



PATIENT 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:	Marital Status: Single Married Other	
Employed: Full Time Part Time Retired	Employer:	
Relationship to Responsible Party / Insurance Policy Holder: Self Spouse Parent Child Other		
INSURANCE INFORMATION		
Primary Insurance	Secondary Insurance	
Insurance Company:	Insurance Company:	
Policy ID #:	Policy ID #:	
Group #:	Group #:	
Policy Holder:	Policy Holder:	
Policy Holder SS#:	DOB:	Policy Holder SS#:
Policy Holder Employer:		DOB:
Policy Holder Employer:		
CONTACTS		
Emergency Contact:	Relationship:	Phone:
Primary Care Physician:		Phone:
Referring Physician:		Phone:

By signing this form,

- I authorize Sleep Centers of Texas to provide medical care as necessary for me.
- I acknowledge receipt of Sleep Centers of Texas' Office Policies, Notice of Privacy Practices, and Patient's Bill of Rights and Responsibilities.
- I authorize Sleep Centers of Texas to photograph me, include my photograph in my medical records, and videotape me during the sleep study for purposes of diagnosing and treating my condition.
- I authorize Sleep Centers of Texas to use and disclose my health information to other healthcare providers for treatment; to obtain payment for services rendered; and to conduct healthcare operations.
- I authorize release of my medical information to my insurance carrier to process my claims and payments.
- I authorize my insurance carrier to pay Sleep Centers of Texas 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 my 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

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



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 Texas is required by law to protect the privacy of your protected health information ("medical information"). We are also required to provide you with this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We are obligated to abide by terms of the Notice of Privacy Practices currently in effect. This Notice takes effect 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 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 permission to provide, coordinate, or manage your health care. For example, we may request that your primary care physician share information with us and we may provide information about your condition to your primary care physician.

PAYMENT. We are permitted to use and disclose your medical information to obtain payment from your insurance plan for items and services rendered to you. For example, we may be required to disclose information about you to your health plan to obtain preauthorization for a sleep study and to seek payment for any services rendered.

HEALTH CARE OPERATIONS. We may use and disclose your medical information without your prior approval for health care operations. Health care operations include: healthcare quality assessment and improvement activities; reviewing and evaluating the competence, qualifications and performance of 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 any other person involved in your care or responsible for payment of your care but will disclose only the information that is relevant to his or her involvement. We will provide you with an opportunity to object to these disclosures, unless you are not present or are 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.

PATIENT'S RIGHTS

With respect to your protected health information, you have certain rights:

-) You have the right to inspect and obtain an electronic or paper copy of your medical record and other health information with limited exceptions.
-) You have the right to request that we contact you with confidential communications in a specific way. For example, you may request that we communicate with you through an alternate address or phone number or that we mail confidential communications to you in a closed envelope rather than postcard.
-) You have the right to request that your protected health information be amended if you believe it is incorrect or incomplete. 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 protected health information with any party, including family or friends, regarding your treatment, payment of services, or our healthcare operations. If you pay in full for an item or service, you have the right to request that we not share your medical information with your insurer. Your request must state the specific restriction and to whom the restriction applies. Except in limited circumstances, we are not required to agree to the request if the request is not in your best interests.
-) You have the right to request an accounting of all uses and disclosures of your protected health information, with the exception of those for your treatment, payment of services, and our healthcare operations, that we may have made during the six years prior to the date of your request.
-) In the event of a breach that may have compromised the privacy or security of your protected health information, you have the right to receive notice of such breach.
-) You have the right to obtain a paper copy of this Notice even if you receive this Notice by electronic mail or view it on our web site.

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 we created or received before we made the change. For further information about our privacy practices, or to submit requests, please contact our Office Manager or Compliance Officer.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with our Office Manager, Compliance Officer, or with the U.S. Department of Health and Human Services, Office for Civil Rights, at 200 Independence Avenue, SW, Room 509F, Washington D.C. 20201. We support your right to privacy in matters pertaining to 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 the medical record, 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, as necessary, to staff members and others involved in the patient's care for diagnosis, treatment, reimbursement, healthcare operations, and other related matters. Except as authorized or required by law, these communications will not be forwarded to independent third parties without the patient's written consent.
- 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 the healthcare provider or go to the hospital for emergency care and not rely on e-mail communications or text messages.
- 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 HIV-related information, 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 Texas 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.

I hereby consent to have Sleep Centers of Texas' staff communicate with me via e-mail or text messages. I understand and acknowledge that Sleep Centers of Texas cannot guarantee the privacy, security or confidential-

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 Texas.

Signature of Patient or Responsible Party

Date

If Responsible Party, Relationship to Patient _____



Welcome to Sleep Centers of Texas!

We are delighted that you have chosen to entrust us with your care and we welcome the opportunity to serve you. Sleep Centers of Texas 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 with 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 8:30 A.M. to 5:00 P.M. For assistance after normal hours regarding the home sleep apnea test or use of the PAP device, please call 210.378.9014 (San Antonio) or 972.878.7378 (Ennis). 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 or polysomnography. 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 normal 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 you 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 for you and a sleep technologist is assigned to you, so costs are incurred in preparation 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 Texas 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 the information. All records that we create or receive concerning your health or medical condition and the services rendered are confidential and cannot be disclosed without your prior written authorization, except as otherwise permitted by law.

RECORDS REQUESTS

To authorize release of your medical information to a specific person / entity, or to request a personal copy of your own medical records, please submit your request in writing to our 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 \$35 per form.

San Antonio Office

7839 Interstate 10 West, San Antonio, TX 78230
Phone: 210.520.8333 Fax: 210.520.8335

Ennis Office

601 South Clay Street, Suite 107, Ennis, TX 75119
Phone: 972.878.7378 Fax: 972.875.8289

FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, cash, and credit cards. Sleep Centers of Texas 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 a covered benefit in all insurance policies. In some instances, you may be responsible for amounts not covered by the contract. We will make every effort to determine, and disclose to you, whether our services are covered by your 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

-) 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 your insurance will be billed to you and it is your obligation to pay the charges. At the time of service, you must pay any applicable deductible, copayment, and/or coinsurance.
-) Private Pay / Uninsured Patients: If you do not have insurance coverage or your insurance carrier declines to cover a specific service, if Sleep Centers of Texas is not contracted with your insurer, or if you are paid directly by your insurance carrier, you are expected to pay in full for services rendered at the time of service. In some instances, payment arrangements may be made prior to 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 written dispute.

COMPLAINTS AND GRIEVANCES

To file a complaint or grievance, kindly fill out 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 grievance.

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

Sleep Centers of Texas 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 BILL OF RIGHTS AND RESPONSIBILITIES

PATIENT'S RIGHTS

-) Patients have the right to considerate and respectful care from all healthcare providers.
-) 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.
-) 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.
-) Patients have the right to emergency care without discrimination due to economic status or payment source.
-) 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.
-) 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.
-) 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.
-) 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.
-) 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.
-) 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.
-) 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.
-) 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.
-) 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.
-) 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 their personal property.
-) 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 fill out our Complaint Form and submit it 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.

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PATIENT'S RESPONSIBILITIES

- J Patients are responsible for providing, to the best of their 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 policies pertaining to patient conduct, being considerate of the rights of other patients and office personnel, and respectful of others' personal property as well as the property of the facility itself.

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	_____	_____	_____
<hr/>			
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? _____

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		Alcoholism
Sinusitis	Diabetes	Drug abuse
Other respiratory disorders _____	Sickle cell anemia	Other psychiatric disorders _____
	Thyroid disease	
	Cancer	

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: _____

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

Name: _____

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 (0-3)

CHANCE OF DOZING

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 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