Oksana Senyk, MD, PhD, FCCP

2704 20th Street South, Suite 100 Birmingham, Al. 35209 (205) 978-0550

PATIENT NAME: (FIRST, MIDDLE, LAST)	SEX: M F	BIRTH DATE:	AGE:	MARITAL STATUS: S M D W	SOCIAL SECURITY #:

HOME PHONE: ( )	CELL PHONE: ( )	WORK: ( )	E-MAIL:

PATIENT'S **PHYSICAL** ADDRESS: (STREET, CITY, STATE, ZIP CODE)
PATIENT'S **MAILING** ADDRESS: (STREET, CITY, STATE, ZIP CODE)

EMPLOYER:	OCCUPATION:	YEARS EMPLOYED?

ARE YOU A STUDENT? YES NO	FULL TIME? YES NO	PART TIME? YES NO	SCHOOL NAME:

PREFERRED PHARMACY:	PHARMACY ADDRESS:	PHARMACY PHONE:

SPOUSE'S NAME:	ADDRESS: (IF DIFFERENT FROM ABOVE, IF NOT WRITE "SAME")	SPOUSE'S SS#:

SPOUSE'S EMPLOYER	OCCUPATION:	SPOUSE PHONE: ( )	BIRTH DATE:	ARE YOU ON HIS/HER INS.? Y N

EMERGENCY CONTACT:	RELATIONSHIP:	PHONE: (NOT YOURS) ( )	ADDRESS:

PRIMARY CARE PHYSICIAN:	*PHONE:*	REFERRING PHYSICIAN:	PHONE:

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME:	ADDRESS: (IF DIFFERENT FROM ABOVE. IF NOT, WRITE "SAME")	HOME PHONE: ( )

FATHER'S EMPLOYER:	OCCUPATION:	WORK PHONE: ( )	SOCIAL SECURITY #:

FATHER'S BIRTHDATE:	IS MINOR ON FATHER'S INSURANCE? Y N	MOTHER'S BIRTHDATE:	IS MINOR ON MOTHER'S INSURANCE? Y N

MOTHER'S NAME:	ADDRESS: (IF DIFFERENT FROM ABOVE. IF NOT, WRITE "SAME")	HOME PHONE: ( )

MOTHER'S EMPLOYER:	OCCUPATION:	WORK PHONE: ( )	SOCIAL SECURITY #:

RESPONSIBLE PARTY AND INSURANCE INFORMATION

PERSON RESPONSIBLE FOR PAYMENT:	RELATIONSHIP:	ADDRESS: (IF DIFFERENT FROM ABOVE. IF NOT, WRITE "SAME")	HOME PHONE: ( )

NAME OF **PRIMARY** INSURANCE:	INSURED'S NAME:	CONTRACT#:	GROUP #:	COVERAGE CODE:
NAME OF **SECONDARY** INSURANCE:	INSURED'S NAME:	CONTACT #:	GROUP #:	COVERAGE CODE:

Dr. Oksana Senyk has my permission to bill my insurance. SIGN: χ ______________________ DATE: ________

Dr. Oksana Senyk, MD, PhD, FCCP

2704 20th Street South, Suite 100, Birmingham, AL 35209* (205) 978-0550

PATIENT AUTHORIZATION TO RELEASE INFORMATION & ASSIGN BENEFITS

I hereby authorize Dr. Senyk to release any information in the course of my examination or treatment to any insurer or government agency providing benefits for me. I further authorize payment directly to the physician(s) of all benefits payable under the terms of my insurance policy and agree to pay the difference of the bill including any co-pays due at time of treatment. In the event this account is turned over to a collection agency or attorney for collections, I shall additionally pay all costs of collections, including reasonable attorney's fees.

SIGNATURE OF PATIENT/LEGAL GUARDIAN: ______________________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received a copy of Dr. Senyk's Notice of Privacy Practices:

SIGNATURE: ______________________ **DATE:** ______________________

I also authorize Dr. Oksana Senyk to disclose and/or release my protected health information to the following (Please select all that apply and list names where applicable.)

- ☐ **Spouse:** ________________ ☐ **Child:** ________________
- ☐ **Child:** ________________ ☐ **Doctor:** ________________
- ☐ **Friend:** ________________ ☐ **Other:** ________________
- ☐ **I do not want my information given to anyone**

Is it okay to leave information on your voicemail: ☐ Yes ☐ No - only speak directly to me

How did you hear about us? Physician Referral__________ Online _____________ from a friend __________ Hospital_________

FORMS, CANCELATION FEES & CHARTS NOTE FEES

There is a $30.00 prepaid fee for completing patient forms. The minimum time for completion of these forms is ten (10) business days. Copying of chart notes or records is subject to the following rates: $5.00 search fee plus $1.00 per page, up to 25 pages, then $.50 per page up to 50 pages. After 50 pages, the charge is $.25 per page.

Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to an Emergency, work and or family obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed medical care. **If an appointment is not cancelled at least 24 hours in advance you may be charged a fifty dollar ($50) fee; this fee will not be covered by your insurance company.**

Please sign below that you have read and understand our cancellation policy:

Patient: ______________________________ **Witness:** ______________________

Medical and Occupational History

Last Name: ________________ First Name: _________ MI: _____ Today's Date: __/__/_____

Employee ID # or SS#: ______________________________ Date of Birth: __/__/_____

Employer: ________________

Medical History

A. Medical Conditions

Do you now or have you had any of the following medical conditions? [Please *check* the box if 'yes.']

- ☐ High Blood Pressure
- ☐ High Cholesterol / Lipids
- ☐ Leukemia / Lymphoma
- ☐ Stroke
- ☐ Irregular Heart Beat
- ☐ Asthma
- ☐ Osteoarthritis
- ☐ Muscle Disease
- ☐ GERD (Reflux)
- ☐ TB (Tuberculosis)
- ☐ Seasonal Allergies
- ☐ Sleep Disorder
- ☐ Schizophrenia
- ☐ Migraine Headaches
- ☐ Hearing Condition
- ☐ Carpal / Cubital / Tarsal Tunnel Syndrome
- ☐ Kidney Stones or Disease
- ☐ Other: ________________
- ☐ Anemia (any kind)
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Chronic Bronchitis
- ☐ Gout
- ☐ Seizure Disorder
- ☐ Hiatal Hernia
- ☐ Crohn's Disease
- ☐ Bee Sting Allergy
- ☐ Depression or Anxiety Disorder
- ☐ Broken Bones: ________________
- ☐ Muscle Tension or Cluster Headaches
- ☐ Chronic Pain
- ☐ Prostate Problems
- ☐ Bleeding Disorder
- ☐ Cancer ________________
- ☐ Eye Disorder ________________
- ☐ Skin Condition ________________
- ☐ Emphysema
- ☐ Pneumothorax (partially collapsed lung)
- ☐ Rheumatoid Arthritis
- ☐ Stomach / Intestinal Ulcer
- ☐ Liver Disease ________________
- ☐ Ulcerative Colitis
- ☐ Hernia (location(s): ________)
- ☐ Alcohol / Drug Dependency History
- ☐ Varicose Veins
- ☐ Heart Valve Conditions

B. Current Medications (Prescriptions, vitamins, OTC medications, allergy shots, aspirin, drops, sprays, etc.)

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

________________ ________________ ________________

C. Drug Allergies or Bad Product Reactions (pills, liquids, creams, eye or ear drops, tape, latex, etc.)

____

____

D. Surgical History (Please note the year and the surgery; also note 'Left' or 'Right' if that applies.)

________________________ ________________________

________________________ ________________________

E. Immunization History (Please complete to the best of your abilities.)

Tetanus Booster (Td) or Tetanus Toxoid (TT): ___/___/________

PPD (Tuberculosis Skin Test): ___/___/________ [Result? __________]

Have you ever had the BCG vaccination (to prevent Tuberculosis)? This is not given in the United States.

□ No □ Yes

Measles/Mumps/Rubella (MMR): ___/___/________ [OR, did you have these as childhood diseases? ____]

Chickenpox Vaccination: ___/___/________ [OR, did you have this as a childhood disease? _____]

Hepatitis A Vaccinations: (#1) ___/___/________ (#2) ___/___/________

Hepatitis B Vaccinations: (#1) ___/___/________ (#2) ___/___/________ (#3) ___/___/________

F. Psychosocial History (Please *check* the appropriate box.)

1. Is English a second language for you?
   □ No □ Yes (If yes, what is your birth language? ____________________)
2. Single Married Divorced Widowed (Please *circle* which currently applies.)
3. What was the last level of education you completed (grade school, middle school, high school, apprentice program, technical college, junior college, college, post graduate program, professional program, etc.)?
   ____
4. How many people live at home with you? _______ Pets (type)? ____________________
5. Do you smoke (cigarettes, cigars, pipe), chew, or use snuff?
   □ No
   □ Yes (Product Type: ________________); Daily Amount: ____________ Years: ______
6. Do you drink alcohol?
   □ No □ Yes (Daily or Weekly Amount: ______________________________)
7. Do you use any recreational drugs or substances?
   □ No □ Yes
8. Do you have any hobbies (hunting, fishing, racing, weight lifting, collecting, biking, reading, sports, etc.) ?
   □ No □ Yes (____)
9. Do you have a regular exercise program (three times a week or more)?
   □ No □ Yes
10. Do you maintain a well-balanced diet more than 80% of the time?
    □ No □ Yes
11. Do you have *your own* regular Doctor (Family Physician, Internist, General Practitioner, Clinic)?
    □ No □ Yes

G. Family Medical History (Please list any medical conditions you can recall.)

Mother: ______________________________ Father: ______________________________

Sister(s): ______________________________ Brother(s): ______________________________

Grandmother(s): ______________________________ Grandfather(s): ______________________________

Aunt(s): ______________________________ Uncle(s): ______________________________

H. Review of Systems (Please check any symptoms that you are *currently* experiencing.)

□ Lightheadedness, Vertigo	□ Vision problems	□ Hearing Problems	□ Ear Ringing
□ Headaches	□ Fainting	□ Unusual Sleepiness	□ Poor Concentration
□ Jaw pain	□ Sinus problems	□ Teeth problems	□ Skin rash or condition
□ Indigestion	□ Stomach pain	□ Constipation	□ Diarrhea
□ Unusual Fatigue	□ Feeling 'Cold'	□ Feeling 'Hot'	□ Difficulty Swallowing
□ Chest Pain or Pressure	□ Muscle Weakness	□ Neck or Back Pain	□ Shortness of Breath
□ Joint Problems	□ Palpitations	□ Swollen legs	□ Difficulty / Pain with urination
□ Cough	□ Fever or Chills	□ Nausea	□ Loss of Appetite
□ Unplanned Weight loss	□ Numbness [location(s): ________________]		□ Recent Weight gain
□ Bloody stools	□ Recent hair loss	□ Anxiety or Panic feelings	□ Bruise easily and often
□ Pregnant or Nursing	□ Irregular periods	□ Breast Pain or Discharge	□ Testicular Pain
□ Vaginal Discharge	□ Penile Discharge	□ New Memory Problems	□ Tremor (hands, head)
□ Sleep Problems	□ Impotence	□ Restless Legs (night)	□ Hemorrhoids
□ Motion sickness	□ Cold Sores	□ Leg pain with walking only	□ 'Blackouts'

Other symptoms that may not have been listed above: ____

I. Occupational History

1. Starting with your *current* Employer, please list job titles you have held in the table below. Also, list separately each different job title within a company (transferred or promoted).

Employer Company	Job Title / Position	From (month/year)	To (month/year)	Brief Description

2. Do you work for more than one Employer? ◻ No ◻ Yes

3. Do you operate a business of your own? ◻ No ◻ Yes

4. Have you served in the military? ◻ No ◻ Yes
If yes, in what branch did you serve? ______________________
What years did you serve? ______________________
Were you discharged with any injury disability ratings? ◻ No ◻ Yes: ______________

5. Have you filed Workers' Compensation Claims previously? If yes, please note them below, starting with the most recent and working back.

Employer Company	Year	Body part or Diagnosis	Final Disability Rating?

6. Do you need any special accommodations with this job? ◻ No ◻ Yes
If yes, please describe any *permanent work restrictions* or special *accommodations* you may need:
____
____

7. Have you ever needed to wear Personal Protective Equipment (PPE) for this or previous jobs? Please *circle* those that you recall using:

Respirator (Type(s): ______________________*)* Ear Plugs or Muffs *Gloves* Safety glasses

Safety goggles Hood *Tinted Visor* Protective Clothing / Gown / Suit *Steel-Toed Boots* Dust Mask

Chain mail Gloves *Lead Apron* Bullet-Proof Vest *Dive Suit*

Did you have difficulty wearing any of this PPE? ◻ No ◻ Yes
If yes, please describe the problem: ______________________________

8. Have you ever had any work-related exposures (chemical, physical, biological, radiation) when <u>not</u> protected by PPE?
◻ No
◻ Yes If yes, please describe the exposure using the table below.

Year	Exposure Type	Medical Evaluation?	Current Status

9. Please *check* those items that you would routinely need to use in the workplace.

◻ Contacts ◻ Glasses ◻ Hearing Aid(s) ◻ Pacemaker

◻ Braces or supportive devices ◻ Wheelchair ◻ Other: ______________

ATTACHMENT 2 (continued)

New Outpatient Visit — Pulmonary Medicine

page 2 patient form

IV. Review of Symptoms other than your breathing problem ☐ **Remainder of systems negative**

Please circle and describe problems you have experienced in the past three months	Nausea or vomiting
Fever, sweats or chills	Abdominal pain
Unusual fatigue	Diarrhea
Loss of appetite	Constipation
Weight loss more than 5 lbs.	Difficult or painful urination
Headaches	Frequent urination
Ear aches	Irregular menstrual periods or vaginal bleeding
Eye irritation	Swelling at the ankles
Blurred or double vision	Joint pains or muscle aches
Nose or sinus problems, including hay fever	Fingers turn white and painful in the cold
Dry eyes or dry mouth	Back or neck pain
Snoring	Automobile accident or other serious injury
Breast discomfort	Unusual dizziness, faintness or loss of consciousness
Chest pain	Numbness or weakness of part of your body
Irregular or rapid heart beats	Anxiety
Heartburn or Indigestion	Depression
Difficulty swallowing or regurgitation	Other symptoms *(list)*