The Arlington Sleep Disorder Center

Patient Medical History Page One

Date: _____/_____/_____ Patient Name: _____

DOB: _____/_____/_____ Age: _____ Height: _____ inches Weight: _____ lbs Race: _____

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Occupation: _____

Primary Care Physician: _____ Referring Physician: _____

Sleep Complaint: _____

_____

Past Medical History Please answer all questions to the best of your ability.

Do you now or have you ever had :

Tuberculosis (TB)	☐ Yes	☐ No		Lung Disease	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No		Thyroid Disease	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No		Stomach Disease	☐ Yes	☐ No	
Diabetes (Blood sugar high or low)	☐ Yes	☐ No		Intestinal Disease	☐ Yes	☐ No	
Heart Attack	☐ Yes	☐ No		Peptic Ulcer	☐ Yes	☐ No	
Other Heart Disease	☐ Yes	☐ No		Liver Disease	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No		Seizures	☐ Yes	☐ No	

Please explain all "Yes" answers:

_____

_____

Habits

Do you now or have you ever used:

1. Tobacco (smoke cigarettes, chew tobacco, etc.) ☐ Yes ☐ No If yes, indicate amount per day: _____
   If yes, how long ? _____ years Have you quit? ☐ Yes ☐ No If yes, when? _____
2. Alcohol (beer, liquor, wine, etc.) ☐ Yes ☐ No If yes, indicate amount per day: _____
   If yes, how long? _____ years Have you quit? ☐ Yes ☐ No If yes, when? _____
3. Caffeinated beverages (soda, coffee, tea, etc.) ☐ Yes ☐ No If yes, indicate amount per day: _____
   Have you quit? ☐ Yes ☐ No

Medications

Please list all medications you are currently taking. Please bring your packages/bottles with you to your appointment.

_____

_____

_____

Allergies

Please list medication allergies: _____

Operations

Please list any operations you have had:

	Date	Hospital	Doctor
Tonsillectomy	_____	_____	_____
Gallbladder	_____	_____	_____
UPPP	_____	_____	_____
Other	_____	_____	_____

Are you in good health now? ☐ Yes ☐ No If no, please describe your current health conditions/illnesses: _____

_____

_____

_____

Continued...

Patient Medical History Page Two

Patient Name: _____ DOB: _____/_____/_____

Do you have:

Frequent or severe headaches	☐ Yes	☐ No		Frequent cough	☐ Yes	☐ No	
Difficulty breathing through nose	☐ Yes	☐ No		Chronic nasal discharge	☐ Yes	☐ No	
Painful sinuses	☐ Yes	☐ No		Shortness of breath	☐ Yes	☐ No	
Allergies/Hayfever	☐ Yes	☐ No		Asthma or wheezing	☐ Yes	☐ No	
Dentures	☐ Yes	☐ No		Emphysema	☐ Yes	☐ No	
Smothering spells at night	☐ Yes	☐ No		Swollen legs	☐ Yes	☐ No	
Irregular heart beat	☐ Yes	☐ No		Heart enlargement	☐ Yes	☐ No	
Chest pain with exercise	☐ Yes	☐ No		Do you sleep on more than one pillow?	☐ Yes	☐ No	
Difficulty swallowing	☐ Yes	☐ No		Heartburn	☐ Yes	☐ No	
Voice changes/ hoarseness	☐ Yes	☐ No		Hiatal hernia	☐ Yes	☐ No	

Comments: (Please explain all 'yes' answers)

_____

_____

Chronic muscular pain	☐ Yes	☐ No		Pain in joints	☐ Yes	☐ No	
Localized muscle weakness	☐ Yes	☐ No		Arthritis	☐ Yes	☐ No	
Goiter or thyroid enlargement	☐ Yes	☐ No		High blood sugar	☐ Yes	☐ No	
Weight loss	☐ Yes	☐ No		Abnormal glucose tolerance test	☐ Yes	☐ No	
Weight gain	☐ Yes	☐ No					
Low blood pressure	☐ Yes	☐ No		Low blood sugar	☐ Yes	☐ No	
Anemia (low hemoglobin)	☐ Yes	☐ No		HIV or AIDS	☐ Yes	☐ No	

Comments: (Please explain all 'yes' answers)

_____

_____

History of Stroke	☐ Yes	☐ No		Personality changes	☐ Yes	☐ No	
Memory loss	☐ Yes	☐ No		Diagnosed Depression	☐ Yes	☐ No	
Difficulty moving or controlling part of your body	☐ Yes	☐ No		Difficulty sleeping	☐ Yes	☐ No	
				"Drop" or paralysis attacks	☐ Yes	☐ No	
Tremors or shakes in your arms or legs	☐ Yes	☐ No		Difficulty speaking	☐ Yes	☐ No	

Comments: (Please explain all 'yes' answers)

_____

_____

Sleep Assessment

The following questions will help us to obtain an understanding of your sleeping problems. It is extremely important that you answer these questions as completely as possible. There are some questions that your bedpartner or room-mate can be helpful with, such as snoring questions.

Do not spend too much time on these questions: your first impression is the best answer in most cases. Answer all questions by considering the past six months, unless otherwise specified. If you are engaged in shift work or other unusual sleep/wake schedule, refer to 'Daytime' as the times you would normally be awake, and 'Nighttime' when you would be sleeping.

1. How many miles do you drive to work each day? _____ Approximately how many miles per year do you drive? _____
2. On a scale of 1 to 10, with 10 being the worst or most problem, how much does sleepiness affect your: (circle one number)
   driving performance? 1 2 3 4 5 6 7 8 9 10 work performance? 1 2 3 4 5 6 7 8 9 10
3. Have you had driving accidents or 'near miss' incidents while driving related to sleepiness? ☐ Yes ☐ No
4. If the answer to number 3 is yes, How many accidents have you had due to sleepiness? _____
   How many near miss incidents have you had due to sleepiness? _____
5. What shift do you normally work? _____ Day /1st _____ Evening / 2nd _____ Night / 3rd _____ Swing
6. How many work related mistakes per year do you have associated with sleepiness? _____ Fatigue? _____
7. How many work related accidental injuries per year do you have associated with sleepiness? _____ Fatigue? _____
8. Do you normally work more than 40 hours per week? ☐ Yes ☐ No

Do you feel that you:

9. get too little sleep at night ☐ Yes ☐ No
10. get too much sleep at night ☐ Yes ☐ No

Continued...

Patient Medical History Page Three

Patient Name: _____ DOB: _____/_____/_____

How much of a problem do you have: (check box of best answer)	Not at all/ None	Slight/ Few times	Moderate/ Sometimes	Often	Severe/ Always
11. with going to sleep at night	☐	☐	☐	☐	☐
12. because of waking up during the night	☐	☐	☐	☐	☐
13. not feeling rested, no matter how much sleep you get	☐	☐	☐	☐	☐
14. with tiredness, not sleepiness, during the day	☐	☐	☐	☐	☐
15. with sleepiness during the day	☐	☐	☐	☐	☐

16. On a **weekday**, what time do you usually ...

Go to bed: _____am/pm get up: _____am/pm

Do you normally take naps: ☐ Yes ☐ No

If yes, how many per day? _____ What time(s)? _____

How long does your typical nap last? _____minutes / hours

17. On a **week-end or day off**, what time do you usually ...

Go to bed: _____am/pm get up: _____am/pm

Do you normally take naps: ☐ Yes ☐ No

If yes, how many per day? _____ What time(s)? _____

How long does your typical nap last? _____minutes / hours

18. Do you watch TV or read in bed before going to sleep? ☐ Yes ☐ No

If yes, how long? _____

19. Do you use sleeping aids or medicine? ☐ Yes ☐ No

If yes, please list: _____ how often do you use it? _____

20. How long are you in bed before deciding to go to sleep? _____ hours _____ minutes
21. How long does it take you to fall asleep after you have decided to? _____ hours _____ minutes
22. How many hours of sleep do you get in a typical night? _____ hours
23. How many times do you wake up in a typical night? _____ times
24. How long is a typical wake time? _____ hours _____ minutes
25. If you do awaken during your sleep, which part(s) of the night is it likely to happen?

_____ First third _____ Second third ____ Last third

26. How many times do you get out of bed in a typical night? _____ times
27. How long is the typical time out of bed during the night? _____ hours _____ minutes

When falling asleep, how often do you: (check box of best answer)	Not at all/ None	Slight/ Few times	Moderate/ Sometimes	Often	Severe Always
28. Have thoughts racing through your mind	☐	☐	☐	☐	☐
29. Feel sad or depressed	☐	☐	☐	☐	☐
30. Have anxiety, or worry about things	☐	☐	☐	☐	☐
31. Feel muscular tension	☐	☐	☐	☐	☐
32. Feel afraid of not being able to go to sleep	☐	☐	☐	☐	☐
33. Feel unable to move or paralyzed	☐	☐	☐	☐	☐
34. Notice parts of your body startle or jerk	☐	☐	☐	☐	☐
35. Experience restlessness in your legs (crawling or aching, unable to keep your legs still)	☐	☐	☐	☐	☐
36. Experience vivid, dreamlike scenes or hallucinations even though you are awake	☐	☐	☐	☐	☐
37. Experience pain or discomfort	☐	☐	☐	☐	☐

Continued...

Patient Medical History Page Four

Patient Name: _____ DOB: _____/_____/_____

Sleep Assessment (continued)

	Not at all/ None	Slight/ Few times	Moderate/ Sometimes	Often	Severe/ Always
During the night, how often do you:					
38. Sleep with someone else in your room	☐	☐	☐	☐	☐
39. Sleep with someone else in your bed	☐	☐	☐	☐	☐
40. Sleep on a special surface	☐	☐	☐	☐	☐
41. Have restless, disturbed sleep	☐	☐	☐	☐	☐
42. Disturb the sleep of your bed partner	☐	☐	☐	☐	☐
43. Provide assistance to someone or something else during the night	☐	☐	☐	☐	☐
44. Have nasal congestion	☐	☐	☐	☐	☐
45. Use nasal spray or other medication to deal with nasal congestion	☐	☐	☐	☐	☐
46. Snore	☐	☐	☐	☐	☐
47. Hold your breath or stop breathing	☐	☐	☐	☐	☐
48. Wake up gasping for air or feeling you can't breathe	☐	☐	☐	☐	☐
49. Wake with a choking sensation	☐	☐	☐	☐	☐
50. Have some other breathing problem during sleep	☐	☐	☐	☐	☐
51. Sweat excessively	☐	☐	☐	☐	☐
52. Sleep walk	☐	☐	☐	☐	☐
53. Sleep talk	☐	☐	☐	☐	☐
54. Grind your teeth	☐	☐	☐	☐	☐
55. Have leg twitching or jerking during your sleep	☐	☐	☐	☐	☐
56. Have other unusual movements during sleep	☐	☐	☐	☐	☐
57. Eat during the night after you go to sleep	☐	☐	☐	☐	☐
During the night, how often is your sleep disturbed because of:					
58. Stomach or abdominal pains	☐	☐	☐	☐	☐
59. Leg cramps	☐	☐	☐	☐	☐
60. Parasthesia (pins and needles sensation) in your arms or legs	☐	☐	☐	☐	☐
61. Itching sensations	☐	☐	☐	☐	☐
62. Feeling short of breath in a flat position	☐	☐	☐	☐	☐
63. 'gas' in your stomach, or indigestion	☐	☐	☐	☐	☐
64. Awakening with regurgitation, or burning in your throat	☐	☐	☐	☐	☐
65. Hunger	☐	☐	☐	☐	☐
66. Thirst	☐	☐	☐	☐	☐
67. Awakening with the urgent need to urinate	☐	☐	☐	☐	☐
68. Intense heart pain (angina)	☐	☐	☐	☐	☐
69. Other chest pains	☐	☐	☐	☐	☐
70. Asthma	☐	☐	☐	☐	☐
71. Persistent coughing	☐	☐	☐	☐	☐

72. How long does it take you to "get going" in the morning? _____ minutes

73. How often do you feel extremely alert and energetic all day?	☐	☐	☐	☐	☐

Thank you! Please bring this form with you to your appointment!

Epworth Sleepiness Scale

Patient Name: _____ Date: _____/_____/_____

Directions: Please read the list of situations and answer how likely you would be to doze off or fall asleep, but not just feel tired, at these times.

This refers to the past three weeks. Even if you have not done, or been in some of these situations, please try to guess how they would have affected you. Use the scale beside each question to choose the most appropriate answers.

Situation	Chance of Dozing
Sitting and reading	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing
Watching television	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing
Sitting quietly in a public place, (ex: in a theater or meeting)	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing
As a passenger in a car for an hour without a break	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing
Lying down to rest in the afternoon	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing
Sitting and talking with someone	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing
Sitting quietly after a lunch without alcohol	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing
In a car, while stopped for a few minutes in the traffic	☐ 0 Would never doze ☐ 1 Slight chance of dozing ☐ 2 Moderate chance of dozing ☐ 3 High chance of dozing

Total Score: _____

The Arlington Sleep Disorder Center
6518 South Cooper St.
Arlington, TX 76001
Phone (817) 962-0381 Fax (817) 962-0385

Patient Information

Patient Name:_____ Date of Birth:_____ Sex : M or F

SS#:_____ Parent or Guardian Name & Phone:_____

Address:_____ City:_____ State:____ Zip:_____

Main Phone:_____ Cell Phone:_____ Employer:_____

Primary Care Physician:_____ Phone:_____

Address:_____

Referring Physician:_____ Phone:_____

Address:_____

Medical Insurance

Subscriber Name:_____ Date of Birth:_____ Relationship:_____

Primary Insurance:_____ Phone:_____ Address:_____

Subscriber SS#:_____ ID/Policy #:_____ Group #:_____

Employer Name:_____ Phone:_____

Emergency Contact

Name:_____ Phone:_____ Relationship:_____

Signature of Patient or Responsible Party:_____ Date:_____

***Please provide your insurance card(s) and ID to receptionist.**

Consent for Medical Treatment

I give consent to The Arlington Sleep Disorder Center, P.A. and its physicians for medical treatment for myself (if I am the patient) or for the patient (if I am the patient's representative, e.g. parent, guardian, or medical power of attorney). I understand that this will involve taking a medical history, performing a physical examination, possibly removing articles of clothing for the examination, forming a clinical impression, making a treatment plan, ordering or performing diagnostic studies, communicating with other persons involved in the medical care, prescribing medications, and ordering medical treatments.

Patient Signature:_____ Date:_____

Patient Printed Name:_____

Representative Signature:_____ Date:_____

Representative Printed Name:_____

Authority of Representative:_____

Insurance Benefits and Information Release

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid directly to me.

Patient Signature:_____ Date:_____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to physician/provider Wesley Dennis, MD and/or The Arlington Sleep Disorder Center for any services furnished me by that physician/provider.

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature:_____ Date:_____

Patient Privacy Questionnaire

Name of Patient:_____

Write the names of the **family members and/or other persons**, if any, whom we may inform about your medical condition and/or your diagnosis (including treatment, payment, and healthcare operations).

_____

_____

Write the names of the family members and/or other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

_____

_____

Write the address where you would like your billing statements and/or other correspondence from our office sent to you if you want it somewhere **other** than your home.

_____

Write the telephone numbers where we may call. If you don't want to be called somewhere, please do not list the number.

Main Phone:_____
Can we leave a message on this number? Yes No
Can we leave a message with a person who answers this number? Yes No

Cell Phone:_____
Can we leave a message on this number? Yes No

Work Phone:_____
Can we leave a message on this number? Yes No

Patient Name Printed:_____ Date:_____

Patient Signature:_____

Authorization for The Arlington Sleep Disorder Center, P.A.
To Disclose Protected Health Information

I authorize The Arlington Sleep Disorder Center, P.A., its physician and its staff, to disclose the following protected health information to the **physician(s)** listed below for their use:

_____

_____

The protected health information to be disclosed is: medical records/sleep studies_____

This protected health information is being used/disclosed for the following purposes: diagnosis and/or treatment

of sleep disorders or other related conditions_____

This authorization shall be in force and effect until I revoke it, at which time this authorization to use or disclose this protected health information expires.

This information may include information on HIV, AIDS, alcohol use, drugs, and mental health.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 6518 South Cooper Street, Arlington, TX 76001. A revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if any authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) healthcare services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

Acknowledgement of Review of Notice of Privacy Practices

I acknowledge I have received this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. This is available upon request.

Responsibility of Payment/No Show Policy

If you do not show up for your scheduled appointment, a **$75** fee will be charged to your account. These charges will NOT be billed to your insurance provider.

There will also be a **$400** charge to your account if you do not show up for your scheduled sleep study without a **48-hour notice**. Again, these charges will NOT be billed to your insurance provider.

By signing this document, I attest that all information provided is true and complete and that my injury/illness is not work related. I authorize the release of any necessary medical information and payment of medical benefits to the physician for services rendered.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Cost of Collection: The Arlington Sleep Disorder Center, PA shall be entitled to recover cost of collection including reasonable attorney fees and collection agency fees in the event payments are not tendered in a timely fashion.