Innovative
Sleep Centers

NEW PATIENT REGISTRATION

Our office strives to understand your sleep symptoms, which may be complex in nature.
Thank you for taking the time to complete this questionnaire.

PERSONAL INFORMATION

Name (Last, First, M.I.): | **DOB:**

Gender: ☐ Male ☐ Female | **Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Social Security #: | **Email:**

Address: | **Primary phone #:** / **Secondary phone #:**

Primary Insurance: | **Secondary Insurance:**

Referring Provider: | **Primary Provider:** | **Pharmacy:**

EMERGENCY CONTACT

Name: | **Relationship:** | **Phone:**

DEMOGRAPHIC INFORMATION

Race:
☐ White ☐ African American ☐ Asian
☐ Decline ☐ Other _____

Ethnicity:
☐ Not Hispanic or Latino ☐ Latino ☐ Decline
☐ Other _____

Preferred Language:
☐ English ☐ Spanish ☐ Other _____

HISTORY OF PRESENT ILLNESS

Please indicate the main symptoms for which you seek help from our sleep clinic:

☐ SNORING ☐ SLEEPINESS ☐ PAUSES IN BREATHING ☐ RESTLESS LEGS ☐ INSOMNIA ☐ TEETH GRINDING ☐ OTHER

Briefly explain:

Are you here because of Commercial Driver's License Renewal? ☐ YES ☐ NO

Have you been evaluated in a sleep clinic in the past? ☐ YES ☐ NO **If YES please complete the section directly below*

Have you had an overnight sleep study before? ☐ YES ☐ NO

When? _____ Where? _____

Have you ever used CPAP/BIPAP/BIPAP-ST/ASV treatment before? ☐ YES ☐ NO If yes, for how long?_____

Do you use supplemental oxygen at home? ☐ YES ☐ NO When? ☐ Daytime ☐ Nighttime ☐ Both

Name: _____

HISTORY

Have you had any of the following surgeries? ☐Nasal surgery ☐Palate Surgery ☐Tonsillectomy ☐Adenoidectomy

Do you have a current/past medical history of:

High blood pressure	☐ YES	☐ NO	A. Fib	☐ YES	☐ NO	Chronic pain	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Heart failure	☐ YES	☐ NO	Seizure disorder	☐ YES	☐ NO
O2 Therapy	☐ YES	☐ NO	Heart disease	☐ YES	☐ NO	Alzheimer/Dementia	☐ YES	☐ NO
COPD	☐ YES	☐ NO	Stroke	☐ YES	☐ NO	Thyroid Disorder	☐ YES	☐ NO

SLEEP SCHEDULE	WORK DAY	DAY OFF
Typical Bed Time:		
How long does it take you to fall asleep?		
How many times do you awaken per night?		
How long does it take you to fall back to sleep?		
Typical wake up time:		
Do you take naps?		

MEDICATIONS

Name the Drug	Strength	Frequency Taken

MEDICATION ALLERGIES

Name the Drug	Reaction You Had

Does any of your <u>immediate family</u> members (mother, father, brother, sister) have a history of:

Sleep apnea	☐ YES	☐ NO	Heart disease	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Seizure disorder	☐ YES	☐ NO	Alzheimer/Dementia	☐ YES	☐ NO

Name: _____

SOCIAL HISTORY & GENERAL HABITS

Employment Status:	**Job Occupation:**	**Start:** _____ am/pm
☐ Full-Time ☐ Part-Time ☐ Temporary/Per Diem		**End:** _____ am/pm
☐ Unemployed ☐ Student ☐ Retired ☐ Disabled		If shifts vary, please specify:

Do you drink caffeine? ☐ YES ☐ NO

How many cups per day: ☐ 1 – 2 ☐ 2 – 3 ☐ 3 – 4 ☐ more than 4

Do you use caffeine to treat or fight off fatigue or sleepiness? ☐ YES ☐ NO

Alcohol: ☐ YES ☐ NO	**Tobacco:** ☐ YES ☐ NO	**Substance Use:** ☐ YES ☐ NO
How Much _____	**How Much** _____	**Current:** ☐ YES ☐ NO
Frequency _____		How Long/When _____
		Type:_____

Exposure to Chemicals: ☐ **None** ☐ **Mercury** ☐ **Arsenic** ☐ **Lead** ☐ **Others** _____

REVIEW OF SYMPTOMS

CONSTITUTIONAL:	◯	fevers	◯	weight loss	◯	night sweats
EYES,NOSE,THROAT:	◯	runny nose	◯	congestion	◯	sore throat
CARDIOVASCULAR:	◯	chest pain	◯	racing heartbeat		
RESPIRATORY:	◯	cough	◯	short of breath		
GASTROINTESTINAL:	◯	nausea	◯	abdominal pain		
URINARY:	◯	frequency	◯	incontinence		
MUSCULOSKELETAL:	◯	joint pain	◯	stiffness	◯	swelling
NEUROLOGICAL:	◯	headaches	◯	memory loss	◯	seizures

SLEEP RELATED OCCURANCES

Please identify how often you experience the following symptoms or behaviors by placing a check under "YES" or "NO"	**YES**	**NO**
My family complains I snore loudly	□	□
I snore so loud that my bed partner has moved into another room	□	□
I have been told that I stop breathing in my sleep	□	□
I awake suddenly gasping for breath, unable to breathe	□	□
At night my heart pounds, beats rapidly, or beats irregularly	□	□
I frequently wake up with a dry mouth	□	□
I have had an overnight oxygen test before (different from sleep study)	□	□
I frequently wake up with congestion	□	□
I sweat a great deal at night	□	□
I frequently wake up in the middle of the night to urinate	□	□
I have morning headaches	□	□
My weight has changed within the last 6 months	□	□
I have heart burn (gastro esophageal reflux)	□	□

Name: _____

Please identify how often you experience the following symptoms or behaviors by placing a check under "YES" or "NO"	**YES**	**NO**
I am very sleepy during the day and I struggle to stay awake	□	□
I fall asleep during quiet activities (watching TV, reading, sitting)	□	□
I have trouble doing my job because of sleepiness or fatigue	□	□
I often have to let someone else drive because I am sleepy	□	□
I have night time leg cramps	□	□
My bed partner says I kick my legs in my sleep	□	□
I grind my teeth	□	□
I have nightmares	□	□
I have been told that I walk or talk in my sleep	□	□
I act out my dreams (Violent behavior during sleep)	□	□
I have trouble getting to sleep	□	□
At bedtime, thoughts race through my mind	□	□
My concentration/ memory skills are poor	□	□
I feel sad and/or irritable frequently due to lack of sleep	□	□
I feel refreshed after a nights sleep	□	□
I wake up with my body feeling paralyzed	□	□
I have episodes of sudden muscle weakness when I laugh, get angry, etc.	□	□
I have dream-like images (hallucinations) as I drift into sleep or as I awaken	□	□
When falling asleep, I have "restless legs" (an urge to move)	□	□

EPWORTH				
SITUATION (what is your chance of dozing?)	**NEVER - 0**	**SLIGHT - 1**	**MODERATE - 2**	**HIGH – 3**
Sitting and reading				
Watching television				
Sitting, inactive, in a public place (e.g. theater, meeting, bus)				
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 alcohol				
In a car, while stopped for a few minutes in traffic				
			TOTAL:	**/ 24**

CONTACT
Please choose one of the two options to get your results
□ Over the phone
□ Schedule an appointment to come in

Name: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may also see your record or request a copy of these records via our web portal. Call our office to set up an account. Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge I was offered the Notice of Privacy Practices.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal)

Persons who can obtain medical records other than the patient:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

Appointments: If you are unable to keep your appointment for an office visit or sleep test, please provide us with a minimum of 48-hours' notice so that another patient may be scheduled during that time. Failure to provide us with this advanced notice will result in a $100 fee for sleep studies, and $75.00 for office visits. **NOTE: This fee cannot be passed on to your insurance company.**

Co-Payments: This is the portion of the bill your insurance requires you to pay. This payment is to be collected at time of service. We accept cash, check, or credit card as form of payment.

Prescription Refills: Please call your pharmacy whenever you need a prescription refilled, even if your bottle indicates no refills available. This process may take up to 3-5 business days depending on the medication that is ordered.

Payment for Services: I understand that I am individually responsible for all payments of any charges and to determine eligibility with my insurance company. I am aware that these policies may change without notice and a copy of this agreement is available to me at my request.

I understand and accept the terms and policies above that apply to Innovative Sleep Centers

_____

Patient or legally authorized individual signature Printed Name Date