MEDICATION LIST

NAME: _____ DOB: _____

Main Phone: _____ (CELL or HOME)

_____ **Consent to Import Medication History**

Initials I give Dr. Heniff consent to import my medication history as provided by SureScripts.

ALLERGIES (food,latex,other)

1._____
2._____
3._____
4._____
5._____

Medication	Strength	Directions	Prescribed By:

Dr. Michael Heniff
11824 Southwest Highway, Suite 130
Palos Heights, IL 60463
Phone: (708) 277-6150 Fax: (708) 277-6110
www.palospulmonary.com

PATIENT INFORMATION
PLEASE PRINT

Name: _____ Birthdate: _____

S. S. # _____-_____-_____

Address: _____City _____ST_____ ZIP_____

Home Phone:_____ Cell Phone_____

Email: _____

Work Name & Address _____

Occupation _____ Work Phone _____ Martial Status _____

***Whom may we thank for referring you? _____**

Family Physician _____ Phone# _____

****Is this work related? _____ Date of Accident_____**

Workmans Comp Carrier: _____

INSURANCE INFORMATION
(Please provide all ins. cards to a make copy for your records)

***Name of Insured _____ Relation to Patient _____**

***Birth date of Insured _____**

Primary Insurance_____ Provider Phone # _____

Policy/ ID # _____ Group # _____

ADDITIONAL INSURANCE? Y or N

***Name of Insured _____ *Birth Date of Insured _____**

Secondary Insurance _____ID/Group_____

AUTHORIZATION AND RELEASE

to process my claims including medical history, diagnosis, prescriptions, other medical and all medical expenses related to my treatment. This authorization is valid for the duration of my claims. A copy of this authorization is also valid as well as the original. I authorize payment of medical benefits go directly to Dr. Heniff. I accept responsibility for bill payment to include any amount not covered by my insurance. In the event that collection efforts are necessary and suit filed against me relative to any bill I incur, I agree to pay reasonable attorney's fees and costs of proceeding incurred by Dr. Heniff.

X_____ _____

SIGNATURE OF PATIENT/ REPRESENTATIVE DATE

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HEALTH HISTORY

NAME: _____ DOB: _____

BACKGROUND (circle answer)

1. Non-Smoker
2. Ex-Smoker Quit Date: _____
3. Current Smoker

FOR CURRENT AND EX-SMOKERS

1. How many years have you smoked? _____
2. Approximately how many packs per day did you smoke? _____

ALCOHOL CONSUMPTION (circle answer)

1. NEVER
2. RARELY
3. A COUPLE OF DRINKS WEEKLY
4. MORE THAN 2 DRINKS DAILY
5. A COUPLE DRINKS DAILY
6. OTHER _____

WHEN WAS YOUR LAST FLU SHOT? _____

WHEN WAS YOUR LAST TETANUS SHOT? _____

RACE: ☐ White ☐ African American ☐ American Indian ☐ Asian ☐ Native Hawiian or Other Pacific Islander

ETHNICITY: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Check off any lung or breathing problems or symptoms:

- ☐ Wheezing
- ☐ Heart Murmur
- ☐ Unable to sleep laying flat or with only one (1) pillow
- ☐ Sudden onset of difficulty breathing
- ☐ Night sweats, fever, chills
- ☐ Coughed up blood
- ☐ Chest pains or pressure
- ☐ Shortness of breath
- ☐ Dizziness
- ☐ Swollen legs
- ☐ Lung cancer
- ☐ Lung surgery
- ☐ Bronchoscopy or bronchial / lung biopsy
- ☐ Pulmonary function or spirometry test
- ☐ Pulmonary stress
- ☐ Allergy shots or allergy testing
- ☐ Heart failure or heart attack
- ☐ Blue lips or fingernails
- ☐ Leg cramps when you walk
- ☐ Cough
- ☐ Hoarseness
- ☐ Discolored sputum
- ☐ COPD
- ☐ Asthma
- ☐ Pneumonia or bronchitis
- ☐ Blood clot in your leg or lung
- ☐ Exposure to tuberculosis or had tuberculosis

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NAME:_____ DOB: _____

PLEASE CHECK OFF ANY SYMPTOMS YOU HAVE / HAD:

- ☐ Lack of energy, daytime sleepiness, trouble sleeping
- ☐ Snoring
- ☐ Loss of appetite, weight changes, fevers
- ☐ Eye problems, such as double or blurred vision, HEENT
- ☐ Glaucoma, cataracts
- ☐ Hearing problems, buzzing or ringing in ears
- ☐ Sinus problems
- ☐ High blood pressure or palpitations
- ☐ Stomach problems, heartburn, indigestion, change in bowel habits, choking on food
- ☐ Bloody or tarry stools
- ☐ Jaundice, liver problems, ulcers, gallstones, diverticulitis
- ☐ Urinary problems: Frequency, infections, stones, bladder issues
- ☐ Men: Prostate problems, night-time urination
- ☐ Women: Abnormal menstrual periods, pregnant
- ☐ If you are a woman, have you experienced menopause?
  ____ Yes ____ No At what age? _____
- ☐ Kidney disease
- ☐ Joint pain, swelling or redness, arthritis, back pain
- ☐ Muscle aches or tenderness, gout
- ☐ Rash, itching or other skin problems
- ☐ Paralysis (even temporary); stroke, numbness, loss of balance
- ☐ Seizures, loss of memory, headaches, loss of consciousness
- ☐ Unusual thoughts, nervousness, crying or sadness, Psychiatric Disorder
- ☐ Depression
- ☐ Thyroid disorder, diabetes, excess thirst, hunger
- ☐ Urination problems/disorders
- ☐ Bleeding, easy bruising, risk factors for HIV, anemia, Hematological Disorder
- ☐ Other:
  _____
  _____

I ATTEST THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Signature: _____ DATE: _____

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NAME:_____ **DOB:** _____

TO ALL NEW PATIENTS

The evaluation you will undergo is considered a specialist's opinion on the probable cause of your complaint and the most likely successful therapy for your problem. The therapy usually can be completed by and followed through by your family physician. This is usually followed with occasional re-evaluation by our staff as necessary. This normally does not replace the role of your private family physician. Please let us know who your family physician is so that they can be informed of your exam findings.

_____

SLEEP QUESTIONAIRRE

How likely are you to doze off or fall asleep in the situations described below in contrast to feeling just tired? This refers to your usual way of life in recent times.
Even if you haven't done some of these things recently try to work out how they would have affected you.

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of dozing
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (e.g a theater or a 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 to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

I ATTEST THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Signature: _____ **Date:** _____

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NOTICE

1. **TEST RESULTS**: (ie: PET scans, CT scans, ECHOs, Biopsy) will no longer be given via the telephone. A follow-up appointment is required. Please schedule your next appointment before leaving the office or when you receive a date for your test.

2. **PHARMACY REFILLS**: If you require a refill, have your pharmacy send us a refill request via FAX. We will no longer call your pharmacy for a refill.

3. **MAIL ORDER PRESCRIPTIONS (90 DAY SUPPLY):** require an office visit. Make sure to obtain your prescriptions at your office visit.

4. **INSURANCE, TELEPHONE, ADDRESS:** It is your responsibility to make sure we have your correct insurance/contact information.

I hereby understand the imposed rules and regulation of this medical facility. I agree to comply with the above mentioned regulations.

Signature: _____ DATE:_____

PRINT: _____

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HIPAA CONSENT FORM

Palos Pulmonary & Critical Care Consultants

Dr. Michael Heniff

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices before signing this consent. A more complete description of this clinic's privacy policy is available upon my request.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Patient Signature _____ **Date:**_____

Print Name: _____

Patient Representative	**Relationship**
1._____	_____
2._____	_____
3._____	_____

****Authorizing a 'Patient Representative' allows our staff to discuss your personal health records with that individual****

Witness _____ **Date:**_____

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