PERSONAL INFORMATION			
Last Name:	First Name:		Middle Initial:
Social Security (SS) #:	Date of Birth (DOB):		Gender: ☐ M ☐ F
Address:			
Home Phone:	Work Phone:	Cell Phone:	
E-mail Address:			
Employer:			
Employed: ☐ Full Time	☐ Part Time	☐ Retired	
Marital Status: ☐ Single	☐ Married	☐ Other	

INSURANCE INFORMATION	
Primary Insurance	Secondary Insurance
Company:	Company:
Group #:	Group #:
Contract #:	Contract #:
Policy Holder:	Policy Holder:
Policy Holder SS#: DOB:	Policy Holder SS#: DOB:
Policy Holder Employer:	Policy Holder Employer:

CONTACTS		
Emergency Contact:	Relationship:	Phone:
Primary Care Physician:		Phone:

By signing this form,

- I authorize Sleep Centers of Alaska to provide medical care to me as necessary; and I acknowledge receipt of the Office Policies, Notice of Privacy Practices, and the Patient's Bill of Rights and Responsibilities.
- I authorize Sleep Centers of Alaska to photograph me, include my photograph in my medical records, and videotape me during the sleep study for diagnostic and treatment purposes.
- I authorize release of my medical records to my primary care physician, referring physician, consultants, and/or DME provider for the purpose of rendering treatment and ensuring continuity of care.
- I authorize release of my medical information to my insurance carrier to process my claims and payments; insurer is authorized to pay Sleep Centers of Alaska directly for benefits, if any, otherwise payable to me.
- I understand that I am responsible for the deductible, co-payment, co-insurance and any other charges not covered by insurance. If I do not have insurance, I acknowledge that I am obligated to pay the full amount.

_____ _____

Signature of Patient or Responsible Party *Date*

MEDICAL RECORDS
RELEASE AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

Address: _____

☐ **I hereby authorize and request release of my medical records TO Sleep Centers of Alaska.**
(Select office location.)

Information to be Released:
☐ Medical History ☐ Physical Examination
☐ Other: _____

From: _____
_____
_____

☐ **I hereby authorize and request release of my medical records FROM Sleep Centers of Alaska.**
(Select office location.)

Information to be Released:
☐ Medical History ☐ Physical Examination
☐ Other: _____

To: _____
_____
_____

OFFICE LOCATION

☐ **Anchorage**
2421 East Tudor Road, Suite 102
Anchorage, AK 99507
Phone: (907) 677-8889
Fax: (907) 677-8886

☐ **Wasilla**
351 West Parks Highway, Suite 100
Wasilla, AK 99654
Phone: (907) 357-8410
Fax: (907) 357-8423

☐ **Soldotna**
35670 Kenai Spur Highway, Suite103A
Soldotna, AK 99669
Phone: (907) 260-9520
Fax: (907) 260-9510

☐ **Fairbanks**
3202 International Street , Suite 200
Fairbanks, AK 99701
Phone: (907) 328-0582
Fax: (907) 328-0586

_____ _____
Patient's Signature *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.

Sleep Centers of Alaska is required by law to maintain the privacy and security of your protected health information, abide by the legal duties and privacy practices described in this Notice, and provide you with a copy of this Notice. This Notice became effective on April 14, 2003, and remains in effect until replaced.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are several ways in which your physician, our office staff and others outside of our office involved in your care are permitted to use and disclose your protected health information without your written authorization. Protected health information ("medical information") is individually identifiable health information that may identify you and that relates to your past, present or future physical or mental health or condition, health care services provided to you, or payment for health care services rendered. The following list describes different ways that we are permitted to use and disclose your protected health information, however this list is not meant to be exhaustive.

- ***TREATMENT.*** We may use and disclose your medical information without your prior approval to provide, coordinate, or manage your health care and related services. For example, we may request information from your primary care physician pertaining to your care or provide information to your primary care physician about your condition.
- ***PAYMENT.*** We are permitted to use and disclose your medical information to obtain payment from your insurer for items / services rendered to you. For example, prior to your sleep study, we may be required to disclose information about you to your health plan in order to obtain preauthorization for the procedure.
- ***HEALTH CARE OPERATIONS.*** We may use and disclose your medical information for health care operations. Our health care operations include: assessment of healthcare quality and improvement activities; reviewing and evaluating the competence, qualifications and performance of our health care professionals; health care training programs; accreditation, certification, licensing and credentialing activities; medical records review, audits, and legal services; business planning, development, management and administrative activities.

We are also permitted to use and disclose your medical information without your prior approval, when authorized and required by law, for the following kinds of public health and benefit activities: 1) for public health, including to report disease and vital statistics, child and adult abuse, neglect or domestic violence; 2) to avert a serious and imminent threat to public health or safety; 3) for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud and abuse agencies; 4) for research; 5) to entities subject to FDA regulation regarding FDA-regulated products or activities; 6) in response to court and administrative orders and other lawful process; 7) to law enforcement officials with regard to crime victims and criminal activities; 8) to comply with OSHA or similar state laws regarding work-related illness or injury; 9) to comply with workers' compensation laws and similar programs; 10) to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; 11) to coroners, medical examiners, funeral directors, and organ procurement organizations; and 12) disclosures otherwise specifically required by law.

We may disclose your medical information to a family member, friend or other person involved in your care or responsible for payment of your care but will disclose only information that is relevant to his / her involvement. We will provide you with an opportunity to object to these disclosures, unless you are not present or incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

In any other situation not described above, we will not use and disclose your medical information without your express written authorization. Uses and disclosures of your medical information for marketing and fundraising purposes and uses and disclosures that constitute sales of medical information about you will only be made with your signed permission. You have the right to opt out of receiving fundraising communications.

If you sign an authorization to disclose your protected health information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

PATIENTS' RIGHTS

You have the following rights regarding the protected health information that we maintain about you:

- You have the right to inspect and obtain an electronic or paper copy of your medical record and other health information with limited exceptions. We will provide your medical information to you in the format that you request unless we cannot practicably do so. Your request must be made in writing. Fees may apply for copying and mailing the information to you.
- You have the right to request that we amend your medical information if you believe that it is incorrect or incomplete. Your request must be made in writing. If we deny your request, you have the right to file a statement of disagreement with us. Upon receipt of your statement, we will prepare and provide you with a rebuttal to your statement within 60 days.
- You have the right to request that we not use or share your medical information for purposes of treatment, payment, or our health care operations, or with family, friends or others whom you specify. Your request must state the specific restriction requested and to whom you want the restriction to apply. Also, if you pay for a service or item out-of-pocket, you can request that we not share your medical information with your insurer. All requests must be made in writing. We are not required to agree to your request if your request adversely affects your care and is not in your best interests.
- You have the right to request an accounting of all uses and disclosures of your medical information to others for purposes other than treatment, payment or health care operations that we have made during the six years prior to the date of your request. Your request must be made in writing.
- In the event of a breach that may have compromised the privacy or security of your medical information, you have the right to receive notice of such breach.
- You have the right to request that we contact you with confidential communications in a specific way, such as by home or office phone, or by mail to a different address. Your request must be made in writing.
- You have the right to obtain a paper copy of this Notice from us, upon request, even if you receive this Notice electronically or view this Notice on our website.

We reserve the right to change the terms of this Notice at any time and to make revisions applicable to all medical information that we maintain, including medical information that we may have created or received before we made the change. For further information about our privacy practices, or to submit requests, please contact the Office Manager or our Compliance Officer.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with our Compliance Officer or with the Office for Civil Rights of the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington D.C. 20201. We support your right to the privacy of your medical information. We will not retaliate against you if you elect to file a complaint under any circumstances.

By signing this form, I acknowledge that I have read and understand the above Notice of Privacy Practices.

_____ _____ /_____ /_____

Signature of Patient or Responsible Party Date

Anchorage
2421 East Tudor Road
Suite 102
Anchorage, AK 99507
Phone: (907) 677-8889
Fax: (907) 677-8886

4048 Laurel Street
Suite 202B
Anchorage, AK 99508
Phone: (907) 677-1015
Fax: (907) 677-1022

Wasilla
351 West Parks Highway
Suite 100
Wasilla, AK 99654
Phone: (907) 357-8410
Fax: (907) 357-8423

Soldotna
35670 Kenai Spur Highway
Suite 103A
Soldotna, AK 99669
Phone: (907) 260-9520
Fax: (907) 260-9510

Fairbanks
3202 International Street
Suite 200
Fairbanks, AK 99701
Phone: (907) 328-0582
Fax: (907) 328-0586

We are delighted that you have chosen to entrust us with your care and we welcome the opportunity to serve you. Sleep Centers of Alaska is a full-service, state-of-the art facility dedicated to providing you with the highest quality of care in sleep medicine. We are committed to working closely with you and with your primary care physician to deliver the most effective treatment available. As part of this commitment, it is important that you have a clear understanding of our administrative and financial policies.

OFFICE HOURS

Normal business hours are Monday through Friday 9:00 A.M. to 5:00 P.M. Should you wish to contact us after hours, please leave a message on the voicemail and we will return your phone call within 12-24 hours.

SCHEDULING APPOINTMENTS

Office visits for initial examinations, consultations, PAP device delivery and setup, and follow-up appointments are scheduled during business hours; in-laboratory sleep studies are scheduled each night of the week with limited exceptions. Generally results of the sleep study are available within one week of the procedure. To schedule an appointment, please call our office during normal business hours.

CANCELLATION POLICY

If you need to cancel or reschedule your appointment, please notify our office during business hours at least 24 hours prior to your appointment. By doing so, you will incur no costs for cancellation. However, if you do not cancel and do not show up for your appointment, a fee of $35 for daytime appointments and a fee of $150 for overnight sleep study appointments may be billed to you for which you may be personally responsible. Please bear in mind that for each overnight sleep study a private room is reserved and a sleep technologist is assigned to you, so costs are incurred when planning and preparing for your sleep study. Kindly call our office as far in advance as possible should you need to reschedule your appointment.

CONFIDENTIALITY OF MEDICAL RECORDS

Sleep Centers of Alaska is committed to protecting the privacy of your medical information. Please review our Notice of Privacy Practices which describes our legal duties, the different ways that we are permitted to use and disclose your protected health information, and your rights to access and control this information. All records that we create or receive concerning your health or condition and the services rendered are confidential and cannot be disclosed without prior written authorization, except as otherwise permitted by law.

RECORDS REQUESTS

To authorize release of your medical information to a specific person(s) or entity(ies), or to request a personal copy of your own medical records, we require that you submit your request in writing to the Office Manager. (Standard authorization forms can be obtained from the receptionist.) By law, we are required to retain your medical records for 7 years. If you are requesting that our staff complete forms on your behalf, such as short-term disability forms or creditor forms, please allow our staff 48 hours to respond to your request. We charge a fee of $35 per form.

Sleep Centers of Alaska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, cash, and credit cards. Sleep Centers of Alaska accepts most major insurance carriers. As a courtesy to you, we will process your claim with your insurance company. Please note that insurance is a contract between you and your insurance company. While we may be the service provider, we are not party to that contract. Not all services are covered benefits in all contracts. In some cases, you may be responsible for amounts not covered by insurance such as the deductible, copayment, coinsurance, and any unpaid balance. We will make every effort to verify your insurance coverage prior to any procedures and relay this information to you. If you have any questions or are uncertain as to your insurance coverage, please do not hesitate to contact us for assistance.

PAYMENT OPTIONS

- Insured Patients: We require that you present a current copy of your insurance card to the receptionist at the time of service. Although we may estimate the amount that you and your insurance carrier owe for services rendered, it is your insurance company that ultimately makes the final determination of eligibility and payment. At the time of service, you must pay in full the deductible, copayments and coinsurance. Once your claim is processed by your insurer, any amounts not covered by insurance will be billed to you and it is your obligation to pay these charges.
- Private Pay / Uninsured Patients: You are expected to pay the full amount for services rendered at the time of service if you do not have insurance coverage; your insurance carrier declines to cover a specific service; Sleep Centers of Alaska is not contracted with your insurer; or you are paid directly by your insurance company. In some instances payment arrangements may be made prior to the date of service. If prearranged payments are approved, we will require a valid credit card on file.

REFUNDS: If there is an overpayment for services rendered, we will refund the amount to you once all claims are settled on the account and no payment is due on any other claim.

RETURNED CHECKS: There will be a returned check fee of $20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to scheduling a new appointment. Future visits will need to be paid in cash.

ACCOUNT BALANCES: If there is a balance on your account, we will send you a monthly statement. Balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days of receipt of the statement are considered past due. Accounts with balances outstanding for 90 days will be referred to a collection agency. If your account is sent to a collection agency, you may be subject to agency fees and penalties.

WORKERS' COMPENSATION / PERSONAL INJURY: We do not accept workers' compensation or personal injury cases nor do we bill attorneys for medical services. Any services performed in relation to a personal injury case will be considered self-pay and payment will be required at the time of service.

DISPUTES: Any disputes of your account should be submitted in writing within 30 days of receipt of the monthly statement. You will be notified of the outcome within 14 days of receipt of your dispute.

COMPLAINTS AND GRIEVANCES

To file a complaint or grievance, please complete our Complaint Form and submit it to the Office Manager. Within 14 days of submission of your complaint, you will receive written notice of the results of our investigation and actions taken to resolve your issues.

To report concerns about safety or quality of care, please notify the Office Manager. If after reporting your concerns, the issues are not fully resolved to your satisfaction, you may also relay your concerns to The Joint Commission at www.jointcommission.org.

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT'S RIGHTS

- The patient has the right to considerate, respectful care from health care providers.
- The patient has the right to impartial access to care regardless of race, gender, religion, national origin, cultural, socioeconomic, or educational background, physical handicap, or ability to pay.
- The patient has the right to emergency care without discrimination due to economic status or payment source.
- The patient has the right to know the identity of the physician who has primary responsibility for coordinating the patient's care and the identity and professional relationships of other physicians and healthcare providers who will be providing the medical services.
- The patient has the right to receive relevant and timely information in a manner that is easily understandable concerning his/her diagnosis, treatment, risks and benefits of treatment, prognosis, plan for follow-up care, unanticipated outcomes of care, reasonable alternatives to proposed care, and consequences of non-treatment.
- Patients with limited English proficiency have right to language assistance services, free of charge. Patients with physical or mental disability have the right to services that will enable them to make informed decisions.
- The patient has the right to discuss and request additional information relating to specific procedures and/or treatments, including their associated risks and benefits, and alternative procedures and treatments.
- The patient has the right to personal privacy and confidentiality of all records and communications concerning his/her medical history and treatment to the extent of the law.
- The patient has the right to inspect his or her medical record; have information explained or interpreted as necessary; request amendment to the medical record if it is not correct, relevant or complete; receive a copy of the medical record for reasonable fee; and an accounting of disclosures of his or her health information.
- The patient has the right to request information on the existence of business relationships between the health care provider and other health care facility, educational institution, or payers that may influence treatment.
- The patient has the right to know if medical treatment is for the purpose of experimental research and the right to consent or refuse participation in the experimental research.
- The patient, or his or her surrogate or representative, has the right to accept or refuse treatment, except as otherwise provided by law, and to be informed of the medical consequences of refusing treatment.
- The patient has the right to receive, prior to treatment, a reasonable estimate of charges for the treatment.
- The patient has the right to receive a reasonably clear and understandable itemized bill and, upon request, to have charges and any financial assistance offered by the facility explained.
- The patient has the right to receive care in a safe setting, free of all forms of abuse or harassment, and expect respect for his or her personal property.
- The patient has the right to file a grievance or complaint regarding violation of his/her rights or any concerns regarding the quality of care received. To file a grievance or complaint, complete and submit the Complaint Form to the Office Manager. Within 14 days of submission of the Complaint Form, the patient will receive written notice of the steps taken on his/her behalf to investigate the grievance, the results of the investigation, and actions taken to resolve the grievance or complaint.

PATIENT'S RESPONSIBILITIES

- The patient is responsible for providing, to the best of his or her knowledge, accurate and complete information concerning his or her medical history, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- The patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- The patient is responsible for reporting whether he or she comprehends the contemplated course of action and what is expected of him/her.
- The patient is responsible for following the recommended plan of treatment.
- The patient is responsible for keeping his/her appointments and, when he/she is unable to do so for any reason, for notifying the health care facility.
- The patient is responsible for his/her actions if treatment is refused or if the health care provider's instructions are not followed.
- The patient is responsible for assuring that financial obligations of his or her health care are fulfilled.
- The patient is responsible for adhering to the facility's rules and regulations pertaining to patient conduct, being considerate of the rights of other patients and the health care personnel, and respectful of the personal property of other patients and the staff, as well as the property of the facility itself.

SLEEP QUESTIONNAIRE
MEDICAL HISTORY

Name: _____ SSN: _____ Date of Birth: _____

Age: ____ Height: _____ Weight: _____ ☐ Male ☐ Female

Primary MD: _____ Referring MD: _____

This questionnaire is designed to assist us in understanding the nature of your sleep-related problem. Please take your time and answer each question as completely and accurately as possible.

SLEEP QUESTIONNAIRE

CHIEF COMPLAINT(S)

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Fatigue despite adequate sleep ☐ Snoring
☐ Significant daytime drowsiness ☐ Witnessed apnea ☐ Gasping / choking upon awakening
☐ Sleep walking / talking ☐ Night terrors ☐ Acting out dreams ☐ Legs kick / move while sleeping
☐ Morning headaches ☐ Insomnia ☐ Other: _____

HISTORY OF PRESENT ILLNESS

1. How long have you had this problem? ☐ < 1 month ☐ 1-6 months ☐ 6 months-2 years ☐ >2 years
2. Rate the severity of your problem. ☐ Mild ☐ Moderate ☐ Severe ☐ Problem only for others
3. Is your sleep-related problem getting worse? ☐ Yes ☐ No
4. What factors aggravate your symptoms? _____
5. Does your problem have a negative impact on your ……. work performance ☐ Yes ☐ No
   …….sex life ☐ Yes ☐ No
   ……. quality of life ☐ Yes ☐ No
   ……. social activities ☐ Yes ☐ No
6. Do you use any medications or other substances to help you sleep? ☐ Yes ☐ No
   If yes, please list drug/substance(s), dose, frequency, and length of usage.
   _____
7. Do any members of your family have significant sleep-related problems? ☐ Yes ☐ No
   If yes, please explain:
   _____
8. Have you discussed your sleep-related problems with another doctor? ☐ Yes ☐ No
   Doctor's Name: _____ Diagnosis: _____
   Current treatment: _____ Prior treatment: _____

PATIENT'S NAME: _____

PLEASE RATE HOW OFTEN YOU OR OTHERS NOTE THAT YOU:

	Never	Occasionally	Frequently
Snore	_____	_____	_____
Snore loudly enough for others to complain	_____	_____	_____
Awaken from sleep feeling short of breath, gasping, or choking	_____	_____	_____
Hold your breath or stop breathing while asleep	_____	_____	_____
Experience other breathing problems at night	_____	_____	_____
Wake up with a headache that improves in less than 2 hours	_____	_____	_____
Have dry mouth upon awakening	_____	_____	_____
Sweat excessively at night	_____	_____	_____
Experience heart pounding or irregular heart beats during night	_____	_____	_____
Feel sleepy or tired during the day	_____	_____	_____
Awaken feeling unrested or unrefreshed	_____	_____	_____
Become drowsy while driving	_____	_____	_____
Have motor vehicle accidents due to sleepiness	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____
Become irritable or crabby	_____	_____	_____
Have difficulty concentrating; experience memory impairment	_____	_____	_____
Fall asleep involuntarily, suddenly or in an awkward situation	_____	_____	_____
Experience sudden weakness, knees buckling, or jaw drop when laughing, scared, angry or crying	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep similar to hallucinations	_____	_____	_____
Perform complex tasks of which you are totally unaware such as driving or navigating without conscious awareness	_____	_____	_____
Have nightmares or night terrors	_____	_____	_____
Act out dreams by yelling and swinging arms and legs	_____	_____	_____
Walk or talk while asleep	_____	_____	_____
Do anything else considered "unusual" while asleep	_____	_____	_____
Move, twitch or jerk your legs while asleep	_____	_____	_____
Feel leg restlessness, agitation or discomfort at or before bedtime	_____	_____	_____
If yes: Do you feel an overwhelming urge to move your legs?		☐ Yes	☐ No
Does it happen only in the evening?		☐ Yes	☐ No
Does it only happen when you are relaxed?		☐ Yes	☐ No
Does it get better if you move around or walk?		☐ Yes	☐ No
Does it disturb your sleep or sleep onset?		☐ Yes	☐ No

How often do you experience this feeling? _____

PATIENT'S NAME: _____

SLEEP HYGIENE

1. Do you often have anxiety around bedtime? ☐ Yes ☐ No
2. Do you have thoughts racing through your mind while trying to fall asleep? ☐ Yes ☐ No
3. Do you sleep better away from home than in your own bed? ☐ Yes ☐ No
4. Are you anxious or upset if you have difficulty falling asleep? ☐ Yes ☐ No
5. Do you usually take coffee, tea, or chocolate within 2 hours of your bedtime? ☐ Yes ☐ No
6. Do you exercise within 2 hours of your bedtime? ☐ Yes ☐ No
7. Do you watch TV or read in bed before falling asleep? ☐ Yes ☐ No
8. Do you ever nap or rest during the awake portion of your day? ☐ Yes ☐ No

   If yes: How often? _____ times per day; _____ times per week
   How long is your nap / rest? ☐ < one hour ☐ ≥ one hour
   After the nap / rest, do you still feel tired? ☐ Yes ☐ No

9. Check conditions that routinely apply to you: ☐ Sleep alone ☐ Sleep with someone else in bed ☐ Sleep with pet in room/bed ☐ Provide assistance during night to child, invalid, bed partner, animal
10. Check factors that generally disturb your sleep: ☐ Heat ☐ Cold ☐ Light ☐ Noise ☐ Bed Partner
    Other: _____

SLEEP HABITS

1. When do you feel your very best? ☐ Morning ☐ Afternoon ☐ Evening
2. Approximately, how many hours do you actually sleep per night? _____
3. What time do you usually go to bed? Workdays: _____ Non-Workdays: _____
4. What time do you usually rise from bed? Workdays: _____ Non-Workdays: _____
5. How long does it usually take for you to fall asleep? _____
6. How many hours of sleep do you need to feel your very best? _____
7. In an perfect world, what would be the ideal hour for you to go to bed? _____
8. In an perfect world, what would be the ideal hour for you to awaken? _____
9. What usually prevents you from quickly falling asleep? _____
10. How many times do you typically wake up during the night? _____
11. What generally causes you to wake up during the night? _____
12. If you wake up during the night, how long do you typically stay awake? _____
13. If you wake up during the night, when do you typically wake up?
    ☐ Soon after falling asleep ☐ In the middle of the night ☐ Near the end of the sleeping period
14. What do you usually do when you awaken during the night? _____

MEDICAL HISTORY

Patient's Name: _____

Please check conditions for which you have been diagnosed:

- ☐ Angina
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Arteriosclerosis
- ☐ Heart murmur
- ☐ Rheumatic heart disease
- ☐ Arrhythmia
- ☐ Hypertension
- ☐ Stroke
- ☐ Peripheral artery disease
- ☐ Other cardiovascular disorders _____

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Other respiratory disorders _____

- ☐ Acid reflux
- ☐ Diverticulitis
- ☐ Hiatal hernia
- ☐ Swallowing disorder
- ☐ Stomach ulcers
- ☐ Other gastrointestinal disorders _____

- ☐ Arthritis
- ☐ Back pain
- ☐ Osteoporosis
- ☐ Chronic fatigue syndrome
- ☐ Fibromyalgia
- ☐ Autoimmune disorder
- ☐ Neuromuscular disorder

- ☐ Diabetes
- ☐ Sickle cell anemia
- ☐ Thyroid disease
- ☐ Cancer

- ☐ Migraines
- ☐ Seizures / Epilepsy
- ☐ Brain infection
- ☐ Brain injury
- ☐ Spinal infection
- ☐ Spinal injury
- ☐ Nerve injury
- ☐ Other neurologic disorders _____

- ☐ Liver disease
- ☐ Kidney disease
- ☐ Blood disorder

- ☐ Depression
- ☐ Anxiety / Panic attacks
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Other psychiatric disorders _____

CURRENT MEDICATIONS: Please list all medications that you are currently taking and their dosages:

_____

_____

DRUG ALLERGIES: Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list:

_____

PAST SURGERIES: Please list all operations and the approximate date of the procedure. _____

_____

FAMILY HISTORY: Has anyone in your blood-related family been afflicted with the following conditions:

☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer
☐ Sleep apnea ☐ Narcolepsy ☐ Restless legs syndrome ☐ Sleep walking / talking ☐ Parasomnias

OCCUPATIONAL HISTORY: Occupation: _____ Are you a shift worker? ☐ Yes ☐ No
If yes, please describe work schedule: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Children living at home: ☐ No ☐ Yes Ages of children: _____
Others living at home: ☐ No ☐ Yes ☐ Spouse ☐ Parents / Grandparents ☐ Friend
Alcohol consumption: ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Alcoholic
Tobacco use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____
Recreational drug use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____

REVIEW OF SYSTEMS

Please check any of the following symptoms which you currently or recently have experienced.

General
- ☐ Fatigue
- ☐ Malaise / lethargy
- ☐ Generalized weakness
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fever / chills

Eyes
- ☐ Vision changes
- ☐ Double vision
- ☐ Discharge
- ☐ Pain
- ☐ Sensitivity to light

Ears, Nose, Throat and Mouth
- ☐ Earache
- ☐ Ringing in the ears
- ☐ Allergies
- ☐ Frequent colds
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sinusitis
- ☐ Toothache
- ☐ Oral ulcers
- ☐ Dry mouth
- ☐ Facial pain
- ☐ Jaw pain
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Swollen glands

Cardiovascular System
- ☐ Chest pain
- ☐ Pain in arm, shoulder, jaw, neck or back
- ☐ Rapid heart rate
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Pain in leg when walking
- ☐ Ankle / leg swelling

Lungs
- ☐ Chronic cough
- ☐ Shortness of breath with mild exertion
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Bloody sputum

Gastrointestinal System
- ☐ Nausea / vomiting
- ☐ Indigestion
- ☐ Acid reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Cramps
- ☐ Bloating
- ☐Vomiting blood
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Rectal pain
- ☐ Rectal bleeding

Genitourinary System
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Blood in urine
- ☐ Pelvic / groin pain
- ☐ Genital ulcers

Male:
- ☐ Erectile dysfunction
- ☐ Testicular pain / swelling

Female:
- ☐ Irregular periods
- ☐ Hot flashes
- ☐ Vaginal discharge

Musculoskeletal System
- ☐ Joint pain / swelling
- ☐ Back pain
- ☐ Muscle pain / weakness
- ☐ Leg cramps

Nervous System
- ☐ Headaches / migraines
- ☐ Dizziness / fainting
- ☐ Seizures
- ☐ Tremors
- ☐ Disorientation
- ☐ Lack of coordination
- ☐ Numbness / paralysis
- ☐ Memory loss / impairment

Psychiatric Symptoms
- ☐ Depression
- ☐ Anxiety / panic attacks
- ☐ Hallucinations
- ☐ Delirium
- ☐ Dementia
- ☐ Suicidal ideation

Endocrine System
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Sexual dysfunction
- ☐ Hair loss
- ☐ Excessive sweating

Skin
- ☐ Rashes
- ☐ Bruises
- ☐ Hives
- ☐ Lesions

Patient's Signature _____ Date _____

EPWORTH SLEEPINESS SCALE

Patient: _____ Date: _____

Age: ____ □ Male □ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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.

Use the following scale to choose the most appropriate number for each situation:

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

It is important that you answer each question as best you can.

SITUATION	**CHANCE OF DOZING (0-3)**
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 score:	_____

BED PARTNER QUESTIONNAIRE

Patient: _____ Observer: _____

Relationship of Observer to Patient: _____ Date: _____

Frequency of observations: ☐ Once or twice ☐ Often ☐ Almost every night

Check any of the following behaviors observed while watching person sleep. Circle behaviors that you consider severe problems for this person.

☐ Light snoring
☐ Loud snoring
☐ Loud snorts
☐ Pause in breathing (How long? ____seconds)
☐ Choking
☐ Gasping for air
☐ Twitching, moving or kicking of legs
☐ Twitching or flinging of arms
☐ Grinding teeth
☐ Apparently sleeping even if person behaves otherwise
☐ Other _____

☐ Sleep talking
☐ Sitting up in bed not awake
☐ Getting out of bed not awake
☐ Head rocking or banging
☐ Awakening with pain
☐ Becoming very rigid or shaking
☐ Biting tongue
☐ Crying out

If person snores, what makes snoring worse?

☐ Sleeping on back ☐ Sleeping on side ☐ Alcohol ☐ Fatigue

Does snoring sometimes require you or your partner to sleep separately? ☐ Yes ☐ No

Does this person drink alcohol or use street drugs? ☐ Yes ☐ No