _____

On weekends, what time do you go to bed? _____ What time do you typically wake up? _____

Do you maintain the same daily sleep schedule? Yes No

Do you take naps? Never Rarely Sometimes Frequently Daily Generally on weekends only

Do you feel your naps are refreshing? Yes No N/A If you nap, how long do you sleep for? _____

Are you sleepy when sitting still? Never Rarely Sometimes Frequently Always

Have you ever had a near miss accident or at fault accident due to sleepiness while driving? Yes No

Are you currently following a diet plan? Yes No

Do you experience any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Impaired cognition/difficulty concentrating | <input type="checkbox"/> Mood disorders |
| <input type="checkbox"/> Insomnia or difficulty falling asleep | <input type="checkbox"/> Waking up repeatedly throughout the night | <input type="checkbox"/> Sleep walking/talking |
| <input type="checkbox"/> Uncontrollable muscle weakness | <input type="checkbox"/> Hallucinations right before falling asleep | <input type="checkbox"/> Sleep paralysis |
| <input type="checkbox"/> Restless legs while falling asleep | <input type="checkbox"/> Moving your limbs while sleeping | <input type="checkbox"/> Seizures during sleep |

Have you been diagnosed with any of the following or have difficulties with any of the following:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> COPD | <input type="checkbox"/> Neuromuscular disease | <input type="checkbox"/> Narcolepsy |
| <input type="checkbox"/> Periodic limb movements | <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Hypoventilation syndrome | <input type="checkbox"/> Tonsillar hypertrophy |
| <input type="checkbox"/> Cranial/facial abnormalities | <input type="checkbox"/> Cognitive impairment | <input type="checkbox"/> Difficulty following instructions | <input type="checkbox"/> Oxygen dependent |
| <input type="checkbox"/> Use of opioid medication | <input type="checkbox"/> Use of sleep medication | <input type="checkbox"/> Excessive use of alcohol | <input type="checkbox"/> Implanted pacemaker |

LONE STAR PULMONARY AND SLEEP SPECIALISTS

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Patient name: _____ DOB: _____

If you are **currently on PAP therapy or an oral appliance**, please complete the following questions:

This section does not apply to me

What year were you diagnosed with sleep apnea? _____ What year was your last sleep study done? _____

How many sleep studies have you had since your initial diagnosis? _____

Do you have a copy of your most recent sleep study report? Yes No

What therapy was recommended following your sleep study?

CPAP/Auto CPAP BiPAP/Auto BiPAP ASV therapy Oral appliance UPPP Inspire

What therapy are you using?

None CPAP/Auto CPAP BiPAP/Auto BiPAP ASV therapy Oral appliance UPPP Inspire

If you are not on therapy at this time, please let us know why:

Never received/couldn't afford Wasn't able to tolerate pressures Device no longer working

Need new supplies Other: _____

Do you feel therapy is beneficial? Yes No Will you continue to use therapy in the future? Yes No

When using therapy, do you snore? Never Sometimes Often Always

Prior to using therapy, did you snore? Never Sometimes Often Always

When using therapy, do you or have you been told you stop breathing while asleep?

Never Sometimes Often Always

Prior to using therapy, did you or were you ever told you stop breathing while asleep?

Never Sometimes Often Always

Additional comments regarding your sleep condition: _____
