Patient Demographics

Today's Date:_____

Patient Name:_____ Date of Birth:_____ Age:_____

SS#_____ Male____ Female___ Marital Status: Married☐ Single☐ Other☐

Primary Address:_____

Mailing Address Or N/A: _____

Home Phone #_____ Work #_____

Cell Phone # _____ Email Address: _____

Patient Employer: _____ Occupation :_____

Spouse's Name:_____ Spouse DOB:_____

Spouse's Employer:_____ Spouse's Work # _____

Chief Complaint:_____

Referring Physician/Clinic:_____ Preferred Language:_____

Physician Phone # _____ Physician Fax #_____

Emergency Contact:_____ Phone: _____ Relation:_____

Primary Insurance Information

Insurance Company:_____Address:_____

Phone # _____ Fax # _____ Policy Holder:_____

Policy Holder's Date of Birth: _____ID # _____Group/ Policy #_____

Secondary Insurance Information

Insurance Company:_____Address:_____

Phone # _____ Fax # _____ Policy Holder:_____

Policy Holder's Date of Birth: _____ID # _____Group/ Policy #_____

Please Indicate the Following

Best Contact: Home☐ Work☐ Alt.☐ Email☐ Other_____ **May we leave a message**: Yes☐ No☐

Copy of HIPAA: Accept☐ Decline☐ **Copy of Patient Rights & Responsibilities:** Accept☐ Decline☐

ALLERGIES:

MID-SOUTH SLEEP DISORDERS CLINIC

386 CARRIAGE HOUSE DR. SUITE D OR 1314 US HIGHWAY 45 N SUITE F
JACKSON, TN 38305 HENDERSON, TN 38340

PHONE: 731-664-8874
FAX: 731-664-8932

PATIENT HISTORY AND PHYSICAL QUESTIONNAIRE

Please fill out the following form **(Black Ink Only)** prior to your visit to the sleep laboratory, as it is pertinent that the physician be aware of certain medical conditions and symptoms of sleep that may affect your test or may help in determining your treatment. Please complete this form the best that you can.

NAME: _____ **Date of Birth:** _____

Referring Physician: _____

PART 1 – CURRENT HEALTH STATUS

Briefly describe your sleep complaint. Explain symptoms, where and how it began, and how severe it is.

Have you ever had a sleep study before? ☐YES ☐NO, If yes Where? and When?

Height: _____ Weight: _____ Weight gain / loss in the past year: _____lbs.
Neck Size: _____ inches
As far as you know, are you in good health?
List any exceptions: _____

For each of the beverages listed, write the average number you drink per day:
Regular coffee _____ cups/day decaffeinated coffee _____cups/day
Tea _____ cups/day caffeinated soft drinks _____cups/day

On the average, how many alcoholic beverages do you drink a week? _____

On the average, how much tobacco do you smoke? (Please fill in number per day).
Cigarettes _____ Cigars _____ Pipe _____ Chewing Tobacco_____

Do you get regular exercise? Yes_____ No _____
What kind _____ How often_____ Time of day _____

Do you use any prescription or over the counter medications regularly or occasionally?
Yes _____ No _____

If yes, please list them on the next page: (If you need more space you can write on the back of this page) Note: If you have a list you can include it or we can make a copy of it on the night of your appointment.

Name of Medication	Amount	How often	Reason used	How long	Prescribing Doctor

PART 2 – REVIEW OF SYSTEMS/PAST MEDICAL HISTORY

Do you presently have any of the following?

Decreased hearing	☐YES ☐NO	Mitral Valve Prolapse	☐YES ☐NO
Ringing in ears	☐YES ☐NO	Heart trouble	☐YES ☐NO
Ear Infection	☐YES ☐NO	Irregular Pulse	☐YES ☐NO
Dizzy Spells	☐YES ☐NO	Heartburn	☐YES ☐NO
Headaches (frequent)	☐YES ☐NO	Difficulty Swallowing	☐YES ☐NO
Fainting Spells	☐YES ☐NO	Peptic Ulcer	☐YES ☐NO
Loss of Vision	☐YES ☐NO	Persistent Nausea	☐YES ☐NO
Eye Pain	☐YES ☐NO	Jaundice/Hepatitis	☐YES ☐NO
Nose Bleeds	☐YES ☐NO	Chronic Fatigue	☐YES ☐NO
Sinus Trouble	☐YES ☐NO	Weight Loss (recent)	☐YES ☐NO
Sleep Apnea	☐YES ☐NO	Muscle Weakness	☐YES ☐NO
Sore Throats	☐YES ☐NO	Anemia	☐YES ☐NO
Hay fever/allergies	☐YES ☐NO	Arthritis/Rheumatism	☐YES ☐NO
Hoarseness	☐YES ☐NO	Cancer	☐YES ☐NO
Thyroid Disease	☐YES ☐NO	Depression	☐YES ☐NO
Pneumonia/Pleurisy	☐YES ☐NO	Diabetes	☐YES ☐NO
Bronchitis/Cough	☐YES ☐NO	Stroke	☐YES ☐NO
Tuberculosis	☐YES ☐NO	Urine Infection	☐YES ☐NO
Asthma/Wheezing	☐YES ☐NO	High Cholesterol	☐YES ☐NO
Shortness of Breath	☐YES ☐NO	Allergy Previously treated	☐YES ☐NO
Chest Pain	☐YES ☐NO	Excessive Noise Exposure	☐YES ☐NO
High Blood Pressure	☐YES ☐NO	Risk of/or exposure to HIV	☐YES ☐NO
Frequent Falls	☐YES ☐NO		

Generalized lymphadenopathy syndrome (GLS) or enlargement of the lymph nodes ☐YES ☐NO
Are you allergic to anything ☐YES ☐NO
Please List:_____

Past History: List any Hospital Admissions or Surgeries: _____
_____
_____

PART 3 – SLEEP HISTORY

Main Sleep Complaint/Reason for night-time awakenings:
_____
_____
_____
At what age did this problem begin? _____ years old
How does this affect your life and daily activities?
_____
_____
Have you had any previous evaluations, examinations or treatment for this sleep problem or any other problem with your sleep? Yes _____ No _____ If yes, briefly describe the evaluation, treatment and results, including medication.

If employed, what are your usual working hours? Start time _____ Stop time _____
What time do you usually go to bed and get up on weekdays (or work days)?
_____ to bed _____ get up
What time do you usually go to bed and get up on weekends (or days off)?
_____ to bed _____ get up

Have you been told, or do you have any of the following?

Problem	Yes	Time/Wk.	Age of onset	Last occurred
a. talk while asleep				
b. walk while asleep				
c. grit teeth while asleep				
d. wake up screaming or afraid for no reason				
e. stop breathing in your sleep				
f. awaken with heartburn or sour taste				
g. other_____				

Does anyone in your family have any sleep problems? Yes _____ No _____
If yes, briefly describe and give their relationship to you.

PART 4 – PROBLEMS SLEEPING (INSOMNIA)

Yes	No	
☐	☐	Do you have trouble falling asleep?
☐	☐	Are you bothered by thoughts that keep you from sleeping?
☐	☐	Are you frightened to go to sleep?
☐	☐	Do you feel depressed or sad?
☐	☐	Does it take you more than a half hour to fall asleep?
☐	☐	Do you awaken much earlier in the morning and are unable to fall back to sleep?

PART 5 – MAIN SLEEP COMPLAINTS

Yes	No	
☐	☐	Do you often feel that you get too little sleep at night?
☐	☐	Are you bothered by sleepy periods during the day?
☐	☐	Do you remember dreaming?
☐	☐	Do you snore, or has someone told you that you snore?
☐	☐	Does the snoring disturb your bed partner or someone else in the house
☐	☐	Are you bothered by nightmares?
☐	☐	Are you bothered by breathing problems at night?
☐	☐	Do you have unusual behavior during sleep?
☐	☐	Do you usually feel tired or sleepy during the day?
☐	☐	Do you have high blood pressure?
☐	☐	Have you been gaining weight?
☐	☐	Have you been undergoing changes in your personality?
☐	☐	Do you sweat during the night?
☐	☐	Do you feel you have lost interest in sex?
☐	☐	Do you waken gasping for breath in the middle of the night?
☐	☐	Do you have headaches in the morning?
☐	☐	When you have a cold do you find falling asleep more difficult?
☐	☐	Have you ever felt your heart pounding or beating irregularly during the night?
☐	☐	Have you been told that your performance on the job is not up to par?

PART 6 - DAYTIME SLEEPINESS

Yes	No	
☐	☐	Do you have difficulty concentrating at school or at work?
☐	☐	Have you fallen asleep at the wheel of a car?
☐	☐	Do you fall asleep during the day?
☐	☐	Have you ever fallen asleep while laughing or crying?
☐	☐	Do your knees get weak if you laugh or get angry?
☐	☐	Have you fallen asleep during physical exertion?
☐	☐	During the day, do you feel dazed as if in a fog?
☐	☐	If you become angry, does your body feel limp?
☐	☐	While falling asleep or awakening, have you experienced vivid dreams?
☐	☐	Soon after falling asleep, have you had nightmares?
☐	☐	Do you often feel that you must fill your day with activity?
☐	☐	No matter how hard you try to stay awake, do you still fall asleep?

PART 7 - GERD

Yes	No	
☐	☐	Do you gasp for breath during the night?
☐	☐	Do you awaken in the night coughing?
☐	☐	Are you hoarse in the morning?
☐	☐	Do you awaken with heartburn?
☐	☐	Do you have a chronic cough?
☐	☐	Are you taking antacids routinely on a weekly basis?
☐	☐	Do you have frequent sore throats?

PART 8 – RESTLESS LEGS/PERIODIC LIMB MOVEMENTS

Yes	No	
☐	☐	Do you have pain that interferes with your sleep?
☐	☐	Do you awaken with muscle aches?
☐	☐	Do you have muscle tension in your legs, even outside of exercise?
☐	☐	Do you kick in bed at night?
☐	☐	Even though you sleep at night, do you awaken feeling tired?
☐	☐	Have you experienced a sensation of “crawling” or aching in your legs?
☐	☐	At night, do you feel the need to move your legs?

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 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 to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

TOTAL _____

THANK YOU FOR COMPLETING THIS QUESTIONAIRE
ALL QUESTIONAIRES ARE KEPT
CONFIDENTIAL TO PROTECT OUR PATIENTS RIGHTS
Thank you for your cooperation