

DATE: _____



UNIVERSITY SLEEP DISORDERS CENTER

Patient Medical and Sleep History Questionnaire

Patient Name: _____ Date of Birth: _____ Email: _____

Address: _____ City, State: _____ Zip: _____

Cell Phone: _____ Home/Alternate Number: _____ Emergency Contact: _____

Social Security Number: _____ Referring Physician: _____

Height: _____ Weight: _____ Neck Size: _____

Please circle: Male/Female Race: _____ Marital Status: _____

Please List all medications that you are currently taking.

Allergies _____ Pharmacy Name/Location _____

Current symptoms or illnesses _____

Medical History (Have you ever been diagnosed with any of the following? Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anxiety Disorder (anxiety attacks) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Deviated Septum |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> GERD – Gastro Esophageal Reflux |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Prostate Disease |
| <input type="checkbox"/> Cancer | |

Other:

Cardiovascular History (Have you ever been diagnosed with any of the following? Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Balloon Angioplasty or Stents |
| <input type="checkbox"/> Cardiac Surgery for Coronary Bypass | <input type="checkbox"/> Cortication of the Aorta |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Diastolic Dysfunction | <input type="checkbox"/> Enlarged Heart |
| <input type="checkbox"/> Heart Attack – Myocardial Infarction | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hyperlipidemia |
| <input type="checkbox"/> Hypertension (High blood pressure treated or untreated) | <input type="checkbox"/> LVH – Left Ventricular Hypertrophy |
| <input type="checkbox"/> Internal Defibrillator | <input type="checkbox"/> Nocturnal Ischemia |
| <input type="checkbox"/> Microalbuminuri | <input type="checkbox"/> Peripheral Arterial Disease |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ventricular Arrhythmia |
| <input type="checkbox"/> Stroke or TIA | |
| <input type="checkbox"/> Cardiac Surgery for valve replacement | |

List any other Cardiovascular Conditions that you have or have had in the past. _____

Surgical History (Have you ever had any of the following surgical procedures? Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Deviated Septum | <input type="checkbox"/> Gastric Bypass |
| <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Herniated Disk Repair |
| <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Spinal Fusion |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Repair of broken bone |
| <input type="checkbox"/> UPPP | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Lung transplant |
| <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Coronary Bypass Surgery (CABG) | |

Please list any other surgical procedures that you have had. _____

Past Sleep Diagnosis - In the past have you been diagnosed with any of the following? Please check all that apply.

- Sleep Apnea
- Periodic Limb Movement
- Insomnia
- Restless Legs Syndrome
- Narcolepsy
- Seizures

Have you had a sleep study performed in the past? _____

If so, with what doctor/facility? _____

Home Care:

Do you currently have a CPAP machine in your home? _____YES _____NO

If so, how many hours per night are you wearing your CPAP mask?_____

Do you have oxygen in your home? _____YES _____NO

How many hours per day are you wearing oxygen? ____During hours of sleep?__ During daytime?____

Do you require the use of any special equipment/devices such as a wheelchair or lift, etc.?__YES__NO

If yes, explain_____

Family History (Have any of your blood relatives ever been diagnosed with any of the following? Check all that apply.)

- Premature Cardiovascular Death (died from heart disease when they were younger than 70 years of age)
- Stroke or TIA
- Sudden Cardiac Death
- Heart Attack
- Coronary Artery disease
- Arrhythmia
- Congestive Heart Failure
- Obstructive Sleep Apnea
- Died in their sleep

Current Sleep Schedule:

During the Week

What time do you normally go to bed on weeknights? _____

What time do you normally get out of bed on weekdays? _____

Do you nap on weekdays? _____ What time do you nap? _____

How long are your naps? _____

On Weekends

What time do you normally go to bed on weekends? _____

What time do you get out of bed on weekends? _____

Do you nap on weekends? _____ What time do you nap? _____

How long are your naps? _____

Sleep Habits

Do you watch television in bed prior to going to sleep? _____

How long is the television left on? _____ hrs. _____ all night

Do you read in bed prior to sleeping? _____

How long do you read in bed prior to turning the lights off? _____

Generally speaking, your challenges with going to sleep at night are related to. (Check all that apply)

- Temperature in bedroom.
- Assisting others
- Pets
- Pain or discomfort
- Restless Legs (creepy crawly feelings in your legs)
- Thoughts running through your mind
- Inability to settle down
- Going to bed prior to being sleepy
- Anxiety
- Fear of not being able to go to sleep or not being able to get enough sleep
- Bed Partner Activities (snoring, reading, lights on, TV on, restless sleep, etc)
- Noise
- Telephone
- Uncomfortable Bed

During the night your sleep is disturbed by? (Check all that apply)

- Noise
- Others requiring your assistance (pets or people)
- Difficulty breathing or shortness of breath (especially when lying flat)
- Chest pain
- Leg cramps
- Other leg discomfort
- Pain or discomfort
- Need to go to the bathroom
- Hunger
- Thirst
- Unusual movements (such as sleep walking or sleep eating)
- Abdominal pain or gas
- Back or joint or muscle pain
- Difficulty breathing through your nose

Please list any other disturbances that you experience. _____

Have you ever been told or are you aware that you do any of the following? (Check all that apply)

- Talk in your sleep
- Walk in your sleep
- Physically act out your dreams during sleep?
- Have you ever awakened to find that you had eaten after going to sleep with no memory of having gotten up to eat.?
- While sleeping, awake to find that you are in a different location other than where you went to sleep.
- Snore
- Stop Breathing
- Move your legs or arms repeatedly in sleep
- Sweat excessively
- Kick or move frequently
- Have tingling in your arms or legs.
- Grind your teeth when sleeping?
- Nightmares or scary dreams

When going to sleep or waking from sleep, do you ever experience a feeling of paralysis? _____

Have you ever experienced a loss of muscle tone or muscle weakness when experiencing strong emotions such as surprise, happiness, fear or sadness? _____

Do you experience vivid dream like sequences that happen when you are awake? _____

Do you experience uncontrollable urges to take brief naps? _____

Work History:

Do you work? _____ What type of work do you do? _____

What time do you go to work? _____ What time do you leave work? _____

Do you experience difficulty doing your job because of sleepiness? _____

Do you experience difficulty driving because of sleepiness? _____

Social Activities

Do you smoke cigarettes or cigars? _____ Did you in the past? _____

Have you quit smoking? _____ How long ago? _____

Do you drink alcoholic beverages? _____ How many a day? _____

Do you use any recreational drugs? If so, please explain _____

How much caffeine do you consume in an average day? _____

How much caffeine do you consume after 2 pm? _____ (caffeine includes chocolate, coffee, tea, soda, some diet/stimulant products)

Do you exercise daily? _____

If so please describe type, frequency and at what time of the day. _____

General Questions

Do you wear dentures? _____ partial _____ complete _____

Do you sleep in a bed or a recliner? _____

Do you require assistance to get in and out of bed at night? _____

Do you use oxygen when sleeping? _____ How much oxygen do you use? _____

When is your sleep most disrupted? first part of the night middle of the night early morning

Do you wake-up too early? _____ Do you feel that you get enough sleep? _____

Do you have difficulty concentrating because you are sleepy or tired? _____

Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired? _____

Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired? _____

Do you have difficulty completing errands because you are too sleepy or tired to drive? _____

Epworth Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation:

- 0 = would *never* doze or sleep.
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Stopped for a few minutes in traffic while driving	0	1	2	3
Total score				

SLEEP CENTER USE ONLY

Clinical Indications:

- | | |
|--|---|
| <input type="checkbox"/> Daytime Sleepiness | <input type="checkbox"/> Overweight/Obese |
| <input type="checkbox"/> Observed apnea episodes | <input type="checkbox"/> Cognitive difficulty |
| <input type="checkbox"/> Awakening, gasping or choking | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Restless legs |
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> History of Stroke |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Other: _____ |

Suspected Diagnosis Sleep Apnea Insomnia RLS/PLMD Other: _____

Notes: _____

PATIENT NAME/DOB: _____ DATE: _____
SLEEP STAFF SIGNATURE: _____ DATE: _____

Name: _____

Date of birth: _____

Date: _____



183 E University Dr, Auburn, AL 36832

AUTHORIZATION FOR MEDICAL TREATMENT: The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of University Sleep Disorders Center. The undersigned understands that no guarantee or assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

INFORMATION PRIVACY: University Sleep Disorders Center will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, copies available upon request. The undersigned acknowledges receipt of this information.

RELEASE OF INFORMATION: University Sleep Disorders Center is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, etc. I agree that University Sleep Disorders Center may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payor for treatment purposes. I also authorize University Sleep Disorders Center to utilize medical information attained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is protected. **I give University Sleep Disorders Center authorization to release my information to the following individuals** (you may leave blank):

_____, _____, _____
_____, _____, _____

ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to University Sleep Disorders Center for application on their patient's bill. The undersigned, and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

FINANCIAL AGREEMENT: The undersigned agrees that in consideration for the services to be rendered to the patient, he-she individually agrees to be totally responsible for all charges for services such as DURABLE MEDICAL SUPPLIES or any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by specialist and by physicians from whom University Sleep Disorders Center is authorized to bill. I, the undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a 33.3 % collection fee, attorney fees, and/or court costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. All delinquent balances shall bear interest at the legal rate.

MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits also apply.

MISCELLANEOUS PROVISIONS: I consent to receive calls, e-mails, and/or text messages regarding my healthcare information and other healthcare-related services at the phone number(s) given. I understand I may be charged for calls to my wireless phone by my wireless carrier, and that calls may be generated by an automated dialing system. I further understand I may revoke this consent at any time by notifying my healthcare provider in writing. I understand that under no circumstances will University Sleep Disorders Center be liable for property of patients.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPTS THE TERMS THEREOF.

University Sleep Disorders Center complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Patient's signature if over 14 years old

Signature of Parent/Responsible party

Date and time of signing

Relationship to Patient

RELEASE OF INFORMATION REQUEST

University Sleep Disorders Center
183 E. University Dr.; Auburn, AL 36832
Ph# 334-209-6555 Fax # 256-329-3339

Patient Name: _____ **Date of Birth:** _____

The person named above hereby authorizes University Sleep Disorders Center to:

- Request health information from
- Send health information to

The person named above authorizes information to be requested or released by representatives of:

Name of Person, Provider, or Facility: _____

Phone: _____ Fax: _____

Scope:

- All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- All information regarding care received by patient between the dates of _____ and _____.
- Other information (specify): _____

Signature of Patient or Representative

Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- Parent or guardian of minor child
- Guardian or conservator of conserved patient
- Beneficiary or personal Representative of a deceased individual

The above named patient has the following rights:

1. I understand I may revoke this authorization in writing at any time except to the extent where information has previously been disclosed.
2. I understand this consent may include disclosure of records related to treatment of : (Please initial each)
___Alcohol and/or Drug Abuse ___Psychiatric ___Sexually Transmitted Disease ___ HIV/AIDS
3. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by and may no longer be protected by Federal Law.
4. I understand this authorization will expire upon completion of the request information.
5. I understand my health care and the payment for my health care will not be affected if I do not sign this form.
6. I understand I may receive a copy of this form upon my request.

HIPAA EMAIL CONSENT

Please read if you intend to request medical documents via email.

Under HIPAA (*Health Insurance Portability and Accountability Act*):

- * HIPAA is a law passed in 1996 to maintain privacy and security protections for patients' health information.
- * Information stored in our computer system is encrypted. **However, most email services** (ex. Yahoo, Gmail, Hotmail, etc.) **are not encrypted**. Therefore, information passed via email (to or from our office from your personal email account) also may not be encrypted.
- * **It is possible that information sent through non-encrypted channels may be accessed by a third party** since it is transmitted via the internet, **OR** a third party which gains access to your email account may gain access to the information.
- * HIPAA guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient consents to still receive private health information via email, then a healthcare provider may send that patient medical information via unencrypted email.

- This guideline is viewable on page 5634 of the HIPAA PDF at:

US Department of Health and Human Services -
<http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>

YES - I understand the risks of unencrypted email and **give permission** for University Sleep Disorders Center to email my personal health information via unencrypted email:

Patient/representative signature: _____ Date: _____

Email address: _____

NO - I understand the risks of unencrypted email and **DO NOT give permission** for University Sleep Disorders Center to email my personal health information via unencrypted email:

Patient/representative signature: _____ Date: _____

University Sleep Disorders
Center
183 E University Dr
Auburn, AL 36832
Fax 256-329-3339
Alt. Fax 334-329-7776



UNIVERSITY SLEEP DISORDERS CENTER
183 E. University Dr. Auburn, AL 36832
334-209-6555

OWNERSHIP DISCLOSURE

I understand that Fred A. McLeod, M.D. and his wife, Jenn McLeod, CRNP, PhD, have an ownership interest in University Sleep Disorders Center, University CPAP, LLC, Sleep South Diagnostics Center, and Sleep South Diagnostics Durable Medical Equipment (DME) company.

I understand that I always have a choice in which medical facility, hospital, sleep center or DME company that I choose to have my testing or treatment with, or to make purchases from.

I understand that any choice I make will not alter the care that I receive at Southern Head and Neck Surgery.

I understand that I am always free to choose from the available options for any of my recommended care.

Signed by

Date



Policy For Completing Disability or FMLA Paperwork

- For disability, FMLA or any other forms filled out by our office, the patient must complete their portion of the form(s) BEFORE turning it in to the office.
- Each form must be paid for separately **when** it is turned in to the office.
- Forms will be returned to the patient in 7-10 business days.

Patient cost per form to be completed:

- 1 – 4 pages = \$30.00
- 5 or more pages = \$50.00

The patient must pick up completed forms at one of our office locations.

CONSENT FOR FMLA PAPERWORK

I, _____, understand that by signing this waiver I agree to pay the full amount listed below to obtain the completed FMLA paperwork I have requested from Dr. McLeod. I understand that all FMLA paperwork will be held until the full amount has been paid.

I have read, understand, and have a copy of the consent and information sheet regarding Dr. McLeod filling out any and all FMLA paperwork.

PATIENT NAME (PRINT): _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

AMOUNT DUE: _____ (THIS AMOUNT IS DUE PRIOR TO ANY FMLA PAPERWORK BEING FILLED OUT)

**Please allow 7-10 business days for all FMLA paperwork to be filled out.
Our office will notify you once your paperwork is finished.**

University Sleep Disorders
Center
183 E University Dr
Auburn, AL 36832
Fax 256-329-3339
Alt. Fax 334-329-7776