Sleep Centers of Texas

| PERSONAL INFORMATION | | | |
|---|---|---|---|
| Last Name: | First Name: | Middle Initial: | |
| Social Security (SS) #: | Date of Birth (DOB): | Gender: ☐ M ☐ F | |
| Address: | | | |
| Home Phone: | Work Phone: | Cell Phone: | |
| E-mail Address: | | | |
| Employer: | | | |
| Employed: ☐ Full Time | ☐ Part Time | ☐ Retired | |
| Marital Status: ☐ Single | ☐ Married | ☐ Other | |

| INSURANCE INFORMATION | |
|---|---|
| Primary Insurance | Secondary Insurance |
| Company: | Company: |
| Group #: | Group #: |
| Contract #: | Contract #: |
| Policy Holder: | Policy Holder: |
| Policy Holder SS#: DOB: | Policy Holder SS#: DOB: |
| Policy Holder Employer: | Policy Holder Employer: |

| CONTACTS | | |
|---|---|---|
| Emergency Contact: | Relationship: | Phone: |
| Primary Care Physician: | | Phone: |

By signing this form,

- I authorize Sleep Centers of Texas to provide medical care to me as necessary; and I acknowledge receipt of the Office Policies and the Patient's Bill of Rights and Responsibilities.
- I authorize Sleep Centers of Texas to photograph me, include my photograph in my medical records, and videotape me during the sleep study for diagnostic and treatment purposes.
- I authorize release of my medical records to my primary care physician, referring physician, consultants, and/or DME provider for the purpose of rendering treatment and ensuring continuity of care.
- I authorize release of my medical information to my insurance carrier to process my claims and payment from my insurance carrier directly to Sleep Centers of Texas for benefits, if any, otherwise payable to me.
- I understand that I am responsible for the deductible, co-payment, co-insurance and any other charges not covered by insurance. If I do not have insurance, I acknowledge that I am obligated to pay the full amount.

_____ _____

*Signature of Patient or Responsible Party* *Date*

_____ _____

*Witness' Signature* *Date*

**7839 Interstate 10 West, San Antonio, TX 78230-4779 ▪ Phone: 210.520.8333 ▪ Fax: 210.520.8335**

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

Address: _____

☐ **I HEREBY AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS TO SLEEP CENTERS OF TEXAS**

Information to be Released: ☐ Medical History ☐ Physical Examination
☐ Other: _____

From: _____
_____
_____

☐ **I HEREBY AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS FROM SLEEP CENTERS OF TEXAS**

Information to be Released: ☐ Medical History ☐ Physical Examination
☐ Other: _____

To: _____
_____
_____

_____ _____
*Patient's Signature* *Date*

_____ _____
*Witness' Signature* *Date*

**7839 Interstate 10 West, San Antonio, TX 78230-4779 ▪ Phone: 210.520.8333 ▪ Fax: 210.520.8335**

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.**

Sleep Centers of Texas is required by law to protect the privacy of your protected health information ("medical information"). We are also required to provide you with this Notice about our privacy practices, our legal duties, and your rights concerning your medical information. We are obligated to abide by terms of the Notice of Privacy Practices currently in effect. This Notice takes effect on April 14, 2003 and remains in effect until replaced.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

There are several ways in which your physician, our office staff and others outside of our office involved in your care are permitted to use and disclose your protected health information without your written authorization. Protected health information is individually identifiable health information that may identify you and that relates to your past, present or future physical or mental health or condition, health care services provided to you, or payment for health care services rendered. The following list describes different ways that we are permitted to use and disclose your protected health information; however, this list is not meant to be exhaustive.

***TREATMENT.*** We may use and disclose your medical information without your permission to provide, coordinate, or manage your health care. For example, we may request that your primary care physician share information with us and we may provide information about your condition to your primary care physician.

***PAYMENT.*** We are permitted to use and disclose your medical information to obtain payment from your insurance plan for items and services rendered to you. For example, we may be required to disclose information about you to your health plan to obtain preauthorization for a sleep study and to seek payment for any services rendered.

***HEALTH CARE OPERATIONS.*** We may use and disclose your medical information without your prior approval for health care operations. Health care operations include: healthcare quality assessment and improvement activities; reviewing and evaluating the competence, qualifications and performance of health care professionals; health care training programs; accreditation, certification, licensing and credentialing activities; medical records review, audits, and legal services; business planning, development, management and administrative activities.

We are also permitted to use and disclose your medical information without your prior approval, when authorized and required by law, for the following kinds of public health and benefit activities: 1) for public health, including to report disease and vital statistics, child and adult abuse, neglect or domestic violence; 2) to avert a serious and imminent threat to public health or safety; 3) for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities, and fraud and abuse agencies; 4) for research; 5) to entities subject to FDA regulation regarding FDA-regulated products or activities; 6) in response to court and administrative orders and other lawful process; 7) to law enforcement officials with regard to crime victims and criminal activities; 8) to comply with OSHA or similar state laws regarding work-related illness or injury; 9) to comply with workers' compensation laws and similar programs; 10) to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; 11) to coroners, medical examiners, funeral directors, and organ procurement organizations; and 12) disclosures otherwise specifically required by law.

We may disclose your medical information to a family member, friend or any other person involved in your care or responsible for payment of your care but will disclose only the information that is relevant to his or her involvement. We will provide you with an opportunity to object to these disclosures, unless you are not present or are incapacitated or it is an emergency or disaster relief situation. In those situations, we will use our professional judgment to determine whether disclosing your medical information is in your best interest under the circumstances.

In any other situation not described above, we will not use and disclose your medical information without your express written authorization. Uses and disclosures of your medical information for marketing and fundraising purposes and uses and disclosures that constitute sales of medical information about you will only be made with your signed permission. You have the right to opt out of receiving fundraising communications.

If you sign an authorization to disclose your protected health information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

**PATIENT'S RIGHTS**

With respect to your protected health information, you have certain rights:

- You have the right to inspect and obtain an electronic or paper copy of your medical record and other health information with limited exceptions.
- You have the right to request that we contact you with confidential communications in a specific way. For example, you may request that we communicate with you through an alternate address or phone number or that we mail confidential communications to you in a closed envelope rather than postcard.
- You have the right to request that your protected health information be amended if you believe it is incorrect or incomplete. If we deny your request, you have the right to file a statement of disagreement with us. Upon receipt of your statement, we will prepare and provide you with a rebuttal to your statement within 60 days.
- You have the right to request that we not use or share your protected health information with any party, including family or friends, regarding your treatment, payment of services, or our healthcare operations. If you pay in full for an item or service, you have the right to request that we not share your medical information with your insurer. Your request must state the specific restriction and to whom the restriction applies. Except in limited circumstances, we are not required to agree to the request if the request is not in your best interests.
- You have the right to request an accounting of all uses and disclosures of your protected health information, with the exception of those for your treatment, payment of services, and our healthcare operations, that we may have made during the six years prior to the date of your request.
- In the event of a breach that may have compromised the privacy or security of your protected health information, you have the right to receive notice of such breach.
- You have the right to obtain a paper copy of this Notice even if you receive this Notice by electronic mail or view it on our web site.

We reserve the right to change the terms of this Notice at any time and to make revisions applicable to all medical information that we maintain, including medical information we created or received before we made the change. For further information about our privacy practices, or to submit requests, please contact our Office Manager or Compliance Officer.

**COMPLAINTS**

If you believe that your privacy rights have been violated, you may file a complaint with our Compliance Officer or with the U.S. Department of Health and Human Services, Office for Civil Rights, at 200 Independence Avenue, SW, Room 509F, Washington D.C. 20201. We support your right to privacy in matters pertaining to your medical information. We will not retaliate against you if you elect to file a complaint under any circumstances.

By signing this form, I acknowledge that I have read and understand the above Notice of Privacy Practices.

_____ _____ /_____ /_____

*Signature of Patient or Responsible Party* *Date*

# Welcome to Sleep Centers of Texas!

We are delighted that you have chosen to entrust us with your care and we welcome the opportunity to serve you. Sleep Centers of Texas is a full-service, state-of-the art facility dedicated to providing you with the highest quality of care in sleep medicine. We are committed to working closely with you and with your physician or dentist to deliver the most effective treatment available. As part of this commitment, it is important that you have a clear understanding of our administrative and financial policies.

## OFFICE HOURS

Our normal business hours are Monday through Friday 8:30 A.M. to 5:00 P.M. For assistance after normal hours regarding the home sleep apnea test or use of the PAP device, please call 210.378.9014. For all other matters, please leave a message on the voicemail and we will return your phone call within 12-24 hours.

## SCHEDULING APPOINTMENTS

Office visits for initial examinations, consultations, PAP device delivery and setup, and follow-up appointments are scheduled during normal business hours; in-laboratory sleep studies are scheduled each night of the week with limited exceptions. Generally test results are available within one week of the sleep study or polysomnography. To schedule an appointment, please call our office during normal business hours.

## CANCELLATION POLICY

If you need to cancel or reschedule your appointment, please notify our office during normal business hours at least 24 hours prior to your appointment. By doing so, you will not incur a cancellation fee. However, if you do not cancel and you do not show up for your appointment, a fee of $35 for daytime appointments and a fee of $150 for overnight sleep study appointments may be billed to you for which you may be personally responsible. Please bear in mind that for each overnight sleep study a private room is reserved for you and a sleep technologist is assigned to you, so costs are incurred in preparation for your sleep study. Kindly call our office as far in advance as possible should you need to reschedule your appointment.

## CONFIDENTIALITY OF MEDICAL RECORDS

Sleep Centers of Texas is committed to protecting the privacy of your medical information. Please review our Notice of Privacy Practices which describes our legal duties, the different ways that we are permitted to use and disclose your protected health information, and your rights to access and control the information. All records that we create or receive concerning your health or medical condition and the services rendered are confidential and cannot be disclosed without your prior written authorization, except as otherwise permitted by law.

## RECORDS REQUESTS

To authorize release of your medical information to a specific person / entity, or to request a personal copy of your own medical records, please submit your request in writing to our Compliance Officer. By law, we are required to retain your medical records for 7 years. For forms, such as short-term disability forms or creditor forms, which you request that our office staff complete on your behalf, please allow our staff 48 hours to respond to your request. We charge $35 per form.

*Sleep Centers of Texas complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*

## FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, cash, and credit cards. Sleep Centers of Texas accepts most major insurance carriers, including Medicare and Medicaid. As a courtesy to you, we will process your claim with your insurance company. Please note that insurance is a contract between you and your insurance company. While we may be the service provider, we are not party to that contract. Not all services are a covered benefit in all insurance policies. In some instances, you may be responsible for amounts not covered by the contract. We will make every effort to determine, and disclose to you, whether our services are covered by your insurance plan before the diagnostic test or treatment is provided. If you have any questions or are uncertain as to your insurance coverage, please feel free to contact us for assistance.

**Payment Options**

- Insured Patients: We require that you present a current copy of your insurance card to the receptionist at the time of service. You must pay all deductibles, copayments and coinsurance in full at the time of service. You may choose to pay with cash, check, or credit card. Although we may estimate the portion that your insurance carrier will pay, it is your insurance carrier that makes the final determination of eligibility and payment. Once your claim is processed by your insurance carrier, any amounts not covered by your insurance will be billed to you and it is your obligation to pay the charges.
- Private Pay / Uninsured Patients: If you do not have insurance coverage or your insurance carrier declines to cover a specific service, if Sleep Centers of Texas is not contracted with your insurer, or if you are paid directly by your insurance carrier, you are expected to pay in full for services rendered at the time of service. In some instances, payment arrangements may be made prior to date of service. If prearranged payments are approved, we will require a valid credit card on file.

**Refunds:** If there is an overpayment for services rendered, we will refund the amount to you once all claims are settled on the account and no payment is due on any other claim.

**Returned Checks:** There will be a returned check fee of $20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to scheduling a new appointment. Future visits will need to be paid in cash.

**Account Balances:** If there is a balance on your account, we will send you a monthly statement. Balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days of receipt of the statement are considered past due. Accounts with balances outstanding for 90 days will be referred to a collection agency. If your account is sent to a collection agency, you may be subject to agency fees and penalties.

**Workers' Compensation / Personal Injury:** We do not accept workers' compensation or personal injury cases nor do we bill attorneys for medical services. Any services performed in relation to a personal injury case will be considered self-pay and payment will be required at the time of service.

**Disputes:** Any disputes of your account should be submitted in writing within 30 days of receipt of the monthly statement. You will be notified of the outcome within 14 days of receipt of your written dispute.

## COMPLAINTS AND GRIEVANCES

To file a complaint or grievance, kindly fill out our Complaint Form and submit it to the Office Manager. Within 14 days of submission of your complaint, you will receive written notice of the results of our investigation and actions taken to resolve your grievance.

# PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

## PATIENT'S RIGHTS

- The patient has the right to be treated with dignity and respect.
- The patient has the right to impartial access to care regardless of race, gender, religion, national origin, cultural, socioeconomic, or educational background, physical handicap, or ability to pay.
- The patient has the right to emergency care without discrimination due to economic status or payment source.
- Patients with limited English proficiency have the right to language assistance services, free of charge.
- The patient has the right to personal privacy and confidentiality of all records and communications concerning his/her medical history and treatment to the extent of the law.
- The patient has the right to receive relevant and timely information in a manner that is easily understandable concerning his/her diagnosis, treatment, risks and benefits of treatment, prognosis, plan for follow-up care, unanticipated outcomes of care, reasonable alternatives to proposed care, and consequences of non-treatment.
- The patient has the right to discuss and request additional information relating to specific procedures and/or treatments, including their associated risks and benefits, and alternative procedures and treatments.
- The patient has the right to inspect his/her medical record, have information explained or interpreted as necessary, request an amendment to the medical record, receive a copy of the medical record for a reasonable fee and an accounting of any disclosures of his/her personal health information.
- The patient has the right to know the identity of the physicians, nurses, and other healthcare providers who are providing medical services and responsible for his/her care.
- The patient has the right to request information on the existence of business relationships between the health care provider and other health care facility, educational institution, or payers that may influence treatment.
- The patient has the right to know if medical treatment is for the purpose of experimental research and the right to consent or refuse participation in the experimental research.
- The patient has the right to accept or refuse treatment, except as otherwise provided by law, and to be informed of the medical consequences of refusing treatment.
- The patient has the right to receive, prior to treatment, a reasonable estimate of charges for the treatment.
- The patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.
- The patient has the right to receive care in a safe setting, free of all forms of abuse or harassment.
- The patient has the right to file a grievance or complaint regarding violation of his/her rights or any concerns regarding the quality of care received. To file a grievance or complaint, complete and submit the Complaint Form to the Office Manager. Within 14 days of submission of the Complaint Form, the patient will receive written notice of the steps taken on his/her behalf to investigate the grievance, the results of the investigation, and actions taken to resolve the grievance or complaint.

## PATIENT'S RESPONSIBILITIES

- The patient is responsible for providing, to the best of his/her knowledge, accurate and complete information concerning his/her medical history, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- The patient is responsible for reporting unexpected changes in his/her condition to the health care provider.
- The patient is responsible for reporting whether he/she comprehends the contemplated course of action and what is expected of him/her.
- The patient is responsible for following the recommended plan of treatment.
- The patient is responsible for keeping his/her appointments and, when he/she is unable to do so for any reason, for notifying the health care facility.
- The patient is responsible for his/her actions if treatment is refused or if the health care provider's instructions are not followed.
- The patient is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.
- The patient is responsible for adhering to the facility's rules and regulations pertaining to patient conduct, being considerate of the rights of other patients and the health care personnel, and respectful of the personal property of other patients and the staff, as well as the property of the facility itself.

# SLEEP QUESTIONNAIRE AND MEDICAL HISTORY

Name: _____ Social Security Number: _____

Date of Birth:_____ Age: ____ Height: ____ Weight: _____ ☐ Male ☐ Female

Primary MD: _____ Referring MD: _____

*This questionnaire is designed to assist us in understanding the nature of your sleep-related problem. Please take your time and answer each question as completely and accurately as possible.*

## SLEEP QUESTIONNAIRE

### Chief Complaint(s)

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Fatigue despite adequate sleep ☐ Snoring
☐ Significant daytime drowsiness ☐ Witnessed apnea ☐ Gasping / choking upon awakening
☐ Sleep walking / talking ☐ Night terrors ☐ Acting out dreams ☐ Legs kick / move while sleeping
☐ Morning headaches ☐ Insomnia ☐ Other: _____

### History of Present Illness

1. How long have you had this problem? ☐ < 1 month ☐ 1-6 months ☐ 6 months-2 years ☐ >2 years
2. Rate the severity of your problem. ☐ Mild ☐ Moderate ☐ Severe ☐ Problem only for others
3. Is your sleep-related problem getting worse? ☐ Yes ☐ No
4. What factors aggravate your symptoms? _____
5. Does your problem have a negative impact on your ……. work performance ☐ Yes ☐ No
   …….sex life ☐ Yes ☐ No
   ……. quality of life ☐ Yes ☐ No
   ……. social activities ☐ Yes ☐ No
6. Do you use any medications or other substances to help you sleep? ☐ Yes ☐ No
   If yes, please list drug/substance(s), dose, frequency, and length of usage.
   _____
7. Do any members of your family have significant sleep-related problems? ☐ Yes ☐ No
   If yes, please explain:
   _____
8. Have you discussed your sleep-related problems with another doctor? ☐ Yes ☐ No
   Doctor's Name: _____ Diagnosis: _____
   Current treatment: _____ Prior treatment: _____

**Patient: _____**

**Please rate how often you or others note that you:**

| | **Never** | **Occasionally** | **Frequently** |
|---|---|---|---|
| Snore | _____ | _____ | _____ |
| Snore loudly enough for others to complain | _____ | _____ | _____ |
| Awaken from sleep feeling short of breath, gasping, or choking | _____ | _____ | _____ |
| Hold your breath or stop breathing while asleep | _____ | _____ | _____ |
| Experience other breathing problems at night | _____ | _____ | _____ |
| Wake up with a headache that improves in less than 2 hours | _____ | _____ | _____ |
| Have dry mouth upon awakening | _____ | _____ | _____ |
| Sweat excessively at night | _____ | _____ | _____ |
| Experience heart pounding or irregular heart beats during night | _____ | _____ | _____ |
| Feel sleepy or tired during the day | _____ | _____ | _____ |
| Awaken feeling unrested or unrefreshed | _____ | _____ | _____ |
| Become drowsy while driving | _____ | _____ | _____ |
| Have motor vehicle accidents due to sleepiness | _____ | _____ | _____ |
| Have trouble at school or work because of sleepiness | _____ | _____ | _____ |
| Become irritable or crabby | _____ | _____ | _____ |
| Have difficulty concentrating; experience memory impairment | _____ | _____ | _____ |
| Fall asleep involuntarily, suddenly or in an awkward situation | _____ | _____ | _____ |
| Experience sudden weakness, knees buckling, or jaw drop when laughing, scared, angry or crying | _____ | _____ | _____ |
| Feel unable to move (paralyzed) when waking or falling asleep | _____ | _____ | _____ |
| Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep similar to hallucinations | _____ | _____ | _____ |
| Perform complex tasks of which you are totally unaware such as driving or navigating without conscious awareness | _____ | _____ | _____ |
| Have nightmares or night terrors | _____ | _____ | _____ |
| Act out dreams by yelling and swinging arms and legs | _____ | _____ | _____ |
| Walk or talk while asleep | _____ | _____ | _____ |
| Do anything else considered “unusual” while asleep | _____ | _____ | _____ |
| Move, twitch or jerk your legs while asleep | _____ | _____ | _____ |
| Feel leg restlessness, agitation or discomfort at or before bedtime | _____ | _____ | _____ |
| If yes: Do you feel an overwhelming urge to move your legs? | | ☐ Yes | ☐ No |
| Does it happen only in the evening? | | ☐ Yes | ☐ No |
| Does it only happen when you are relaxed? | | ☐ Yes | ☐ No |
| Does it get better if you move around or walk? | | ☐ Yes | ☐ No |
| Does it disturb your sleep or sleep onset? | | ☐ Yes | ☐ No |

How often do you experience this feeling? _____

**Patient: _____**

**Sleep Hygiene**

1. Do you often have anxiety around bedtime? ☐ Yes ☐ No
2. Do you have thoughts racing through your mind while trying to fall asleep? ☐ Yes ☐ No
3. Do you sleep better away from home than in your own bed? ☐ Yes ☐ No
4. Are you anxious or upset if you have difficulty falling asleep? ☐ Yes ☐ No
5. Do you usually take coffee, tea, or chocolate within 2 hours of your bedtime? ☐ Yes ☐ No
6. Do you exercise within 2 hours of your bedtime? ☐ Yes ☐ No
7. Do you watch TV or read in bed before falling asleep? ☐ Yes ☐ No
8. Do you ever nap or rest during the awake portion of your day? ☐ Yes ☐ No

   If yes: How often? _____ times per day; _____ times per week
   How long is your nap / rest? ☐ < one hour ☐ ≥ one hour
   After the nap / rest, do you still feel tired? ☐ Yes ☐ No

9. Check conditions that routinely apply to you: ☐ Sleep alone ☐ Sleep with someone else in bed ☐ Sleep with pet in room/bed ☐ Provide assistance during night to child, invalid, bed partner, animal
10. Check factors that generally disturb your sleep: ☐ Heat ☐ Cold ☐ Light ☐ Noise ☐ Bed Partner
    Other: _____

**Sleep Habits**

1. When do you feel your very best? ☐ Morning ☐ Afternoon ☐ Evening
2. Approximately, how many hours do you actually sleep per night? _____
3. What time do you usually go to bed? Workdays: _____ Non-Workdays: _____
4. What time do you usually rise from bed? Workdays: _____ Non-Workdays: _____
5. How long does it usually take for you to fall asleep? _____
6. How many hours of sleep do you need to feel your very best? _____
7. In an perfect world, what would be the ideal hour for you to go to bed? _____
8. In an perfect world, what would be the ideal hour for you to awaken? _____
9. What usually prevents you from quickly falling asleep? _____
10. How many times do you typically wake up during the night? _____
11. What generally causes you to wake up during the night? _____
12. If you wake up during the night, how long do you typically stay awake? _____
13. If you wake up during the night, when do you typically wake up?
    ☐ Soon after falling asleep ☐ In the middle of the night ☐ Near the end of the sleeping period
14. What do you usually do when you awaken during the night? _____

## MEDICAL HISTORY

**Patient: _____**

Please check conditions for which you have been diagnosed:

- ☐ Angina
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Arteriosclerosis
- ☐ Heart murmur
- ☐ Rheumatic heart disease
- ☐ Arrhythmia
- ☐ Hypertension
- ☐ Stroke
- ☐ Peripheral artery disease
- ☐ Other cardiovascular disorders _____

- ☐ Asthma

- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Other respiratory disorders _____

- ☐ Acid reflux
- ☐ Diverticulitis
- ☐ Hiatal hernia
- ☐ Swallowing disorder
- ☐ Stomach ulcers
- ☐ Other gastrointestinal disorders _____

- ☐ Arthritis
- ☐ Back pain
- ☐ Osteoporosis
- ☐ Chronic fatigue syndrome
- ☐ Fibromyalgia
- ☐ Autoimmune disorder
- ☐ Neuromuscular disorder

- ☐ Diabetes
- ☐ Sickle cell anemia
- ☐ Thyroid disease
- ☐ Cancer

- ☐ Migraines
- ☐ Seizures / Epilepsy
- ☐ Brain infection
- ☐ Brain injury
- ☐ Spinal infection
- ☐ Spinal injury
- ☐ Nerve injury
- ☐ Other neurologic disorders _____

- ☐ Liver disease
- ☐ Kidney disease
- ☐ Blood disorder

- ☐ Depression
- ☐ Anxiety / Panic attacks
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Other psychiatric disorders _____

**Current Medications:** Please list all medications that you are currently taking and their dosages:

_____

_____

**Drug Allergies:** Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list:

_____

**Past Surgeries:** Please list all operations and the approximate date of the procedure. _____

_____

**Family History:** Has anyone in your blood-related family been afflicted with the following conditions:

☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer
☐ Sleep apnea ☐ Narcolepsy ☐ Restless legs syndrome ☐ Sleep walking / talking ☐ Parasomnias

**Occupational History:** Occupation: _____ Are you a shift worker? ☐ Yes ☐ No If yes, please describe work schedule: _____

**Social History**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Children living at home: ☐ No ☐ Yes Ages of children: _____
Others living at home: ☐ No ☐ Yes ☐ Spouse ☐ Parents / Grandparents ☐ Friend
Alcohol consumption: ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Alcoholic
Tobacco use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____
Recreational drug use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____

## REVIEW OF SYSTEMS

Please check any of the following symptoms which you currently or recently have experienced.

**General**
- ☐ Fatigue
- ☐ Malaise / lethargy
- ☐ Generalized weakness
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fever / chills

**Eyes**
- ☐ Vision changes
- ☐ Double vision
- ☐ Discharge
- ☐ Pain
- ☐ Sensitivity to light

**Ears, Nose, Throat and Mouth**
- ☐ Earache
- ☐ Ringing in the ears
- ☐ Allergies
- ☐ Frequent colds
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sinusitis
- ☐ Toothache
- ☐ Oral ulcers
- ☐ Dry mouth
- ☐ Facial pain
- ☐ Jaw pain
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Swollen glands

**Cardiovascular System**
- ☐ Chest pain
- ☐ Pain in arm, shoulder, jaw, neck or back
- ☐ Rapid heart rate
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Pain in leg when walking
- ☐ Ankle / leg swelling

**Lungs**
- ☐ Chronic cough
- ☐ Shortness of breath with mild exertion
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Bloody sputum

**Gastrointestinal System**
- ☐ Nausea / vomiting
- ☐ Indigestion
- ☐ Acid reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Cramps
- ☐ Bloating
- ☐Vomiting blood
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Rectal pain
- ☐ Rectal bleeding

**Genitourinary System**
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Blood in urine
- ☐ Pelvic / groin pain
- ☐ Genital ulcers

Male:
- ☐ Erectile dysfunction
- ☐ Testicular pain / swelling

Female:
- ☐ Irregular periods
- ☐ Hot flashes
- ☐ Vaginal discharge

**Musculoskeletal System**
- ☐ Joint pain / swelling
- ☐ Back pain
- ☐ Muscle pain / weakness
- ☐ Leg cramps

**Nervous System**
- ☐ Headaches / migraines
- ☐ Dizziness / fainting
- ☐ Seizures
- ☐ Tremors
- ☐ Disorientation
- ☐ Lack of coordination
- ☐ Numbness / paralysis
- ☐ Memory loss / impairment

**Psychiatric Symptoms**
- ☐ Depression
- ☐ Anxiety / panic attacks
- ☐ Hallucinations
- ☐ Delirium
- ☐ Dementia
- ☐ Suicidal ideation

**Endocrine System**
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Sexual dysfunction
- ☐ Hair loss
- ☐ Excessive sweating

**Skin**
- ☐ Rashes
- ☐ Bruises
- ☐ Hives
- ☐ Lesions

Patient's Signature _____ Date _____

# EPWORTH SLEEPINESS SCALE

Name: _____ Date:_____

Age: _____ □ Male □ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you haven't 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

***It is important that you answer each question as best you can.***

| **SITUATION (0-3)** | **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 to someone | _____ |
| Sitting quietly after a lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |
| Total score: | _____ |

# BED PARTNER QUESTIONNAIRE

Patient: _____ Observer: _____

Relationship to Patient: _____ Date: _____

Frequency of observations: ☐ Once or twice ☐ Often ☐ Almost every night

Check any of the following behaviors observed while watching person sleep. Circle behaviors that you consider severe problems for this person.

- ☐ Light snoring
- ☐ Loud snoring
- ☐ Loud snorts
- ☐ Pause in breathing (How long? ____seconds)
- ☐ Choking
- ☐ Gasping for air
- ☐ Twitching, moving or kicking of legs
- ☐ Twitching or flinging of arms
- ☐ Grinding teeth
- ☐ Apparently sleeping even if person behaves otherwise
- ☐ Other _____

- ☐ Sleep talking
- ☐ Sitting up in bed not awake
- ☐ Getting out of bed not awake
- ☐ Head rocking or banging
- ☐ Awakening with pain
- ☐ Becoming very rigid or shaking
- ☐ Biting tongue
- ☐ Crying out

If person snores, what makes snoring worse?

☐ Sleeping on back ☐ Sleeping on side ☐ Alcohol ☐ Fatigue

Does snoring sometimes require you or your partner to sleep separately? ☐ Yes ☐ No

Does this person drink alcohol or use street drugs? ☐ Yes ☐ No

**7839 Interstate 10 West, San Antonio, TX 78230-4779 ▪ Phone: 210.520.8333 ▪ Fax: 210.520.8335**