





## 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 the Office Manager, 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 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



### **Terms and Conditions of Use of Email Communications and Text Messages**

- J Email/text communications to and from patients concerning diagnosis or treatment may be printed out and included in patients' medical records. Because email/text communications may be part of medical records, individuals authorized to access these records, such as clinical staff and billing personnel, will have access to the communications.
- J Email/text communications may be forwarded internally to staff members and others involved in the patient's care, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other related matters. These communications will not be forwarded to independent third parties without the patient's written consent, except as authorized or required by law.
- J Although every effort will be made to read and respond to email/text communications promptly, there is no guarantee that these communications will be read and responded to within any particular time frame. In an urgent or emergency situation, the patient should call healthcare provider or go to Emergency Room and not rely on e-mail or texts.
- J If the patient's email/text communications require or invite a response and the patient has not received a response within a reasonable period of time, it is the patient's responsibility to determine whether the intended recipient received the communication and when the recipient will respond.
- J Email/text communications should not be used to communicate sensitive medical information such as that relating to HIV, mental health or substance abuse.
- J The patient is responsible for notifying the office staff of any type of information that the patient does not want to be sent by email or text messages.
- J Sleep Centers of Alaska is not responsible for loss of information due to technical failures associated with patient's email or text messaging software or internet service provider.
- J In the event that the patient does not comply with the conditions herein, the patient's privilege to communicate by email or text messages may be terminated.

### **Guidelines for Communicating via Email or Text Messages**

- J Limit or avoid using an employer's computer or other third party's computer.
- J Notify the office staff of any changes to the email address or cell phone number for text messages.
- J Insert topic of email communication in the subject line and patient's name in the body of the email.
- J Take precautions to preserve privacy and confidentiality by using, for example, screen savers and by protecting computer passwords.
- J Exercise caution when using mobile devices in public places where others may eavesdrop on these communications.

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I hereby consent to have Sleep Centers of Alaska's staff communicate with me via e-mail or text messages. I understand and acknowledge that Sleep Centers of Alaska cannot guarantee privacy, security or confidentiality of information transmitted via email or text messaging.

I certify that I have read and understand this form and I voluntarily agree to the uses and disclosures of information as described. Furthermore, I understand that I may revoke this authorization at any time by submitting written notice to Sleep Centers of Alaska.

\_\_\_\_\_  
*Signature of Patient or Responsible Party*

\_\_\_\_\_  
*Date*

*If Responsible Party, Relationship to Patient* \_\_\_\_\_



## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*As required by the Health Insurance Portability and Accountability Act of 1996, Sleep Centers of Alaska may not use or disclose your health information except as specified in its Notice of Privacy Practices without your written authorization. To authorize disclosure of your health information under special circumstances, please complete and sign this form.*

Patient's Name:	Date of Birth:	Age:
I Hereby Authorize Sleep Centers of Alaska to Release My Health Information to the Following:		
Person / Agency:		
Address:		
Phone #:	Fax #:	
Description of Specific Information:		
Purpose of Releasing Information:    Treatment    Billing    Legal    School    Employment    Disability Determination		
Other: _____		
Effective dates of authorization : ___/___/___ through ___/___/___ or until further notice is given.		
I Hereby Authorize Sleep Centers of Alaska to Obtain My Health Information from the Following:		
Person / Agency:		
Address:		
Phone #:	Fax #:	
Description of Specific Information:		
Purpose of Obtaining Information:    Treatment    Billing    Legal    School    Employment    Disability Determination		
Other: _____		
Effective dates of authorization : ___/___/___ through ___/___/___ or until further notice is given.		

The following information will not be released unless you specifically authorize it by marking the relevant box(es) below:
Drug, Alcohol or Substance Abuse Records
Mental Health Records (except Psychotherapy Notes)
HIV / AIDS-Related Information (including Test Results)
Genetic Information (including Test Results)

I certify that I have read this form and agree to the uses and disclosures of information as described. I understand that I have the right to revoke this authorization at any time by submitting written notice to Sleep Centers of Alaska. I also understand that Sleep Centers of Alaska may not condition my treatment, payment, enrollment, or benefits eligibility on my authorization to use or disclose the above information. Furthermore, I acknowledge that any disclosure carries with it the potential for unauthorized redisclosure by the recipient and that the information disclosed may not be protected by federal or state privacy laws.

\_\_\_\_\_  
*Signature of Patient or Responsible Party* \_\_\_\_\_  
*Date*  
*If Responsible Party, Relationship to Patient:* \_\_\_\_\_



### **Anchorage**

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

4120 Laurel Street  
Suite 106  
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**

206 W. Rockwell Avenue  
Suite 101B  
Soldotna, AK 99669  
Phone: (907) 260-9520  
Fax: (907) 260-9510

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 network of full-service, state-of-the-art sleep disorder clinics dedicated to providing you with the highest quality of care in sleep medicine. We are committed to working closely with you and your 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**

Our normal business hours are Monday through Friday 9:00 A.M. to 5:00 P.M. For assistance after normal hours with the home sleep apnea test or use of the PAP device, please call 907.231.3758. For all other matters, please leave a message on the voicemail and we will return your phone call within 24 hours.

### **SCHEDULING APPOINTMENTS**

Office visits for initial examinations, consultations, PAP device delivery and setup, and follow-up appointments are scheduled during normal business hours; in-laboratory sleep studies are scheduled each night of the week with limited exceptions. Generally test results are available within one week of the sleep study. 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 not incur a cancellation fee. 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 responsible. Please bear in mind that for each overnight study a private room is reserved for you 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 or entity, 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 insurance policies. 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 determine, and disclose to you, whether our services are covered by your health insurance plan before the service is provided. If you have any questions or are uncertain as to your health plan's coverage, please do not hesitate to contact us for assistance.

### PAYMENT OPTIONS

- J 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 your insurance carrier will pay for services rendered, it is your insurer that ultimately makes the final determination of your benefits eligibility and payment. Once your claim is processed by your insurance company, any amounts not covered by insurance will be billed to you and it is your obligation to pay these charges. At the time of service, you must pay any applicable deductible, copayment, and/or coinsurance.
- J 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](http://www.jointcommission.org).





## PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

### PATIENT'S RIGHTS

- J Patients have the right to considerate and respectful care from all healthcare providers.
- J Patients have the right to impartial access to care regardless of race, gender, age, religion, national origin, cultural, socioeconomic, or educational background, physical handicap, or ability to pay.
- J Patients with limited English proficiency have the 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.
- J Patients have the right to emergency care without discrimination due to economic status or payment source.
- J Patients have the right to know the identity of the physician who has primary responsibility for coordinating his/her care and identity and professional relationships of other physicians and healthcare providers who will be providing services.
- J Patients have the right to receive as much information as necessary to make informed decisions regarding their treatment, including information pertaining to the 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. The information relayed to the patient should be accurate, relevant, timely, and easily understandable.
- J Patients have 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.
- J Patients have the right to accept or refuse treatment, except as otherwise provided by law, and to be informed of the medical consequences of refusing treatment.
- J Patients have the right to personal privacy and confidentiality of all records and communications regarding their medical care to the extent of the law. Consultations, case presentations, examinations and treatment are confidential.
- J Patients have the right to inspect their medical record and obtain a copy of the medical record for a reasonable fee; have information explained or interpreted as necessary; request amendment to the medical record if it is not correct, relevant or complete; and receive an accounting of any and all disclosures of their protected health information.
- J Patients have the right to request information on the existence of business relationships between the healthcare provider and healthcare facilities, educational institutions, or payers that may influence treatment.
- J Patients have the right to know if their medical treatment is the subject of experimental research and the right to consent or refuse participation in such research projects.
- J Prior to treatment, patients have the right to receive a reasonable estimate of charges for the proposed treatment. After treatment, patients have 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.
- J Patients have the right to receive care in a safe setting, free of all forms of abuse or harassment; patients have the right to expect respect for his or her personal property.
- J Patients have the right to file a grievance regarding violation of their rights or any concerns regarding the quality of care received. To file a complaint, the patient must submit the Complaint Form in writing to the Office Manager. Within 14 days of submission of the form, the patient will receive written notice of the steps taken on his or her behalf to investigate the grievance, the results of the investigation, and actions taken to resolve the complaint.

*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.*

## PATIENT'S RESPONSIBILITIES

- J Patients are responsible for providing, to the best of his or her knowledge, accurate and complete information concerning their medical history, past illnesses, hospitalizations, medications, and other matters relating to their health.
- J Patients are responsible for reporting unexpected changes in their condition to the healthcare provider.
- J Patients are responsible for reporting whether or not they comprehend the contemplated course of action and what is expected of them.
- J Patients are responsible for following the recommended plan of treatment, including following the instruction of other healthcare professionals who carry out the physician's orders.
- J Patients are responsible for keeping their appointments and, when they are unable to do so for any reason, for notifying the medical office.
- J Patients are responsible for their actions if treatment is refused or if the healthcare provider's directives are not followed.
- J Patients are responsible for assuring that financial obligations for medical services rendered are fulfilled.
- J Patients are responsible for adhering to the office rules and regulations pertaining to patient conduct, being considerate of the rights of other patients and office personnel, and respectful of the personal property of other patients and staff and the property of the office facility itself.



## SLEEP QUESTIONNAIRE MEDICAL HISTORY

PATIENT PROFILE			
Last Name:	First Name:	Age:	Date of Birth:
Male:      Female:	Height:	Weight:	
Contact Phone Number(s):			
Primary Care Physician:			Phone:
Referring Physician:			Phone:
Pharmacy			Phone:

### SLEEP QUESTIONNAIRE

*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.*

#### 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(s) / 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: \_\_\_\_\_

**Please rate how often you or others note that you:**

	<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>
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	_____	_____	_____
<hr/>			
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	_____	_____	_____
<hr/>			
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	_____	_____	_____
<hr/>			
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	_____	_____	_____
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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 Initials \_\_\_\_\_

## 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? \_\_\_\_\_

Patient's Initials \_\_\_\_\_

## MEDICAL HISTORY

Please check conditions for which you have been diagnosed:

Angina	Acid reflux	Migraines
Congestive heart failure	Diverticulitis	Seizures / Epilepsy
Coronary artery disease	Hiatal hernia	Brain infection
Arteriosclerosis	Swallowing disorder	Brain injury
Heart murmur	Stomach ulcers	Spinal infection
Rheumatic heart disease	Other gastrointestinal disorders _____	Spinal injury
Arrhythmia		Nerve injury
Hypertension	Arthritis	Other neurologic disorders _____
Stroke	Back pain	
Peripheral artery disease	Osteoporosis	Liver disease
Other cardiovascular disorders _____	Chronic fatigue syndrome	Kidney disease
	Fibromyalgia	Blood disorder
Asthma	Autoimmune disorder	Depression
Bronchitis	Neuromuscular disorder	Anxiety / Panic attacks
Emphysema	Diabetes	Alcoholism
Sinusitis	Sickle cell anemia	Drug abuse
Other respiratory disorders _____	Thyroid disease	Other psychiatric disorders _____
	Cancer	

**Current Medications:** Please list all medications that you are currently taking and their dosages:

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**Drug Allergies:** Are you allergic to any drugs?    Yes    No    If yes, please list:

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**Past Surgeries:** Please list all operations and the approximate date of the procedure. \_\_\_\_\_

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**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: \_\_\_\_\_

Patient's Initials \_\_\_\_\_

## 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

### Gastrointestinal System

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

### Psychiatric Symptoms

Depression  
Anxiety / panic attacks  
Hallucinations  
Delirium  
Dementia  
Suicidal ideation

### 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

### 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

### Endocrine System

Heat intolerance  
Cold intolerance  
Excessive thirst  
Sexual dysfunction  
Hair loss  
Excessive sweating

### 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

### 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

### 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	Sleep talking
Loud snoring	Sitting up in bed not awake
Loud snorts	Getting out of bed not awake
Pause in breathing (How long? ____ seconds)	Head rocking or banging
Choking	Awakening with pain
Gasping for air	Becoming very rigid or shaking
Twitching, moving or kicking of legs	Biting tongue
Twitching or flinging of arms	Crying out
Grinding teeth	
Apparently sleeping even if person behaves otherwise	
Other _____	

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