Texas Christiancare SLEEP CENTER, LLC

PATIENT DEMOGRAPHICS

____NPSG ____CPAP ____CPAP Retitration ____Split Night

PATIENT INFORMATION:

Name: Last _____ First _____ Middle Initial _____
Address:_____City:_____State:_____Zip:_____
Social Security #: _____ DOB: _____ Gender: _____ Age: _____
Phone Number: _____ Cell: _____Work: _____
Employer: _____ Occupation: _____
Referring Physician: _____ Phone: _____
Primary Care Physician: _____ Phone: _____
Emergency Contact Person:_____ Phone: _____
E-mail_____

INSURANCE INFORMATION:

Primary Insurance: _____
Insured Person's Name (if different): _____ Relation: _____
Insured Person's Employer (if different): _____
Insured Person's Social security Number: _____ DOB: _____
ID# _____ Group # _____ Effective Date: _____

SECONDARY INSURANCE INFORMATION:

Secondary Insurance: _____
Insured Person's Name (if different): _____ Relation: _____
Insured Person's Employer (if different): _____
Insured Person's Social security Number: _____ DOB: _____
ID# _____ Group # _____ Effective Date: _____

_____ _____/_____/_____
Patient Signature Date

ChristianCare
SLEEP CENTER, LLC

SLEEP HISTORY
(TO BE COMPLETED BY PATIENT)

Name: _____ Date: _____/_____/_____

Spouse or emergency contact(s): _____

Send copy of results to (e.g., family physician, internist): _____

CHIEF COMPLAINT

Check any of the following that apply:
____Loud snoring
____Breathing or snoring stops for brief periods in my sleep

My MAIN sleep problem has bothered me:
____Awaken gasping for breath
____Do not feel restored when I awaken
____Become sleepy during the day
____sitting ____talking
____riding ____eating
____driving ____standing
____Difficulty falling asleep
____Difficulty remaining asleep
____Awaken too early

[ ] 1 to 2 years
[ ] longer than 2 yrs.
[ ] several months to 12 months
[ ]within the last 3 months
[ ]within the last month

SLEEP TREATMENT

I was previously diagnosed with:
___Sleep apnea When? _____ Where? _____

My prior treatment included:
____CPAP or BiPAP
Indicate treatment level (if known) _____cm H2O
____Oral appliance
____Sinus, deviated septum or turbinate reduction
____Restless legs syndrome
____Uvulopalatopharyngoplasty
____Laser or other procedure on uvula
____Mandibular surgery
____Tonsils and/or adenoidectomy

When? _____ Where? _____ Treatment: _____

___Periodic limb movements
When? _____ Where? _____ Treatment: _____

___Narcolepsy
When? _____ Where? _____ Treatment: _____

___Insomnia
When? _____ Where? _____ Treatment: _____

SYMPTOMS DURING SLEEP

Indicate ON AVERAGE how often you experience the following symptoms especially when sleeping or trying to sleep:

Times per week

None	1-3	4-6	Daily	Symptom
				My mind races with many thoughts when I try to fall asleep
				I often worry whether or not I will be able to fall asleep
				Fatigue
				Anxiety
				Memory impairment
				Inability to concentrate
				Irritability
				Depression
				Awaken with a dry mouth
				Morning headaches
				Pain which delays or prevents my sleep
				Pain which awakens me from sleep
				Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
				Inability to move as you are trying to go to sleep or wake up
				Sudden weakness or feel your body go limp when you are angry or excited
				Irresistible urge to move legs or arms
				Creeping or crawling sensation in your legs before falling asleep
				Legs or arms jerking during sleep
				Sleep talking
				Sleep walking
				Nightmares
				Fall out of bed
				Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
				Bed wetting
				Frequent urination disrupting sleep
				Teeth grinding
				Wheezing or cough disrupting sleep
				Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
				Shortness of breath disrupting sleep

SLEEP HABITS

Please answer the following questions as accurately as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week then indicate your schedule using the "shift work" column.

Activity	Usual schedule	Weekends	Shift Work
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
I usually wake up from sleep at			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
Do you take naps and, if so, for how long?			
Begin work time			
End work time			

If you do rotating shift work, or have other work schedule changes and need more space to describe:

_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Please check if you have had any of the following:

( ) Heart disease List type: (e.g., CHF)_____ ( ) Diabetes ( ) Depression
( ) High blood pressure ( ) Asthma/Emphysema ( ) Reflux ( ) Thyroid condition
( ) Fibromyalgia ( ) Anxiety ( ) Seizures ( ) Parkinson's disease
( ) Stroke ( ) Head Injury or brain surgery

( )Pain which disrupts sleep. The typical location(s) for this pain is/are:
___Headaches ___Neck ___Back ___Chest ___Limb (arm(s) or leg(s))
___Abdominal ___Pelvic ___Joint (arthritis)

( )Other medical problems which may affect sleep (please list):_____
_____
_____
_____

WEIGHT

What is your weight? _____ 1 year ago _____ 5 years ago _____
What is your collar size?_____ 1 year ago _____ 5 years ago _____

MEDICATION

Do you take anything to help you sleep? Y/N
What?_____ How often?_____

List current medications and dosages, including both prescriptions and over-the-counter medications:
_____
_____
_____
_____

Are you on supplemental oxygen? Yes___ No ____ If yes, how much? _____ (Liters/min)

SOCIAL HISTORY

Do you smoke? _____ Did you previously smoke? _____
How many years of smoking? _____ How much per day? _____
Do you drink alcohol? _____ How much? _____ drinks per (day/week/month) (please circle)
How much caffeinated coffee, tea or cola do you drink daily? _____
What do you usually do at work? _____

ENVIRONMENT

Is your bedroom (loud/quiet) and (light/dark)? (please circle)
Is your mattress (soft/hard/just right)? (please circle)
Do you go to sleep with the television on? Yes ___ No ___
Is your sleep disturbed because of your bed partner or others in your household (children or pets)? Yes ___ No ___

FAMILY HISTORY (Please check all that apply)

Is there a family history of:	**Apnea**	**Snoring**	**Narcolepsy**	**Insomnia**	**Restless Legs Syndrome**	**Other sleep disturbances**
Mother						
Father						
Sister(s)						
Brother(s)						
Grandparent(s)						

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 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 and reading ……	_____
Watching TV ……	_____
Sitting, inactive, in a public place (e.g., a theater or a meeting) ……	_____
As a passenger in a car for an hour without a break ……	_____
Lying down to rest in the afternoon when circumstances permit ……	_____
Sitting and talking with someone …….	_____
Sitting quietly after a lunch without alcohol …….	_____
In a car, while stopped for a few minutes in traffic ……..	_____
Total	_____