Marshall Sleep Disorders Center

PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE:______________________________

Name:____SSN#________________________________
Last First MI

Address:____
Street City State zipcode

Date of Birth:_________________________Age:________________________________Sex: M F

Height:___________________ Weight:____________________

Home Phone: (   ) _____________________ Work Phone: (   ) ______________________________

Cell Phone: (   ) ______________________ Pharmacy Name/City:_____________________________

Employer: ____

Martial Status: ( )S ( )M ( )D ( )W Birthplace: ______________________________

Spouse/Significant Other's name: ____

In case of an emergency: _____________________________________ Phone: ___________________________
(other than home/work)

Nearest relative:____ Phone: ___________________________
(other than emergency #, please list relation)

Family Physician:____ Phone: ___________________________

Referring physician: ____ Phone: ___________________________

Insurance: ____ Name of Insured: _________________________

Please list insured's full name, date of birth, place of employment, and SSN:

____

May we inquire as to how you heard about our sleep center so we may thank them for their kind words?

____

Marshall Sleep Disorders Center

RECORDS RELEASE

I hereby authorize & request the Sleep Disorder Center of MMC to release any & all of my records in their possession to my primary care physician, referring physician, medical facility, durable medical equipment supplier, pharmacy, or any other health care providers referred by my sleep specialist.

______________________________	______________________________	______________________________
Patient signature	**Sleep Center Personnel**	**Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

______________________________ DOB___________SSN#____________________

Authorizes:

____

To release my records to:

____

Please release the following:

____NPSG scored results ____Physician's admission/discharge orders
____NPSG Interpretation ____Any follow up since NPSG
____MSLT scored results ____Lab/Xray results
____MSLT Interpretation
____MMPI Interpretation ____Other:
____History & Physical ___________________________

Reason information is being released: ____

I voluntarily allow the release of the above information. No threat or other coercive measures have Induced me to sign this consent form. I understand this information will not be forwarded to anyone else by the recipient without my written consent.

I understand that I may revoke this consent at any time except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this document will be null & void after 60 days or on:

____.

______________________________/__________ ______________________________/_________
Signature of patient date Signature of staff member date

____ ____
Relative Relationship to patient

____
Reason patient can not sign

PROHIBITION ON REDISCLOSURE: If the information disclosed contains data related to alcohol, drug abuse, psychiatric, or psychosocial impairment, the information has been disclosed from records whose confidentiality is protected by Federal Law (42 CFR Part 2). The rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains to or as otherwise by (42 CFR Part 2)

Marshall Sleep Disorders Center: ***Sleep History Questionnaire***

What is your main sleep problem? ____

When did this problem begin? ____

(Circle one) Is your problem: Increasing Decreasing Remaining the same

Do you snore when you sleep? YES______ NO________

If you do snore, please circle in which position: ALL BACK SIDES STOMACH

Has anyone ever told you that you stop breathing at night? YES_______ NO_________

*********_**CURRENT MEDICAL INFORMATION**_*************************************

Are you currently receiving medical treatment? YES________ NO____________

If yes, please provide the following information:

Current Illness (i.e. high blood pressure, diabetes, heart problems, thyroid, depression, etc)

1.________________________ **2.**________________________

3.________________________ **4.**________________________

Current Medications (please list dose also)

1.________________________ **5.**________________________

2.________________________ **6.**________________________

3.________________________ **7.**________________________

4.________________________ **8.**________________________

How would you describe your current state of health? Excellent___ Good___ Moderately___ Fair___ Poor___ Very Poor___

Do you have problems with nasal congestion, obstruction, or discharge? YES_____ NO______

Do you use nasal decongestants (tablets, sprays, etc.) to help you get to sleep? YES___ NO___

For office use only:

Interviewed By: Date:

*****<u>***PAST MEDICAL HISTORY***</u>**

Have you ever had a sleep study before? YES______ NO______ What year?______________

Name & Phone number of sleep center you were tested at:___________________________________

Are you currently using Oxygen or CPAP? YES______ NO_______ Supplier________________

Please list all <u>past</u> major medical problems below:

Illness/Surgery/Accident	**Date:**
1. ____	________________________________
2. ____	________________________________
3. ____	________________________________
4. ____	________________________________

Have you ever had a head injury? YES______ NO_______

Any complications with surgery and/or anesthesia? If so please explain:

____

____

List any medications you might be allergic to and the side affect:

____

*****<u>***CURRENT HABITS***</u>***
Do you drink alcohol? YES___ NO___ If so, how much and how frequently?______________
Do you drink coffee, tea, or soda? YES___ NO____ If so, how much per day?_____________
Do you smoke? YES____ NO____. If so, number of packs per day?________________
Do you exercise regularly? YES____ NO_____
How often do you eat (including snacks) within two hours of trying to go to sleep?____________
Are you on a diet right now? YES____ NO____ How long since you started?______________
Are you currently taking anything (herbal, homeopathic, prescription, pharmacy over the counter)for your general health or to help with your sleep? YES____ NO_____ Product:________________

******<u>***DAYTIME FUNCTIONING***</u>**Do

Do you feel **FATIGUE (**tiredness, exhaustion, lethargy) in the daytime even when not sleepy?
NO____ Infrequently____ Occasionally_____ Often____ Always_____

Do you feel **SLEEPY** (or struggle to stay awake) in the daytime?
NO____ Infrequently____ Occasionally_____ Often____ Always_____

If so, under what circumstances do you fall asleep easily?
____Driving ____After Meals ___Meetings, class, church
____Other ____On the phone ___Watching/TV/Reading

Physician's Notes:

Have you had a car accident or near miss because of falling asleep driving? YES____ NO_____
Were you sleeping well before the incident, or had you been keeping late hours, etc?___________________________________
____

Do you fall asleep during the day enough to interfere with your (check all that apply): School work_____
Household chores?_______ Marriage/Relationships?_______ Job performance?_______

How often do you feel alert and energetic for an entire day?
Never_____ Upon Occasion_____ Most of the time_____ All of the time________

Do you take naps (international and/or unintentional) during the Day? YES______ NO_______
If yes, please list the time and frequency below:____
____

Do you feel refreshed after your naps? YES_______ NO_______

Do any of your sleep problems seem to go in cycles or recur at regular intervals? YES___ NO___
Describe the cycle:____

On a scale of 1 to 5 (1 being worst, 5 being best)

Morning?	1	2	3	4	5
Midday?	1	2	3	4	5
Afternoon?	1	2	3	4	5
Late Afternoon?	1	2	3	4	5
Evening?	1	2	3	4	5

*****_**MOOD**_***

Has your memory been getting worse lately? ____________________________________
Have you had difficulty concentrating lately? ____________________________________
Have you been feeling more irritable lately? ____________________________________

Have you ever been treated for depression, anxiety, or severe stress? YES______ NO______

If yes, what were the circumstances and how were you treated?____
____

How much stress would you say you were under right now?____

If you are under stress, is it related to: Work___ Personal life___ Other___

Have you been feeling: Hopeless___ Helpless___ Useless___?

Have you seriously thought about suicide recently?____

How is your appetite?____

How much weight have you: Lost_____ or Gained_______ in the past year?

Physician's Notes:

*****<u>***CURRENT SLEEP HABITS***</u>***

Do you sleep alone? YES_____ NO______

If NO, who sleeps in bed with you? Spouse___ Significant Other____ Child/Parent____

Do you have any pets that sleep in the bed with you? YES______ NO_______

Do you consider **yourself** to be a:

Very good sleeper____ Moderately poor sleeper____
Moderately good sleeper_____ Very poor sleeper_____

Do you consider **bed partner** to be a:

Very good sleeper____ Moderately poor sleeper____
Moderately good sleeper_____ Very poor sleeper_____

How regular are your sleep habits?

Very Regular ______ Usually quite irregular ______
Usually quite regular _____ Very irregular ______

Weekdays, what time do you usually go to bed?____________ Does this vary by: Minutes______ Hours______?

Weekdays, what time do you get up in the morning? ____________ Does this vary also?________

Approximately how long does it take you to fall asleep after turning out the lights?_________________

When you wake up during the night, how difficult is it for you to go back to sleep?_________________

If you can't sleep, do you get out of bed? YES____ NO____

Do you watch television to help you sleep? YES____ NO____

How many on times do you wake up at night on average?____

How many hours do you feel you actually sleep on weeknights? ___________________________Hours

Do you keep the same sleep schedule on weekends (or days off from work)? YES____ NO____

If no, what is your bedtime:____________ Waking Time:____________ and do you feel better on weekends? YES___ NO___

How often do you get up at night to provide care for someone (child, invalid, spouse)?______________________________

How often is your sleep disturbed because of pain or discomfort?_______________________________________

Describe your normal work hours: (i.e. do you work Mon-Fri 9-5, list all jobs and time of work)

____

____

If you do shift work, how often does your shift change?____

In general, what effect does shift work have on your sleep complaint?

____Marked worsening ____Some worsening ____No effect

____Some improvement ____Marked improvement ____Precipitates problem

Physician's Notes:

How do you feel when you wake up to start your day?

____Alert, Awake ____Energetic ____Refreshed ____Anxious

____Drowsy, Sleepy ____Low Energy ____Confused ____Depressed

****

In response to intense ***Emotion*** (laughter, anger, and surprise) have you felt sudden muscle weakness in your legs, neck, or other

extremities? (This does not refer to known muscle or joint problems, or to lightheadedness.)

YES__________ NO____________. Please describe the emotions involved and what muscles went limp:___________________

____

Before you are fully asleep do you have very vivid, sometimes frightening, hallucination like dreams?

YES_____ NO_____.

Have you ever awakened from sleep and found your body was "paralyzed" and you couldn't move at all, even though you

could breath and see? YES______ NO________

Do you have difficulty falling asleep because your legs are restless or have crawling sensation?

YES____ NO_____

***********Family Sleep History***

Has any member of your family been diagnosed with a sleep problem? YES_____ NO_____

If yes, what was the diagnoses, and what is their relation to you?____

____

Has any member of your family died in their sleep? YES______ NO_______

Physician's Notes:

****_**CHILDHOOD SLEEP HISTORY**_**

Please check any of the following sleep behaviors that occurred when you were a child or an adolescent:

____Sleep Walking ____Sleep talking ____Bed Wetting

____Twitching/Jerking ____Head Banging ____Night terrors/Screaming & Shouting

____Snoring/Asthma ____Grinding teeth ____Excessive sleepiness in school

____Seizures in Sleep ____Insomnia ____Inability to sleep until very late at night

****

During your sleep, do you currently (in the last six months) have problems with the following:

SYMPTOM	ALWAYS	MOST of the TIME	OCCASIONALLY	NEVER
Chocking/Gasping				
Shortness of breath				
Chest pains				
Heart palpitations				
Night sweats				
Increased urination				
Tossing and turning				
Leg or body jerks				
Grinding teeth				
Sleep walking				
Shouting/nightmares				
Falling out of bed				
Back pains while asleep				
Heartburn/gas pains				
Anxiety/ panic attacks				
Cold feet at night				
Morning Headaches				
Dry mouth in morning				
Any other unusual Behavior (please describe below)				

Behavior:____

Physician's Notes:

PLEASE READ CAREFULLY

How likely are you to doze off or fall asleep in the following situations, in contrast to simply feeling 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 affect 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:

Sitting and reading	**0**	**1**	**2**	**3**
Watching television	**0**	**1**	**2**	**3**
Sitting, inactive in a public place (movie or meeting)	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon (when circumstances permit)	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**

Score_________

****

IMPORTANT!!
Please list the names and addresses of all doctors you want a copy of your test result to go to:

____

____

____

____

Is there anything else you feel is important about your sleep/medical/psychological history that we may not have covered? YES_____ NO_____
Please feel free to write below and use another sheet of paper if needed.

Name of person answering this questionnaire:____

Thank you for your cooperation

Physician's Notes: