Regional Sleep Center Patient Information Form

DATE:______________ ***THIS FORM MUST BE FILLED OUT COMPLETELY***

Is this your first visit with us? ☐ yes ☐ no   If no, did you have an ☐ Overnight Oximetry ☐ Sleep Study

Name ______________ ______________ ______________ ______________ ☐ male ☐ female
Last First Middle Maiden

Date of Birth ______________ SS# ______________ Race ______________

Mailing Address ______________________________ Apt# __________

City______________ State______________ Zip__________ COUNTY__________

Home Phone (_____)__________ Cell Phone (_____)__________ Work phone (_____)__________

Can we leave a message? ☐ yes ☐ no   Can we leave a message? ☐ yes ☐ no   Can we leave a message? ☐ yes ☐ no

Martial Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced   Mother's Name______________
(for registration purposes)

Primary Care Physician ______________ Phone#______________ Last Seen ______________

Referring Physician ______________ Phone#______________

Religious Preference: ______________   Preferred Language:______________

Are you employed? ☐ yes **Please complete this box* ☐ no **If not employed, go to next box*

☐ Full Time ☐ Part Time ☐ LOA ☐ Laid Off Your Occupation ______________

EmployerName______________ Telephone______________ ext# ________

Employer Address ______________________________

*If not employed, please check only **one** of the following

Are you disabled? ☐ yes ☐ no Disability Date __________ Are you retired? ☐ yes ☐no Retirement Date __________

Are you a student? ☐ yes ☐ no If yes, name of school ______________ Are you a homemaker? ☐ yes ☐ no

Next of Kin ______________ Relationship ______________ Phone (_____)__________

Address ______________ City ______________ State __________ Zip __________

Emergency Contact ______________ Relationship ______________ Phone (_____)__________

Address ______________ City ______________ State __________ Zip __________

Insurance Company Name ______________ Subscriber Name on Card ______________

Insurance ID # ______________ Group # ______________

Subscriber's Employer ______________ Birth date __________ SS# __________

Secondary Insurance ______________ Subscriber Name on Card ______________

Insurance ID # ______________ Group # ______________

It is the policy of this office to keep all medical records confidential. There may be occasions when you need this information released to another office/person. Please answer the following questions and authorize us to give your confidential information in these situations:

1. May we leave your medication information, including test results, on an answering machine or give it to another person, such as; a spouse, adult, or caregiver? ☐ yes ☐ no Names of person's to notify or leave messages:______________

2. May we leave detailed appointment reminders or messages to call us back on your answering machine at home, work, or cell phone? ☐ yes ☐ no

I, the understand, give my authorization to treat and assign directly to **Vincent A Viscomi, Tareck A. Kadrie, Anuj Chandra, MD**, all medical benefits, if any otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges other or not paid for by insurance. I hereby authorize the physician to release all information necessary to secure payment of benefits and authorize the use of the signature on all insurance submissions. I authorize release of medical information for treatment.

Signature______________________________ Date:______________

REGIONAL SLEEP DISORDERS CENTER Patient Questionnaire

Name: ______________________ Date: ______________
DOB: ______________ Height: ______________ Weight: ______________

Have you ever seen any other physician for your sleep problem?
☐No ☐Yes (please provide the Date, Sleep Center Name, and Address of any Sleep Studies)

How would you describe your sleep problem?
Check all that apply.
☐Snoring / Witnessed Apnea ☐Difficulty falling asleep ☐Daytime sleepiness ☐Difficulty awakening
☐Unwanted Behaviors During Sleep ☐Waking up during the night ☐Other: ______________
How many nights per week do you have a sleeping problem? ______________
How long have you had this problem? ______________
Please estimate the severity of your problem
☐Mild ☐Moderate ☐Extreme
Please describe your sleep problem, including when and how it began

PERSONAL HABITS
Tobacco: Do you presently smoke? Yes ____ No ____ #Cigarettes / Day ____ How many years? ____
Did you ever smoke? Yes ____ No ____ #Cigarettes / Day ____ How many years? ____
When did you quit smoking? ________
Alcohol: Do you drink alcohol? Yes ____ No ____ #Drinks / Day ____
Did you ever drink alcohol? Yes ____ No ____ #Drinks / Day ____ When did you quit? ________
Recreational Drug Use: Have you in the past or do you currently use recreational drugs? Yes___ No___
If so, what did you use and when did you last use recreational drugs? ______________

Caffeine: Do you drink or consume caffeinated products (coffee, tea, soda or chocolate)? Yes___ No___
What Products and quantity do you consume daily? ______________

FAMILY HISTORY: Married: Yes __ No __ Children: Yes __ No __ Age(s) of Children: _____ _____ _____

	Mother	Father	Brother(s)	Sister(s)	Grandparent(s)
High Blood Pressure					
Coronary Disease					
Stroke					
Diabetes					
Cancer (Type)					
Thyroid Disorder					
Obstructive Sleep Apnea					
Restless Legs					
Insomnia					
Other					

SLEEP SCHEDULE, ENVIRONMENT, and HYGIENE

On weekdays I sleep _______ hours, mostly from ______ to ______. Do you work? ___________
On weekends I sleep _____ hours, mostly from _____ to _____. Work Hours: ________________________________
Do you take frequent naps during the day? _____ Yes _____ No
If yes, how many days a week? ___________ How long is/are the nap(s)? ____________________
What time of day is the nap? __________________ Are they refreshing? _____ Yes _____ No
On scale of 1 to 10 where 1 is very bad and 10 is very good, how would you rate your sleep overall? ______________

Please Check ALL That Apply To You:

____ Do you have headaches in the morning
____ Do you have a Sore throat or dry mouth on awakening
____ You feel sudden muscle weakness when laughing, angered, or been surprised
____ Have you been told of any abnormal behaviors during sleep
____ Have you awakened short of breath or gasping for air
____ Do you Stop breathing during sleep
____ Difficulty waking in the morning
____ Do not feel tired at bedtime
____ Do you function best in the evening
____ Do you have jaw pain in the morning
____ Has daytime sleepiness affected your job or school performance
____ Do you sweat during sleep
____ Do you sleep better in unfamiliar settings
____ Do you have nightmares
____ Do you drink caffeine within 2 hours of bedtime
____ Have you ever had sudden attacks of sleeping
____ Do you watch TV in bed before falling asleep.
____ Have you had increased irritability or trouble thinking
____ Do you fall asleep easily while riding as a passenger
____ Have you ever fallen asleep while driving or when stopped
____ Do you have Loud Snoring
____ Your snoring is worse on your back
____ Do you have family members who snore
____ Do you feel very sleepy during the day
____ Does your bed partner disturb your sleep
____ Do you feel refreshed on waking
____ Do you ever have chest pain or palpitations
____ Do you have cramping in your legs at night
____ Does movement help the legs feel better
____ Restless legs are worse at night
____ You have restless feelings in your legs
____ Do you do physical activity before bed
____ Your bedroom is quiet and dark
____ Do you sleep with pets
____ Do you worry excessively in bed
____ Have you been told you talk in your sleep
____ Have you been told you walk in your sleep
____ Do you grind your teeth at night
____ Do you read before falling asleep
____ You have restless feelings in your legs

SNORING AND SLEEP APNEA

PLEASE DESCRIBE:

How often do you snore? ________________________________

How many years have you been snoring? ________________________________

If so, How severe is your snoring? ________________________________

Has your snoring become progressively worse? ________________________________

Have you ever awakened because of your snoring? ________________________________

In what positions do you snore? (please check all that apply) ▯ Back ▯ Side ▯ Stomach ▯ Sitting

Which best describes your pattern of snoring? ▯ Continuously ▯ Occasionally ▯ Rarely
▯ I snore, stop breathing then snore again

PAST MEDICAL HISTORY:

___ Gastric Reflux
___ Fibromyalgia
___ Hypothyroidism
___ Enlarged Prostrate
___ Depression
___ Seizures
___ Epilepsy
___ Memory Issues
___ Restless Legs
___ Emphysema / COPD
___ Asthma
___ Hay Fever /Allergy
___ Pulmonary Hypertension
___ Other Lung Disease
___ Cancer/Type_____________
___ Angina
___ Atherosclerotic heart disease or heart attack
___ Cardiac Arrhythmia (irregular heart rate)
___ Hypertension
___ Stroke
___ Diabetes
___ Congestive Heart Failure
___ High Cholesterol / Triglycerides
___ Edema (water retention)

REVIEW OF SYSTEMS

- Have you gained __ No __ Yes or lost __ No __ Yes WEIGHT in the past 12 months? How much? ________
- Do you regularly have a problem breathing through your nose? ____ No ____ Yes
- If you are male, have you had problems with Impotency? ____ No ____ Yes How long? ______________
- Do you become short of breath with physical exertion (walking / exercise)? ____ No ____ Yes
- Do you have a Chronic Cough? ____ No ____ Yes – ____________________________________
- Do you have excessive Phlegm or sputum? ____ No ____ Yes – ____________________________
- Do you have episodes of Wheezing or chest tightness? ____ No ____ Yes – ____________________
- Do you have Swelling of your ankles or feet? ____ No ____ Yes – ___________________________
- Do you have difficulty Swallowing Food, Indigestion, heartburn, or regurgitation of acid back into your chest or mouth (Reflux)? ____ No ____ Yes - ____
- Have you had any change in your usual Bowel Habits recently, such as constipation, change in shape, color, etc.? ____ No ____ Yes – ____
- Have you had any difficulty when urinating, such as burning, blood in urine, or poor urine stream? ____ No ____ Yes – ____
- Have you experienced any neurologic problems, such as:
  1. persistent loss of sensation ____ No ____ Yes– ______________________________
  2. loss of muscle strength ____ No ____ Yes– ______________________________
  3. poor coordination, clumsiness, balance difficulty ____ No ____ Yes– ________________
     ____
  4. memory loss? ____ No ____ Yes– ______________________________
     ____

- Do you have any persistent Arthritis, joint pains, or other musculoskeletal discomfort? ____ No ____ Yes
- Do you have excessively Dry Skin? ____ No ____ Yes – ____
- Do you have a strong preference for a cool __ No __ Yes or warm __ No __ Yes environment? ____
- Describe any other persistent symptom(s) important to you: ____

MEDICATIONS

Please list all the current medications, vitamins, herbal supplements, and oxygen you currently take and the doses

ALLERGIES: If none, please state so, otherwise list them.

Name	Reaction	Name	Reaction

OPERATIONS:	YEAR		YEAR

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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

SITUATION	CHANCE OF DOZING (0–3)
Sitting and reading	
Watching television	
Sitting inactive in a public place (e.g. a theater 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 a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL SCORE	