PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS AND DEMOGRAPHIC INFORMATION

DATE: _________________________ **SS #:** ________________________________

PATIENT NAME: ____ **BIRTHDATE:** _______/_______/_______

PATIENT ADDRESS: ____

CITY: __________________________**STATE:**___________**ZIP CODE:**__________________________________

HOME PHONE #: ________________________________**CELL PHONE #:** ______________________________

REFERRING PHYSICIAN OR INDIVIDUAL: ____

EMERGENCY CONTACT: __________________________________**PHONE NUMBER:** ___________________

EMAIL: ____

PHARMACY NAME:______________________________________**LOCATION:** __________________________

INS NAME (FOR LAB REFERRALS ONLY):____

DESIGNATED LAB DRAWING STATION: ____

PLEASE PROVIDE A COPY OF YOUR HEALTH INS. CARD: ____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO MARC SCHLOSSER MD AND BOCA HEALTH, LLC.

PATIENT SIGNATURE: ____

DATE: ____________________________________ **WITNESS:** ____

NOTICE OF RECEIPT OF PRIVACY PRACTICES

I RECEIVED A COPY OF THE BOCA HEALTH, LLC CENTER'S NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT IF BOCA HEALTH WISHES TO USE MY PERSONAL HEALTH INFORMATION IN A MANNER DIFFERENT THAN DESCRIBED BY THE NOTICE OF PRIVACY PRACTICES THEY MUST FIRST GET MY PERMISSION IN WRITING.

SIGNATURE OF PATIENT:____

1601 Clint Moore Rd. Suite 178 Boca Raton, FL 33487

Telephone: 561-939-0350 Fax: 561-939-0351

Patient Physical and Medical History

Full Name: ____ Age: _____ Height:_______ Sex:_______

Occupation/Place of Employment: ____

Primary Care Physician Name: _____________________________________ Phone: ________________________

Cardiologist Name: ________________________________ Endocrinologist name: ___________________________

Are you being treated by any other physicians? ____

Do you have a personal trainer? _____ Yes _____ No Trainer's Name: ____________________________________

Do you snore? ___ Yes ___ No Has anyone told you that you choke, stop breathing or gasp for air while sleeping? __ Yes __ No

Do you now have or have you ever been treated for any of the following:

Condition	NO	YES	Please list any medications you are taking, amount and dosage
High Blood Pressure	___	___	____
Heart Disease	___	___	____
Diabetes	___	___	____
Thyroid disorder	___	___	____
Hormones or Birth Control	___	___	____
High Cholesterol	___	___	____
Depression	___	___	____
Other Psychiatric conditions	___	___	____
Eating Disorders	___	___	____
Bariatric Surgery (lap band Gastric sleeve, gastric bypass)	___	___	____
Sleep Disorder	___	___	____
Lung Disease	___	___	____
Asthma	___	___	____
Glaucoma	___	___	____

Condition	NO	YES	Please list any medications you are taking, amount and dosage
Hypokalemia (low potassium)	___	___	___
Polycystic Ovary	___	___	___
Cancer	___	___	___
Hepatitis	___	___	___
HIV/AIDS	___	___	___
Stroke	___	___	___
Gastrointestinal disorders	___	___	___
Headaches	___	___	___
Bleed or Bruise easily	___	___	___
Any other regular medicines	___	___	___

Please answer if you have had any of the following conditions and if yes please provide dates:

Please list any major surgeries you have had and the dates: ___

___

Please list any serious illnesses or hospitalizations you have had and the dates: ___

___

Have you had any family member under the age of 40 die any sudden death? ___

Have you ever been treated for alcohol or any other substance abuse or dependence? ___

Do you smoke currently? ___ How much? ___ Did you recently stop smoking if so when? ___

Is your menses regular? ___ Number of pregnancies? ___ Number of children? ___

Did you have gestational diabetes? ___ Are you pregnant now? ___Date last menstrual period:___

Allergies to medications? (Please list): ___

Allergies to food? (Please list): ___

Do you have family history of the following if yes please indicate maternal or paternal by circling M or P or both:

Heart Disease: ___ M P Stroke:___ M P Diabetes:___ M P Cancer: ___ Obesity: ___ M P Overweight: ___ M P

Psychiatric conditions: ___ M P Depression: ___ M P High Cholesterol: ___ Other: ___ M P

What would you like to weigh (goal weight)?:___ At what age were you last that weight?___

What other means of weight loss have you tried? ______________________________ Diet_________ Exercise___________

Have you tried prescription medications for weight loss? ____ Yes ___ No If yes which medications: ___________________

Did you have any side effects from any weight loss medications? ____ Yes ___ No If yes please describe the complications you experienced: ____

Do you exercise regularly? _______________ How Often? _________________ Any problems with exercise? _____________

Do you eat nutritiously? _________________ Excessively? _________________ Do you count calories? __________________

Have you been overweight all of your life? _________________________ If not how long? ____________________________

Please briefly describe what you eat and drink in a normal day.

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Any other issues that you would like to bring to the attention of the physician?

____

____

Physician Signature: ____ Date: _________________________________

BOCA HEALTH

Medically Supervised Metabolism and Weight Management

EPWORTH SLEEPINESS SCALE EVALUATION

Please use the following scale to choose the most appropriate number for each situation listed:

0 = no chance of dozing **1 = slight chance of dozing**

2 = moderate chance of dozing **3 = high chance of dozing**

Situation:

_____ Sitting and Reading

_____ Watching TV

_____Sitting inactive in a public place (such as a theater or in 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 lunch without alcohol

_____In a car, while stopped for a few minutes in traffic

_____ Total Score

To be completed by Physician, to evaluate Risk Factors for a potential sleep disorder:

___Snoring

___Hypertension

___Headaches

___Overweight/Obesity

___Stroke

___Restless Leg

___Diabetes

___Fibromyalgia

___Heart Disease

___Depression/Anxiety

___Kidney Disease

A score of 10 or greater on the Epworth Scale or a score of 3 or greater in addition to one or more of the confirmed risk factors indicates the possibility of a sleep disorder which can be confirmed by a PSG.

Study Requested:

__ POLYSOMNOGRAM (PSG) for OSA/EDS , return for polysonogram with nasal CPAP (PSG/CPAP) – if indicated

__ POLYSOMNOGRAM (PSG) for OSA/EDS only

__ POLYSOMNOGRAM with nasal CPAP (PSG/CPAP) only

__ POLYSOMNOGRAM with nasal BIPAP (PSG/BIPAP) only

Recommend patient for sleep study__________ Yes _____________No

Physician signature: ____