Name_____
DOB_____

Sleep Medicine Associates of Texas, P.A.

SLEEP HISTORY

These questions should be answered by you keeping in mind the following:
a) Answer them in relation to the last 6 months, unless otherwise specified.
b) A "weekday" should be thought of as any day that you routinely work.
c) If you are engaged in shift work or have any type of unusual sleep/wake schedule, "day" and "night" should be interpreted as your major wake and sleep periods respectively.

NAME DATE

My main sleep complaint involves (mark all that apply and describe):

☐ trouble sleeping at night ☐ being sleepy all day ☐ unwanted behaviors during sleep (explain below) ☐ other

Please describe your sleep problem(s):_____

My sleep/wake problem began (date and details):_____

What have you done to treat your problem? _____

I hope the Sleep Medicine Associates staff will help me by:_____

Form 207b

DALLAS SLEEP DISORDERS QUESTIONNAIRE

Sleep Medicine Associates of Texas, P.A.

Name:_____ **DOB**___/___/___ **Weight**_____**lbs Date**_____

Before your appointment, please rate yourself by **circling number 1 to 7** that most closely describes the degree or the frequency that you are bothered by a particular complaint or problem.

1 None or Never	2 Very Slight or Rarely	3 Slight or Seldom	4 Moderate or Occasionally	5 Major or Often	6 Great or Very Often	7 Very Great or Always

1)	1 2 3 4 5 6 7	How often do you fall asleep during the day when you are still or not busy?
2)	1 2 3 4 5 6 7	How often do you awaken feeling unrested even after adequate hours of sleep?
3)	1 2 3 4 5 6 7	How often do you suffer from unexplained fatigue or tiredness during the day?
4)	1 2 3 4 5 6 7	How often do you awaken feeling really sleepy or groggy?
5)	1 2 3 4 5 6 7	How great of a problem do you have with snoring?
6)	1 2 3 4 5 6 7	How often has a bed partner noted you stop breathing during sleep?
7)	1 2 3 4 5 6 7	How often is your sleep disturbed by other breathing problems? (Describe:_____)
8)	1 2 3 4 5 6 7	Do you suffer from headaches on awakening?
9)	1 2 3 4 5 6 7	How often do you awaken from heartburn or stomach acid in the mouth?
10)	1 2 3 4 5 6 7	How great of a problem do you have getting to sleep?
11)	1 2 3 4 5 6 7	How often do you wake up and have trouble falling back to sleep?
12)	1 2 3 4 5 6 7	How much do you toss and turn during your sleep?
13)	1 2 3 4 5 6 7	How often has a bedpartner noted that your legs twitch or kick in your sleep?
14)	1 2 3 4 5 6 7	How often are you troubled by restless or "creepy" legs in the evening or night?
15)	1 2 3 4 5 6 7	How often do you feel completely paralyzed or "stuck" when just falling asleep or waking up?
16)	1 2 3 4 5 6 7	How often do you hallucinate people, voices, or sounds in the room when just falling asleep or when just awakening?
17)	1 2 3 4 5 6 7	How often during the day do you have episodes of sudden muscular weakness when laughing, angry, or in other emotional situations?
18)	1 2 3 4 5 6 7	How often do you have unusual behaviors in your sleep? (Circle type(s) of sleep behavior: walking, screaming out, nightmares, violence, eating, confusion, _____, _____).
19)	1 2 3 4 5 6 7	How much does your current sleep problem affect your family life?
20)	1 2 3 4 5 6 7	How much does your current sleep problem affect your work performance?
21)	1 2 3 4 5 6 7	How much does your current sleep problem affect your sense of well being?
22)	1 2 3 4 5 6 7	How often is your sleep disturbed by other problems? (Describe below).

Comments: _____

Try to be specific with the following questions and avoid using ranges (example: Do not write "8-10 pm" or "5 to 6 times"). Please rate your answer based on your average night.

23) What time do you usually go to bed? _____ am / pm

24) How long does it usually take you to fall asleep after deciding to go to sleep? _____ minutes

25) How many times do you wake up during a typical night? _____ times

26) What are the total hrs. of sleep that you usually get at night? _____ hours _____ minutes

27) What time do you usually arise for the day? _____ am / pm

Form 207c

Medical History

Name_____ DOB ___/___/___ Date_____

1) Height _____ inches 2) Weight _____lbs 3) Last physical exam (year)? _____

4) In the last 12 months how many pounds have you (circle appropriate term) gained or lost? _____

5) Do you currently smoke? yes no

If no, but you smoked in the past, how long has it been since you stopped? _____

For how many years did (have) you smoke(d)? _____

How many (circle type of usage) cigarettes, cigars, or pipefuls of tobacco do (did) you use daily? _____

6) Briefly list below the health problems you have had and their treatment:

System	Type of Problem/Treatment	Date	Treating Physician, Clinic, or Hospital
Respiratory conditions (asthma, COPD, etc.)			
Eyes, ears, nose, throat/mouth (glaucoma, sinus, obstruction, allergies, surgery, etc.)			
Heart, circulation, blood pressure			
Stomach, digestive disorders			
Kidney, urological or sexual disorders			
Head/nervous system (e.g. head trauma, convulsions)			
Psychological or psychiatric			
Accidents injuries (e.g. bone fracture, dislocations)			
Surgical operations (e.g. tonsillectomy, nasal surgery, hysterectomy, etc.)			
Other conditions (e.g. painful conditions, hormone abnormalities, diabetes, thyroid, etc.)			

- Continued -

Medical History – (continued)

Name_____

7) List the amounts of the following beverages you consume. If not used daily, list in the far right column the average per week.

Beverages	Daily	After 6:00 pm	Weekly
Cups of coffee			
Decaffeinated coffee (cups)			
Tea (glasses or cups)			
Carbonated drinks (cans/bottles)			
Beer, wine, liquor (cans/drinks)			
Recreational drugs (list below)			

8a) List all medications (prescribed by a doctor or non-prescribed (Unisom, Sominex, Vivarin, Melatonin, etc.) that you have ever taken **for your sleep problems** including herbal, holistic, or natural medications.

Medication for Sleep	Dose	Times Daily	Helpful?	Date Started	Use It Now?	Date Stopped?	Prescribing Doctor

8b) Apart from the sleep medicines listed above, name **all other medications** you are currently taking (prescribed or otherwise): **Including herbal, holistic, natural medications, etc.**

Current Medication(s)	Dose	Times Daily	Reason	How Long Used?	Prescribing Doctor

8c) **Any known medication allergies?** _____

_____

- Continued -

Medical History – (continued)

Name_____

9) Family Health History: For each family member, write current age or age at death, present state of health (good, fair, poor) or cause of death, as well as sleep problems (snoring, insomnia, sleepiness, etc.) and major illnesses.

Relationship	If Living, Age / Health	If Deceased, Age/ Cause	Sleep / Medical Problems
Father			
Mother			
Spouse			
Brother(s)			
Sister(s)			
Children			

10) Treating Physicians

List name, address, and phone number of primary care physician.	List name, address, and phone number of treating physician (if not your primary care physician).

Use the space below for additional comments that you may wish to make about your health, or intake of drugs, medicines, or alcohol.

BED PARTNER QUESTIONNAIRE

(Please ask someone who has watched you sleep to complete this form)

Patients Name_____Date:_____

Observer's Name:_____ Relationship to Patient:_____

I have observed this person's sleep:

❑ Once or Twice ❑ Often ❑ Almost Every Night

Check any of the following behaviors that you have observed this person doing ***while asleep.***
Circle those that you consider **severe problems** for this person.

- ❑ light snoring
- ❑ loud snorts
- ❑ pause in breathing (how long?_____ seconds)
- ❑ twitching or kicking of legs
- ❑ sleep talking
- ❑ bed-wetting
- ❑ awakening with pain
- ❑ getting out of bed not awake
- ❑ becoming very rigid and/or shaking
- ❑ apparently sleeping even if he/she behaves otherwise
- ❑ loud snoring
- ❑ choking
- ❑ gasping for air
- ❑ twitching or flinging of arms
- ❑ grinding teeth
- ❑ sitting up in bed not awake
- ❑ head rocking or banging
- ❑ biting tongue
- ❑ crying out
- ❑ other_____

If this person snores, what makes it worse?

❑ sleeping on his/her back ❑ sleeping on his/her side ❑ alcohol ❑ fatigue

Does the snoring sometimes require you or your partner to sleep separately? ❑ Yes ❑ No

Modified Epworth Sleepiness Scale

As an observer, please complete the following information on your estimation of the chances of his/her dozing in the following situations. (Even if none of these things have occurred recently, try to work out how they would have affected him/her.) Use the scale below to choose the most appropriate number for each situation.

Scale	Situation	Chance of Dozing
0 – would never doze 1 – slight chance of dozing 2 – moderate chance of dozing 3 – high chance of dozing	Sitting & Reading	
	Watching TV	
	Sitting inactive in a public place (i.e.: theater)	
	As a car passenger for an hour without a break	
	Lying down to rest in the afternoon	
	Sitting & talking to someone	
	Sitting quietly after lunch without alcohol	
	In a car, while stopping for a few minutes in traffic	
	Total Score	

-Continued-

BED PARTNER QUESTIONNAIRE - (CONTINUED)

Patient's Name_____

Does this person drink alcohol? ❑ Yes ❑ No

If yes, this person usually drinks: (check as many as you believe appropriate)

❑ beer ❑ wine ❑ shots of liquor

Please estimate the **per week** use of:

_____ 12 oz. bottle/can/tap **BEER**

_____ 6-8 oz. glasses of **WINE**

_____ 1-12 oz. **LIQUOR**

Please estimate how much this person drinks in the 3 hours before bed:_____

Do you consider this person's drinking a problem? ❑ Yes ❑ No ❑ Uncertain

Comments:_____

If this person uses street drugs, please describe both the types and frequency of usage:

_____

_____

_____

_____

_____

Do you believe that this person and yourself share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/drug usage? ❑ Yes ❑ No

Comments:

_____

_____

_____

_____

_____

EPWORTH SLEEPINESS SCALE

Name:_____ Date:_____

In Contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (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**
Sitting & Reading	_____
Watching TV	_____
Sitting inactive in a public place (i.e. theatre)	_____
As a car passenger for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting & talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopping for a few minutes in traffic	_____
TOTAL SCORE	_____

Patient Registration Form

Patient's Legal Name (last, first, middle)		E-Mail		Sex	Date of Birth	Marital Status
Social Security Number	Home Phone	Business Phone	Cell Phone			
Address, City, State, Zip						
Emergency Notification	Relationship	Home Phone	Other Phone			

Insured's Legal Name if different from patient (last, first, middle)		Relationship to Patient	Date of Birth
Social Security Number	Home Phone	Business Phone	Other Phone
Address, City, State, Zip (if different from above)			
Employer Name			Employer Phone
Primary Insurance Company Name	ID Number		Group Number
Mailing Address, City, State, Zip			Benefits Phone Number
Secondary Insurance Company Name	ID Number		Group Number
Mailing Address, City, State, Zip			Benefits Phone Number

Insurance Policy:
Payments of our fees are your responsibility and are due in full at the time of service. As a courtesy to you, we will verify benefits and file our charges with your insurance carrier. The guarantor and/or patient agrees to:

1. ***Verification of coverage and benefits is not a guarantee of payment.***
   - **The information provided to us by your insurance company may be inaccurate. It is the patient's responsibility to clarify this information directly with their insurance company.**
2. Pay any portion of our fees that are not covered by the insurance company, excluding contracted rates.
3. Respond to requests from their insurance company for additional information in order to process claim(s).
4. Monitor claims filed with the insurance company by reviewing the "Explanation of Benefits" (EOB's) received from the insurance company, and by calling to check the status of outstanding claims.

Out of Network with Your Health Insurance Plan
If we are not a participating provider ("Out of Network") with your health insurance plan, please call your insurance company to clarify your out of network benefits. Please understand that insurance carriers have established usual and customary fees for reimbursement. Since we are not a contract provider with your insurance company, our standard fees may not be consistent with the usual and customary fees established by your insurance company.

Financial Agreement/Assignment of Benefits:
As the responsible party (guarantor and/or patient), I hereby assign to Sleep Medicine Associates of Texas, P.A. (physician practice), any and all payments of health insurance benefits and all interest and rights (including causes of action and the right to enforce payment) for services rendered under any insurance policies or any reimbursement or prepaid health care plan. If my condition was caused by events, which result in legal action, I assign to the physician practice an interest in any claims I may have. I hereby promise to pay for all services rendered to me to the extent I am legally responsible for such payment; I understand I am financially responsible for all health insurance deductibles, co-payments, coinsurance, and any services not covered by my insurance policy. I also agree to accept the terms of the above listed Physician Practice Insurance Policies.

Signature of Guarantor and/or Patient Date