Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

Owensboro Advanced Sleep Center

Describe your sleep problem and how long you've had it_____
_____

_____

Have you ever been seen at a sleep center before? YES NO When? _____

Where? _____ Have you ever been on CPAP? YES NO

Work Schedule:

When does your usual work shift start? _____ AM or PM

When does your usual work shift end? _____ AM or PM Do you do shift work? YES NO

Sleep Schedule: **Weekday** **Weekend** **Weekday** **Weekend**

Average Time you go to bed _____ _____ Time you get up _____ _____

How long does it take you to go to sleep? _____ minutes How often do you wake up during the night? _____

How many hours do you sleep each night? _____ on average

Do you take planned naps? YES NO How many days per week? _____ On average, how long are naps?_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life recently.

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

0 = would NEVER doze **2 = MODERATE chance of dozing**

1 = SLIGHT 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, such as a meeting or church	**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	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch (when you have not had alcohol)	**0**	**1**	**2**	**3**
In a car, while stopped in traffic	**0**	**1**	**2**	**3**
TOTAL				

Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

Bed Partner Questionnaire: Ask someone familiar with your sleep to answer the following section about you (spouse, parent, child, or other.) ***Name of person filling out this section*** _____

Does the patient…	**Circle Your Answer Below**
Stop breathing in his/her sleep?	Yes No
How often do the pauses in breathing occur?	Every Night Occasionally Never
Snore Heavily?	Yes No
Make loud snorting or choking noises during sleep?	Yes No
Snore Every Night?	Yes No
Snore in the follow positions:	Back Left Side Right Side All Positions
Move legs or feet during sleep frequently?	Yes No
Violent activity during sleep like punching or kicking?	Yes No

Comments _____

SLEEP REVIEW OF SYSTEMS

Are you frequently tired or drowsy during the day? Yes No

Have you had any accidents or problems at work due to drowsiness? Yes No

Have you had any traffic accidents, near misses or hit the rumble strip due to drowsiness? Yes No

Has anyone told you that you snore loudly? Yes No

Have you awakened with a dry mouth or "cotton mouth"? Yes No

Has anyone told you that you quit breathing or hold your breath at night? Yes No

Do you ever wake up choking or gasping? Yes No

Do you ever wake up with chest pain? Yes No

Do you wake up with heartburn, sour taste in the mouth, burning in the chest or indigestion? Yes No

Do you have trouble breathing through your nose at night? Yes No

Do you have trouble breathing through your nose during the day? Yes No

Do you wake up with headaches? Yes No

How many pillows do you sleep on at night? _____

How many times do you get up during the night to urinate, on average? _____

EXCESSIVE DAYTIME SOMNOLENCE

Do you have any sudden episodes of sleepiness during the day? Yes No

Have you ever had periods in which you feel paralyzed while going to sleep or waking up? Yes No

Have you ever had visual hallucinations or dream-like mental images when falling to sleep? Yes No

Have you ever experienced sudden physical weakness during laughter or strong emotion? Yes No

RESTLESS LEGS

When you try to relax in the evening, do you ever have unpleasant or restless feelings in your legs? Yes No

INSOMNIA: Do you take a sleep aid or sleeping pill? Yes No If Yes, please list: _____

Do you have difficulty falling asleep at night? Yes No

Do you have difficulty staying asleep? Yes No

Do you have pain that bothers you at night? Yes No

MOOD

Over the past two weeks, have your felt down, hopeless or depressed? Yes No

Over the past two weeks, have you felt little interest or pleasure in doing things? Yes No

Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

PARASOMNIAS

Do you sleepwalk? Yes No
Do you wet the bed at night? Yes No
Do you ever wake up screaming? Yes No
Do you eat in your sleep? Yes No
Do you talk in your sleep? Yes No
Do you act out your dreams during sleep? Yes No
Do you have frequent nightmares? Yes No
Do you grind your teeth in your sleep? Yes No

CHILDHOOD Did you have childhood sleep problems of any type? Yes No
If yes, Describe (such as sleepwalking, bedwetting, sleep terrors) _____

TOBACCO Ever smoked? Yes No …….. If yes, how many years? _____ Packs per day? _____
Do you still smoke? Yes No …….. If no, when did you quit? _____

ALCOHOL/DRUGS Do you drink alcohol? Yes No
If yes, how often? _____ days/wk How much on average? _____
Have you ever had a problem with drinking too much alcohol? Yes No

CAFFEINE and OTHER SUBSTANCES
Regular caffeinated coffee_____ cups/day Energy drinks Yes No
Soft drinks with caffeine? Yes No ……. If yes, How many cans of soda per day? _____
Do you drink tea with caffeine? Yes No…….. If yes, how many cups/glasses of tea per day _____
Do you currently use street drugs? Yes No ……. Any illicit drug usage in the past? Yes No

MEALS/EXERCISE How many meals do you eat daily? _____ Do you exercise regularly? Yes No

WEIGHT CHANGE during past 5 years → Gained _____lbs. or Lost _____lbs.

SOCIAL HISTORY
Occupation: _____ ( ) Retired ( ) Disabled
Marital Status: ( ) Single ( ) Married ( ) Divorced Other: _____
Number of children: _____
Who is currently living in your household? _____

SURGICAL HISTORY Circle or check all that apply and dates of surgery (year)

Tonsils & Adenoids	Cardiac Bypass	Gall Bladder
Nose or Sinuses	Appendectomy	Hysterectomy
Back Surgery:	Knee or Hip:	Other:

Other Surgery: _____

OTHER ILLNESSES Circle or check all that apply

Diabetes	High Blood Pressure	Emphysema or COPD	Cancer
Stroke	Irregular Heart Beats	High Cholesterol	Kidney Disease
Depression	Coronary Artery Disease	Migraines	Stomach Ulcers/ Reflux
Anxiety	Chronic nasal congestion	Thyroid Disease	Seizures

Other ILLNESSES_____

How did you hear about Owensboro Advanced Sleep Center and/or Dr. Pope?
□ Family □ Friend □ My Doctor □ previously saw Dr. Pope □ Newspaper □ Website □ Facebook □ TV
□ Other (please explain if you wish) _____

Name: _____ D.O.B: _____ Age: ____ Gender: M F Date of Service: _____

REVIEW OF SYSTEMS: Check the boxes of any symptoms that YOU have.

EYES, ENT
- □ Blurry vision
- □ Allergies
- □ Double vision
- □ Dry Eye
- □ Dry mouth
- □ Nose bleed
- □ Nasal congestion
- □ Nasal blockage
- □ Hoarseness
- □ Ear pain
- □ Sore throat
- □ Neck lumps

GENERAL
- □ Weight change
- □ Fatigue
- □ Night sweats
- □ Concentration
- □ Memory Loss

HEART
- □ Chest pain or heaviness
- □ Swelling of ankles/legs
- □ Racing or pounding heart
- □ Palpitations

STOMACH & GI TRACT
- □ Heartburn
- □ Nausea/Vomiting
- □ Trouble swallowing
- □ Constipation
- □ Diarrhea
- □ Bright blood in stool
- □ Stool black as Tar

GENITOURINARY
- □ Trouble emptying the bladder
- □ Incontinence
- □ Urgency
- □ Frequent urination during the day
- □ Loss of sex drive or performance

MUSCULOSKELETAL
- □ Back Pain
- □ Neck Pain
- □ Arthritis
- □ Joint swelling

PULMONARY
- □ Chronic cough
- □ Cough up phlegm daily
- □ Pleurisy
- □ Cough up blood
- □ Short of breath
- □ Wheezing
- □ Asthma

NEUROLOGIC

□ Headaches □ Numbness □ Tingling □ In-coordination □ Dizziness
□ Light headedness □ Imbalance □ Weakness □ Forgetfulness □ Irritability
□ Slurred speech □ Seizures □ Tremors □ Passing out □ Stroke

PSYCHOLOGICAL

□ Personality changes □ Loss of Interest □ Angry □ Withdrawn □ Mood swings
□ Depression □ Suicidal Thoughts □ Sad □ Crying spells □ Nervous

****

FAMILY HISTORY Circle the Conditions and then List Affected Family Members

CONDITION	AFFECTED FAMILY MEMBER	CONDTION	AFFECTED FAMILY MEMBER
Diabetes	_____	Narcolepsy	_____
Heart Disease	_____	Daytime Sleepiness	_____
High Blood Pressure	_____	Depression or Anxiety	_____
Stroke	_____	Restless Legs	_____
Obesity	_____	Sleep Apnea	_____
Other – Describe	_____		

Please bring a current list of your medications (including vitamins and over the counter medications) or the medications in their original containers.

ALLERGIES:

Please List any medication allergies:_____

One final question: What is your goal or what do wish to accomplish by this visit to the Sleep Center?

_____

_____

Thanks for taking the time to complete this questionnaire!! Revised Oct 2012

□ **Owensboro Heart & Vascular**
□ **Owensboro Primary Care**
□ **Immediate Care Center**
□ **The Hancock Clinic**
□ **The McLean Clinic**
□ **The Muhlenberg Clinic**
□ **Owensboro Advanced Sleep Center**
□ **Owensboro Physical Therapy**
□ **Owensboro Medical Practice Laboratory**

OWENSBORO
Medical Practice

DATE: _____

MRN#: _____

Dear Valued Patient,

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information in PRINT. All Information is Confidential and is only released with consent.

PATIENT INFORMATION

Patient Name				Date of Birth	Sex	Age	
Patient's Social Security Number	Home Telephone Number			Cell Phone Number			
Home Address	City	State	Zip				
Mailing Address if Different	City	State	Zip				
Race: Asian	Black/African American	More than one race	Native Hawaiian or other pacific Islander	Other Race	Unknown	White	Hispanic/Latino
Please Circle all that apply:	Married	Widowed	Single	Separated	Minor	Student	Smoker	Veteran
Preferred Language	Primary Care Physician			Email Address			
Employer's Name	Work Telephone Number			Driver's License No.			
Employer's Address	City	State	Zip				

LEGAL GUARDIAN/SPOUSE INFORMATION

Legal Guardian/Spouse Name	Social Security Number	Date of Birth	
Employer's Name	Work Telephone Number		
Employer's Address	City	State	Zip

NOTIFY IN CASE OF EMERGENCY

Contact Name (not living with you)	Relationship	Contact Name	Relationship
Home Telephone Number	Date of Birth	Home Telephone Number	Date of Birth

POLICY HOLDER INSURANCE INFORMATION

Primary Policy Holder Name		Secondary Policy Holder Name	
Social Security Number	Date of Birth	Social Security Number	Date of Birth
Name of Insurance	ID/Group Number	Name of Insurance	ID/Group Number
Phone Number		Phone Number	

ACCIDENT INFORMATION

Were You Injured on the Job? YES NO		Were you involved in an Auto Accident? YES NO	
Have you Informed Your Employer? YES NO		Claim Number:	
Original Injury Date:		Time of Injury:	State Injury Occurred:
Worker's Compensation/Auto Insurance Carrier Name		Billing Address	

AUTHORIZATIONS

I hereby authorize examination and any other medical services deemed necessary. I authorize Owensboro Medical Practice to forward results of any tests and/or medical services to medical facilities or insurance companies including Workers Compensations that they may require concerning my case. I authorize and request my insurance company/companies to pay directly to Owensboro Medical Practice, PLLC, the amount due them in my pending claim for medical, surgical or laboratory services. I understand any balance remaining after insurance payment or denial is my responsibility and that interest may be charged on accounts due past 90 days. I agree my records may be used and reviewed during quality assurance programs. I hereby release Owensboro Medical Practice from liability for any loss or damage to property which is brought to or kept in the facility during treatment.

DATE_____SIGNATURE_____PRINTED_____

OWENSBORO
Medical Practice

□ Owensboro Heart & Vascular
□ Owensboro Primary Care
□ Immediate Care Center
□ The Hancock Clinic
□ The McLean Clinic
□ The Muhlenberg Clinic
□ Owensboro Advanced Sleep Center
□ Owensboro Physical Therapy

DATE: _____

CHART #: _____

PATIENT'S NAME: _____

PRIVACY CONSENT FORM FOR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT AND PAYMENT

- I consent to Owensboro Medical Practice, PLLC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out Owensboro Medical Practice's health care operations.
- I consent to Owensboro Medical Practice, PLLC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity.
- I consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- o Chemical Dependency/Substance Abuse
  - Drugs
  - Alcohol
- o Sexually Transmitted Diseases

I further acknowledge Owensboro Medical Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

(LIST FAMILY OR FRIENDS WE CAN DISCUSS REGARDING YOUR MEDICAL CARE AND/OR BILL)

NOTE: This release is applicable for any of the Owensboro Medical Practice entities listed at the top of this form.

RELEASE INFO TO: _____

_____

_____

□ Please check if office is able to leave message on answering machine or voice mail.

DATE: _____ **SIGNATURE:** _____