Sleep Medicine
Washington Regional

PATIENT INFORMATION- PLEASE PRINT

SOC SEC #: _____-_____-_____ MRN#: _____

Name: _____
Last First Mid Initial

Home Phone: _____

Work Phone: _____ Ext: _____

Address: _____

Cell Phone: _____

City: _____

Date of Birth: _____-____-_____ Age: _____yrs

State: _____ Zip Code: _____

Employer: _____

SEX: ☐ Male ☐ Female

Work Address: _____

City: _____ State: ____ Zip: _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced
☐ Partner ☐ Widowed Separated☐

Occupation: _____

Email: _____@_____

PRIMARY CARE PHYSICIAN: _____

REFERRAL

Who referred you to our clinic? (***PLEASE CHECK BOX***)

☐ Washington Regional Medical Center
☐ Newspaper or Magazine
☐ Recommended by friend or family member
☐ Drove by Location of Clinic
☐ Community or Company Health Fair
☐ Treated by Physician in hospital
☐ Internet
☐ Phone Directory (Yellow pages)
☐ Referred by a Physician: _____
☐ Employer
☐ Insurance Plan Directory
☐Return Patient/ Not Applicable
☐ Other: _____

SPOUSE/PARENT INFORMATION

Spouse/Parent Name: _____

Cell: _____

Employer: _____

Work: _____ Ext: _____

Work Address: _____

Spouse/Parent SEX: ☐ Male ☐ Female

City: _____ State: _____ Zip: _____

Spouse/Parent Date of Birth: ____/____/____

Occupation: _____

Social Sec. #: _____-_____-_____

EMERGENCY CONTACT INFORMATION

Emergency contact: _____

Cell Phone: _____

Address: _____

Home Phone: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

PRIMARY INSURANCE

Patient's Relationship to ***Main Policy Holder***: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ Main Holder's Date of Birth: ____/____/_____

Main Holder's Address: _____ Main Holder's Soc Sec#: _____-_____-_____

City: _____

State: _____ Zip: _____

SECONDARY INSURANCE

Patient's Relationship to ***Main Policy Holder***: ☐ Myself ☐ Spouse ☐ Child ☐ OTHER: _____

Name of Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID# _____ Group # _____

Insurance Company's Phone Number: _____

Main Holder's Name: _____ Main Holder's Date of Birth: ____/____/_____

Main Holder's Address: _____ Main Holder's Soc Sec#: _____-_____-_____

City: _____

State: _____ Zip: _____

GENERAL INFORMATION

Who is responsible for Payment?: ☐ Myself ☐ Other:_____ (FILL OUT BELOW)

Responsible Party Name: _____ **Responsible Party DOB:** _____/_____/_____

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐OTHER **SS#**_____-_____-_____

Address: _____ **Phone#:**_____

Have you ever been seen as patient at one of our Washington Regional Medical System Clinics? ☐ Yes No☐

If Yes, When?:_____/_____/_____ **Where?:**_____

RELEASE OF INFORMATION (spouse, children, parents, etc)

Who may we discuss your information with? For example: Medical issues/care, results, billing, etc.

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

Preferred Language: ☐English ☐Spanish ☐Marshallese ☐Arabic ☐DECLINE **OTHER:** _____

Race: ☐ White ☐African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ Native American Indian/ Alaskan ☐Hispanic ☐Unknown ☐ DECLINE

Ethnicity (Origin): ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐Unknown ☐DECLINE

Preferred Communication Method: ☐Print ☐Save to Flash Drive ☐DECLINE

Wellness Reminders: ☐Mail ☐Cell Phone ☐Home phone ☐Work Phone ☐DECLINE

PREFERRED PHARMACY: _____ LOCATION: _____

I authorize release of any medical information necessary to process my claim to all my insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in the place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys, or insurance companies involved in my care. I give my permission for messages to be left on my answering machine or sent by email. I, the undersigned, authorize and consent to the rendering of medical care, including diagnostic procedures, and medical treatment by authorized members of Washington Regional Medical System or their designees, as may in their professional judgment be necessary for the above named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. I have received a copy of the Notice of Privacy Practices of the clinic. I permit this facility to obtain my medication history electronically.

X_____ **Date:** _____/_____/_____

Signature (Patient or Parent/Guardian if minor)

Sleep Medicine
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Consent for Treatment

I authorize and consent to the rendering of medical care, including diagnostic procedures and medical treatment by authorized members of Sleep Medicine as many in their professional judgment be necessary for the below named patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment.

Assignment of Insurance Benefits

Patient-Physician Agreement: I, the undersigned, authorize Sleep Medicine to release any information acquired in the course of my examination or treatment to my insurance company(s) or another physician. I, recognizing that the medical insurance I possess may not completely cover the fee(s) for professional services rendered me; hereby agree that I am responsible for said fee(s). I authorize payment directly to me for their services. A photocopy hereof shall be valid as the original. I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Authorization to Release Information

I authorize Sleep Medicine to release any information requested by the insurance company necessary to collect benefits under any policy we make claim against for services on this or a related date of service.

Guarantee of Payment

I understand that office visits are to be paid for at the time of service unless other arrangements have been made. I understand that I am responsible for the balance not covered by insurance. I understand that Sleep Medicine does not accept any insurance policy assignment as a guarantee of full payment.

Patient Signature:
X_____

_____
(Patient or Parent/Guardian if under 18 years of age)

_____
Relationship of Guardian

_____
Date

Sleep Questionnaire

Patient Name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

Occupation: _____ Phone Number: _____

Chief Complaint:

1. What are your major complaints related to sleep and wakefulness? _____

_____

2. How long have you had the above sleep problem? _____

3. Have you ever had a sleep study or been treated for a sleep disorder? _____

If yes, when/where? _____ What was diagnosis? _____

Epworth Sleepiness Scale:

How likely are you to **doze off** or **fall asleep** in the following situations as opposed to just feeling tired? Please use the scale below and write the appropriate number for each situation.

0= No chance of dozing
1=Slight chance of dozing
2=Moderate chance of dozing
3=High chance of dozing

_____ Sitting and reading

_____ Watching TV

_____ Sitting inactive in a public place (theatre or meeting)

_____ As a passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon when circumstances permit

_____ Sitting and talking to someone

_____ Sitting quietly after lunch (without having had alcohol)

_____ In a car while stopped for a few minutes in traffic

_____ Total

Sleep Habits

1. What time do you usually go to bed? _____

2. How long does it take you to fall asleep? _____

3. How many times do you awaken at night?_____ What wakes you up? _____

4. Do you have trouble returning to sleep? _____

5. How do you wake up? (alarm clock, naturally) _____ # of snoozes? _____

6. What time do you usually wake up? _____

7. What time do you get up out of bed? _____

8. Do you usually sleep longer when you don't have to get up? _____ How long? _____

9. Upon awakening, do you generally feel: Completely rested Partially rested Not rested at all

10. Do you take anything to help you sleep? (Ambien, Lunesta, Tylenol PM, Unisom, Melatonin)

_____

11. Do you have a bed partner? _____

12. Do you sleep better when you are away from home? _____

13. When you wake up, do you feel refreshed but get tired in a few hours? _____

14. Before going to sleep, do you like to read, watch TV, or listen to the radio in bed? _____

15. Do your legs feel uncomfortable when you are trying to rest or go to sleep? _____

16. Do you wake up from nightmares? _____

17. As you fall asleep or wake up, do you have vivid or life-like visions? _____

18. When you have high emotion (angry, excited, scared) do you have sudden weakness or does any part of your body go limp? _____

19. As you are trying to fall asleep or wake up, do you ever have the inability to move? _____

20. Do you sleep propped up? _____

21. Does any of the following disturb your sleep on a regular basis? (circle all that apply)

Pain Noises Light Room Temperature

Daytime Symptoms: (Circle all that apply)

Morning headaches Excessive sleepiness/Fatigue Irritability/Moodiness Decreased Libido

Trouble Concentrating/Memory problems Waking up with dry mouth /sore throat

1. Do you take naps during the day? No _____ Yes _____ How long? _____
2. Have you had any motor vehicle accidents or "close calls" due to sleepiness? _____

Symptoms During Sleep: (Circle all that apply to you during sleep)

Tossing and turning	Sleep walking/talking	Stop breathing
Teeth grinding/clenching	Waking yourself with snoring	Snoring/Loud snoring
Night Sweats	Leg jerks/leg cramps	Morning headaches
Wake startled	Struggling to breathe	Choking/gasping
Frequent urination	Heart palpitations/pounding	Other: _____

Medical History: (Check any you have currently or in the past)

_____ High Blood Pressure _____ Diabetes _____ Atrial fibrillation

_____ Stroke, Parkinson's or other neuro- muscular disease _____ Chronic back pain

_____ Obesity _____ Frequent hay fever or allergies _____ Coronary artery disease/heart attack

_____ Fibromyalgia _____ Thyroid Disease _____ Epilepsy or Seizure disorder

_____ COPD/emphysema _____ Psychiatric problems (Anxiety, Depression or Bipolar Disorder)

Review of Systems: (Check any that apply to you in the past month)

_____ itchy, watery eyes _____ stuffy/runny nose _____ coughing _____ wheezing

_____ abnormal blood sugar _____ thyroid problems _____ shortness of breath

_____ chest pain _____ chest pressure _____ palpitations

_____ heartburn or acid coming up my throat _____ nausea _____ bedwetting

_____ having to use bathroom at night _____muscles hurting _____ joints hurt

_____ joints stiff _____ forgetful _____ migraines _____ numbness in hands/feet

_____ anxiety/depression _____ panic attacks _____ claustrophobia

Please list any medication allergies: _____

List all medications (supplements and over the counter) you take regularly. Please include dosage:

_____

_____

_____

_____

List any surgeries or major injuries/illnesses and approximate dates:

_____

_____

_____

Social and Family History:

Do you currently or have you previously smoked? _____ How long? _____

How much? _____ When did you quit? _____

Do you chew tobacco? _____

Do you drink alcohol? _____ Type? _____ How much? _____

Current or previous illicit drug use? _____ Type? _____

How much coffee, tea or caffeinated soda do you drink? _____

What do you do at work? _____

What are your normal working hours? _____

Do any blood related family members (mother, father, brother, sister, child) have apnea, narcolepsy, snoring or any other sleep disorder?

_____

_____

Other family medical problems? _____

Bed Partner Questionnaire

(To be completed by Bed Partner)

Check all that apply:

_____ I sleep in the same room as the patient

_____ I sleep in the same bed as the patient

_____ I have noticed no problem with the patient's sleep

_____ For the past _____ weeks months years (circle one), I have noticed a problem

_____ I hear the patient snoring

_____ I notice when he/she stops breathing during sleep. How long will they stop? _____

_____ I notice the patient has restless arm/leg movements

_____ I notice that the patient has difficulty going to sleep.

_____ I notice the patient gets up at night.

_____ I cannot easily awaken the patient in the morning

_____ For the past _____weeks months years (circle one), I have noticed a change in the patient's personality: _____

_____

_____

Other Comments: _____

_____

_____