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**_____
Current symptoms or illnesses_____

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

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

Other:

_____

_____

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

- ☐ Angina
- ☐ Arrhythmia
- ☐ Atrial Fibrillation
- ☐ Balloon Angioplasty or Stents
- ☐ Cardiac Surgery for Coronary Bypass
- ☐ Cortication of the Aorta
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Diastolic Dysfunction
- ☐ Enlarged Heart
- ☐ Heart Attack – Myocardial Infarction
- ☐ High Cholesterol
- ☐ Chest Pain
- ☐ Hyperlipidemia
- ☐ Hypertension (High blood pressure treated or untreated)
- ☐ Internal Defibrillator
- ☐ LVH – Left Ventricular Hypertrophy
- ☐ Microalbuminuria
- ☐ Nocturnal Ischemia
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ Stroke or TIA
- ☐ Ventricular Arrhythmia
- ☐ 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.)

- ☐ Deviated Septum
- ☐ Gastric Bypass
- ☐ Hip Replacement
- ☐ Herniated Disk Repair
- ☐ Knee Replacement
- ☐ Spinal Fusion
- ☐ Tonsillectomy
- ☐ Repair of broken bone
- ☐ UPPP
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Lung transplant
- ☐ Kidney Transplant
- ☐ Heart Valve Replacement
- ☐ 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, where?_____

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 he/she was 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 his/her 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

<u>During the night</u> 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:

____ Daytime Sleepiness
____ Observed apnea episodes
____ Awaking, gasping or choking
____ Headaches
____ Loud Snoring
____ Hypertension
____ Cardiac Disease
____ Overweight/Obese
____ Cognitive difficulty
____ Fatigue
____ Restless legs
____ Irritability
____ History of Stroke
____ Other: _____

☐ RLS/PLMD ☐ Other:

Suspected Diagnosis ☐ Sleep Apnea ☐ Insomnia _____

Notes: _____

SLEEP STAFF SIGNATURE: _____ DATE: _____

Name: _____

Date of Birth: _____

Date: _____

University Sleep Disorders Center
334-209-6555
1891 Honeysuckle Road Suite 1
Dothan, AL 36305

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
1891 Honeysuckle Road Suite 1 Dothan, AL 36305
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
1891 Honeysuckle Road Suite 1
Dothan, AL 36305
Fax 256-329-3339

University Sleep Disorders Center
334-209-6555

1891 Honeysuckle Road Suite 1
Dothan, AL 36305-4291

OWNERSHIP DISCLOSURE

I understand that Fred A. McLeod,M.D. and his wife, Jenn McLeod,CRNP,PhD. has an ownership interest in University Sleep Disorder Center.

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 University Sleep Disorder Center.

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

_____ _____

Signed by Date