



Note: You can fill out all the information using your computer keyboard (type) or print the forms and then fill them by hand.

[Personal Information](#) | [Epworth Sleepiness Scale](#) | [Fatigue Severity Scale](#)

PATIENT'S PERSONAL INFORMATION

Full Name:	DOB (mm-dd-yyyy):	-	-	Today's date:	-	-
Address:	City:			State:		
Zip Code:	Phone (Home):	-		Phone (Work):		
Patient SSN:	Gender:	Male	Female	Not Specified		
Marital Status:	Single	Married	Divorced	Widowed	Other:	
Race:	Ethnicity:			Preferred Language:		
Need Interpreter:	Yes	No	Hearing Impaired:	Yes	No	
What is the reason for your visit today?					Since your last visit:	

Since your last visit have you.

Developed any new symptoms?	Yes	No	if yes, please explain:
Been hospitalized or had surgery?	Yes	No	if yes, please explain:
Developed any new Allergies?	Yes	No	if yes, please explain:
Taking any new medicines?	Yes	No	if yes, please explain:
Do you presently smoke?	Yes	No	
Do you use oxygen at home?	Yes	No	
Do you have a CPAP or BIPAP Machine?	Yes	No	
Do you need any prescription refills?	Yes	No	30 days 60 days 90 days

I give permission for Tallahassee Pulmonary Clinic to view my prescription history at the pharmacy.

Date: - - Signature: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze or fall asleep in the following situation, in contrast to just feeling 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 below:

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

- Make sure you circle a number for each situation.

Situation	Chance of dozing			
Sitting & Reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (e.g., a theater or 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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
Total Score				

(Maximum = 24. Normal < 10)

FATIGUE SEVERITY SCALE

This questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you. A low number indicates strong disagreement with the statement, whereas a high value indicates a strong agreement with the statement

- Make sure you circle a number for every statement.

During the past week, I have found that:	Disagree ----- Agree							
My motivation is lower when I am fatigued	0	1	2	3	4	5	6	7
Exercise brings on my fatigue	0	1	2	3	4	5	6	7
I am easily fatigued	0	1	2	3	4	5	6	7
Fatigue interferes with my physical functioning	0	1	2	3	4	5	6	7
Fatigue causes frequent problems for me	0	1	2	3	4	5	6	7
My fatigue prevents sustained physical functioning	0	1	2	3	4	5	6	7
Fatigue interferes with carrying out certain responsibilities	0	1	2	3	4	5	6	7
Fatigue is among my three most disabling symptoms	0	1	2	3	4	5	6	7
Fatigue interferes with my work, family, or social life	0	1	2	3	4	5	6	7
Total Score								

(Maximum = 63. Normal < 36)

TALLAHASSEE PULMONARY CLINIC
Disclosure of Ownership

Please be advised the following physicians own an investment interest in Tallahassee Pulmonary Clinic:

Clifton J. Bailey, MD	J. Daniel Davis, MD	F. Ray Dolly, MD;
David Y. Huang, MD	Praful B. Patel, MD	Carlos E. Campo, MD;
John S. Thabes, MD	Joseph M. Gray, MD	Alberto L. Fernandez, MD
Muhanad A. Hasan, MD		

Pulmonary Function Diagnostic Testing and chest x-ray radiology

You are entitled to obtain the items or services for which you have been referred to Tallahassee Pulmonary Clinic from the provider or supplier of your choice including Tallahassee Pulmonary Clinic.

The names and address of alternative sources of the items or services for which you have been referred are as follows:

Tallahassee Memorial Hospital
1300 Miccosukee Drive
Tallahassee, Florida

Capital Regional Medical Center
2626 Capital Medical Blvd.
Tallahassee, Florida 32308

Acknowledgement by patient:

I acknowledge disclosure of ownership to me by Tallahassee Pulmonary Clinic of the information set forth above.

Signature of Patient/legal Guardian

Signature: _____

Printed Name:

Date: - -

DISCLAIMER OF LIABILITY

Multiple Radiologic Studies and Laboratory Values

Multiple Radiological Studies

In the event you or your physician provides a disk or other media that contains multiple radiology images or studies, Tallahassee Pulmonary Clinic physicians will only review those images or radiologist reports related to the problem for which you are being treated by a Tallahassee Pulmonary Clinic physician. In some cases, your Tallahassee Pulmonary Clinic physician will only review the radiologist report for the radiological study performed related to the problem for which you are being treated, and will not review any other images contained on the disk or other media. Tallahassee Pulmonary Clinic is not responsible for study results that have not been sent to Tallahassee Pulmonary Clinic or brought by the patient.

Laboratory results

In the event that you or your physician provides laboratory results contain multiple values, Tallahassee Pulmonary Clinic physicians will review only those values related to the problem for which you are being treated by a Tallahassee Pulmonary Clinic physician. Tallahassee Pulmonary Clinic is not responsible for laboratory values that have not been sent to Tallahassee Pulmonary Clinic or brought by the patient.

Acknowledgement

By signing below, I acknowledge Tallahassee Pulmonary Clinic physicians will not review all radiologic images, studies, and reports on the computer disk or other media, and will only view to the extent deemed medically necessary and appropriate the report issued by the Radiologist and those specific images relevant to the treatment to be provided by Tallahassee Pulmonary Clinic.

I acknowledge Tallahassee Pulmonary Clinic physicians will only review those laboratory values related to the medical condition that is being treated by Tallahassee Pulmonary Clinic.

I acknowledge and agree that, I my successors and my assigns forever release from liability Tallahassee Pulmonary Clinic, its Board of Directors, Shareholders, employees, independent contractors from any and all claims or demands from personal injury, sickness or death arising out of any condition not reviewed by Tallahassee Pulmonary Clinic. To the extent the radiology report or laboratory analysis values indicate that follow up should be initiated for any condition, injury, or illness that is not associated with the basis for the treatment provided by Tallahassee Pulmonary Clinic, it shall be the responsibility of the patient and his or her primary physician to arrange for any need follow up or treatment. This release is signed voluntarily, under no duress and with the full understanding of these terms.

Patient Signature: _____

Date: