SLEEP CLINIC OF AMERICA

Patient Information

Name: _____
Last First M.I.

Address: _____
Street Address

_____
City State Zip

DOB: ____ /____ /____ Sex: M/F SSN: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Optional: Race: _____ Ethnicity: _____ Language: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Employer: _____ Phone: _____

Emergency Contact

Name: _____ Relation to Patient: _____

Home Phone: _____ Cell: _____

Name: _____ Relation to Patient: _____

Home Phone: _____ Cell: _____

Referred by: ☐ Physician ☐ Self

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Insurance Information: Please choose a method for services to be paid: ☐ Self-Pay ☐ Insurance Pay

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ DOB: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ DOB: _____

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Authorization to Release Medical Information:

I, _____, authorize permission to Sleep Clinic of America to discuss my
(**Printed** Patient Name)
medical care and account information with the following person(s):

_____	_____	_____
Name of authorized person	Relation	Phone
_____	_____	_____
Name of authorized person	Relation	Phone
_____	_____	_____
Name of authorized person	Relation	Phone

_____	_____	_____
Signature of Patient/Guardian	Relationship to patient	MR #
_____	_____	
Printed Name of Patient/Guardian	Today's Date	

SLEEP CLINIC
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Consent for Treatment:

I, _____, consent for treatment by Sleep Clinic of America. By signing
(**Printed** Patient Name)
below, I hereby authorize Sleep Clinic of America and Its affiliated physicians and other medical personnel in charge of my care to administer examinations, treatments and view my prescription history from an external source as may be deemed medically necessary in the exercise of their professional judgment.

_____ _____ _____

Signature of Patient/Guardian | Relationship to patient | MR #

_____ _____

Printed Name of Patient/Guardian | Today's Date

SLEEP CLINIC
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Patient Financial Responsibility:

In order to better serve you Sleep Clinic of America requires all patients to sign the financial responsibility please read over the patient financial policy and sign below to acknowledge:

- All patients or guardians are responsible for 100% of the charges incurred for treatment at Sleep Clinic of America.
- The patient or guardian who signs the financial policy statement is the responsible party.
- Established patients who have health insurance benefits that have been verified will be expected to pay that portion of the charges not covered under their policy as well as any applicable co-payments under the terms of their policy.
- Patients who have health insurance benefits that have been verified will be responsible for all charges, paid in full on the day of service, until their policy out of pocket has been met.
- Sleep Clinic of America is not responsible for incorrect information given by your insurance company.
- Patients who have health insurance benefits that have not been verified will be responsible for any portion of the charger that are not covered, as well as any applicable co-payments under the terms of their policy.
- Patients who do not have health insurance benefits that have been verified will be responsible for all charges incurred, payable on the day of service.
- Having an active health insurance policy in no way negates a patient's responsibility for payment of their medical charges. If these charges are denied or not covered by the patients insurance carrier.
- Patients may pay their bills by cash, check, or credit card. Payments can be done on our website: https://sleepclinicamerica.com/

Cancellation Policy: It is not the intent of Sleep Clinic of America to charge you for a visit that you cannot attend but due to collateral costs that occur as a result of unplanned cancellations we will be obligated to charge a cancellation or no show fee. Therefore we ask you to adhere to our cancellation policy of 48 hours.

- Sleep Clinic of America has a **48 hour cancellation policy** on **ALL** sleep studies. **If you are scheduled for an overnight sleep study and do not show up to the appointment or do not cancel 48 hours prior to the scheduled appointment an automatic $300.00 cancellation and/or no-show fee will apply. This cancellation policy also applies if you leave the study before its completion.**
- Sleep Clinic of America has a **48 hour cancellation policy** of $20.00 for **ALL** regular office visits.
- Cancellation is done only during Sleep Clinic of Americas regular office hours of 9:00 am to 5:00 pm. Any cancellations after 5:00 pm **will not** be honored.

Patients who fail to pay their outstanding balance within 90 days of the service being provided may be turned over to a collection agency. The patient will still be responsible for the charges as well as all collection agency costs and fees, including reasonable attorney fees.

We ask that you adhere to these policies as part of your financial responsibility. Our staff will assist you in any way that we can. If you have any questions regarding our fees or your insurance coverage and filing of your insurance claims please ask to speak with one of our friendly staff.

I authorize Sleep Clinic of America to process financial transactions to pay my account balance. I agree to be financially responsible for any and all related charges, if they are not covered by my insurance policy.

_____	_____	_____
Signature of Patient/Guardian	Relationship to patient	MR #
_____	_____	
Printed Name of Patient/Guardian	Today's Date	

SLEEP CLINIC
OF AMERICA

NOTICE OF PRIVACY PRACTICES:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Sleep Clinic of America is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Sleep Clinic of America is required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED: The following describes how Sleep Clinic of America may use your protected health information for treatment, payment or health care operations.

Treatment: Sleep Clinic of America may use health information about you to provide you with health care treatment or services. Sleep Clinic of America may disclose health information about you to doctors, nurses, or other essential personnel who are involved in your care.

Payment: Sleep Clinic of America may use and disclose health information about you to receive payment for services provided to you. Under Florida law we must obtain your written consent in order to submit claims for services provided to you. Failure to sign may force us to decline you as a new patient or discontinue you as an active patient.

Health Care Operations: Sleep Clinic of America may use and disclose health information about you for operational purposes related to our office. We may also and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointments Reminders Treatment Information Disclosure to Department of Health and Human Services
Family and Friends Notification Disaster Relief
Health Oversight Activities Abuse or Neglect Judicial and Administrative Proceedings
Law Enforcement Specialized government Functions Organ Donation
Coroners, Medical Examiner's and Funerals Directors Research Business Associates
Public Health Activities Public Safety Worker's Compensation

MINIMUM NECESSARY INCIDENTAL DISCLOSURES AND SUPER CONFIDENTIAL INFORMATION: Our staff will not use or disclose your medical information unless it is necessary to perform their jobs. We will follow both state and federal laws related to the use and disclosure of super-confidential information such as HIV/AIDS, alcohol/substance abuse and mental health records.

AUTHORIZATIONS and CONSENTS: We will not use or disclose your medical information for any other purpose other than treatment, payment or health care operations without your written authorization. Once given, you may revoke your authorization in writing at any time. This consent is required under Florida law in order for our office to submit claims and other information needed to receive for services rendered to you or your family.

PATIENT RIGHTS REGARDING THEIR MEDICAL INFORMATION:

- You may ask us to restrict certain uses and disclosures for your medical information. We are not required to agree to your request, but if we do we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by Sleep Clinic of America during the last 6 years. Except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please require at the Registration desk (you will be directed to our Privacy Officer).
- To file a complaint with the U.S. Department of Health and Human Services you must submit your complaint in writing, within 180 of the alleged violation to: Region I.V, Office for Civil Rights U.S. Department of Health and Human Services Atlanta Federal Center, Suite 3B70 61 Forsyth Street, S.W Atlanta, GA 30303-8909 Voice phone 404-562-7886 Fax 404-562-7881

***For the full version of the Sleep Clinic of America privacy policy, view our website at** https://sleepclinicamerica.com/

SLEEP CLINIC
OF AMERICA

Acknowledgement of Receipt of Privacy Practices and Patient Rights and Responsibilities

Our notice of privacy practices and patient rights and responsibilities provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change. If we change our notices, you may request a revised copy.

I, _____ have been provided a copy of the Sleep Clinic of
(Printed Patient Name)
America Privacy Practices and Patient Rights and Responsibilities. I understand that I may ask questions to Sleep Clinic of America if I do not understand any information contained in the privacy practices and the patient rights and responsibilities.

_____ _____ _____
Signature of Patient/Guardian Relationship to patient MR #

_____ _____
Printed Name of Patient/Guardian Today's Date

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Sleep Center Appointment Policy

1. If you are being evaluated for sleep apnea we typically adhere to the following schedule:
   - **First Visit-Consultation:**
     - This appointment is to meet the physician/provider, see the clinic, discuss symptoms and history, and order necessary study.
   - **Sleep Study #1: Baseline**
     - This is the sleep study that will determine whether you have sleep apnea or not. The sleep study will be done in our sleep center by a certified sleep technician.
   - **Sleep Study #2 (if needed): CPAP Titration Sleep Study**
     - If the baseline shows sleep apnea, this sleep study would be used to determine optimal pressure for correction of apneas.
   - **Post Titration Follow-Up 45 Days/90 Days after CPAP: Can be done in office OR via telemedicine**
     - This appointment is to pull the patients compliance, insurance guidelines require full compliance by 90 days to make sure there is no leakage, Apnea Hypopnea Index (AHI) is good after CPAP titration, as well as percentage of CPAP usage is above 70%. Typically, we schedule this visit at 45 days in case there are any issues we have time to correct them before the 90 day deadline.
   - **1 Year Follow-Up: Can be done in office OR via telemedicine**
     - This appointment is mainly to go over patients AHI and make sure it is good range, and leakage to make sure they don't need a mask refit. Also, to note any changes in supplies, etc.
2. **Acknowledgement of Receipt of Sleep Center Appointments Policy:** If you are being evaluated for conditions other than sleep apnea your provider will determine your visit frequency based on your clinical needs.
3. Cancellation Policy: It is not the intent of Sleep Clinic of America to charge you for a visit that you cannot attend but due to collateral costs that occur as a result of unplanned cancellations we will be obligated to charge a cancellation or no show fee. Therefore we ask you to adhere to our cancellation policy of 48 hours.
   - Sleep Clinic of America has a **48 hour cancellation policy** on ALL sleep studies. **If you are scheduled for an overnight sleep study and do not show up to the appointment or do not cancel 48 hours prior to the scheduled appointment an automatic $300.00 cancellation and/or no-show fee will apply. This cancellation policy also applies if you leave the study before its completion.**
   - Sleep Clinic of America has a **48 hour cancellation policy** of $20.00 for ALL regular office visits.
   - Cancellation is done only during Sleep Clinic of Americas regular office hours of 9:00 am to 5:00 pm. Any cancellations after 5:00 pm **will not** be honored.

_____ _____ _____

Signature of Patient/Guardian | Relationship to patient | MR #

_____ _____

Printed Name of Patient/Guardian | Today's Date

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please fill out highlighted areas ONLY.

Patient Name:	**DOB:**

Previous Physician/Office Name:	
Specialty:	
Phone:	**Fax:**
City:	**State:**

I hereby authorize and release the custodian of my/my dependent's medical records to Sleep Clinic of America, including psychological, psychiatric, developmental/rehabilitative alcohol, and/or drug abuse human immunodeficiency virus (HIV) testing and treatment, ARC (AIDS related condition), and/or acquired immunodeficiency syndrome (AIDS) information.

Release To: Sleep Clinic of America ****IF RECORDS EXCEED 15 PAGES, WE REQUEST THAT THEY BE MAILED****	**Address:** 1980 N Prospect Ave. Lecanto, FL 34461 **Phone:** 352-527-6673 ***Fax:** 352-527-9314	**Purpose of Use or Disclosure:** ☐ Continuity of Care ☐ Other:

Information to be Released: **Patient Initials: _____**	☐ Complete Chart ☐ Other: _____ _____ I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV, or AIDS information.

-I understand that all medical, surgical, psychiatric, and psychological information is confidential and that the patient records are the property of Sleep Clinic of America and its related corporate entities. I will not hold Sleep Clinic of America or its employees, staff, or representatives responsible for any damage, mental or physical, which may be caused by the release of patient records and the information contained therein.

-I understand that my authorization for release may be revoked at any time by written request to Sleep Clinic of America, but may not be revoked to include the release allowed by this document. Also, if this authorization is permission for Sleep Clinic of America to disclose information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest your coverage.

-I understand that the person or organization that receives the information because of this authorization may disclose this information to other people or organizations without my knowledge or consent. Therefore, I hereby release Sleep Clinic of America, its employees, its staff, and representatives from all liability relating to or arising out of this release of information Sleep Clinic of America records.

-I understand I can refuse to sign this authorization and I do not need to sign this authorization to receive treatment services from Sleep Clinic of America. However, if the only purpose for providing the service is to obtain information in order to release information to myself or third party, then I understand that I must sign the authorization in order to receive the service.

-I understand that there may be a charge of $1.00 per page for the first 25 pages and then $.25 per page thereafter, plus postage and handling, for copy services unless copies provided by Sleep Clinic of America are sent directly to a physician or health facility for the purpose of continuity of care.

This authorization will expire in twelve (12) months following the date of signature, unless otherwise specified below:

Expiration Date or Circumstance: _____

Patient Signature: _____ **Date:** _____

Relationship to Patient if Not Self: _____

Witnessed/Requested By: _____ **Date:** _____

SLEEP CLINIC OF AMERICA

Comprehensive Sleep History: Specific Sleep Disorder Questionnaire

Patient Name: _____ **DOB:** _____ **Date:** _____ **MR#:** _____

What is your sleep problem(s)?

_____

_____

Do you wake up refreshed after sleep? ☐ Yes ☐ No

Mark the statements below as they relate to you.		
Insomnia		
	1	Have you noticed that it takes you more than 30 minutes to fall asleep?
	2	Do recurring thoughts keep you from sleeping?
	3	Do you find yourself worried about your lack of sleep?
	4	Do your sleep problems occur more than 3 times a week?
	5	When you wake up do you find in difficult to fall back asleep?
	6	Are you so tense, stressed or worrisome that it causes difficulties relaxing?
	7	Is the time you wake up earlier than you would like?
	8	Do you find yourself unable to get to sleep for 30 minutes or more in your bed?
	9	Have you ever been diagnosed with insomnia?
	10	Do you take sleep medications (prescription or over the counter) to help you sleep?
	11	Do you wake up multiple times after falling asleep?
Sleep Apnea		
	12	Do you snore?
	13	Have you ever been diagnosed with sleep apnea?
	14	Do friends or family members avoid sharing a bed with you due to your snoring?
	15	Has anyone witnessed you stop breathing while you were sleeping?
	16	Do you excessively wake during the night to urinate?
	17	Do you have hypertension (high blood pressure)?
	18	Does your sleep position affect your snoring?
	19	Do you have a favorite sleeping position? What is your favorite sleeping position?
		☐ Belly ☐ Back ☐ Right Side ☐ Left Side ☐ Other:
	20	Have your loved ones noticed that you have been irritable or grumpy?
	21	Have you fallen asleep while driving?
	22	Have you noticed during sleep that you heart rate is at times irregular or pounding?
	23	Do you wake up in the morning with headaches?
	24	Have your loved ones noticed you suddenly wake and gasp for air while sleeping?
	25	Do you consider yourself overweight or obese?
	26	Have you noticed a decrease in your sex drive?
	27	Do you feel tired during the daytime and fall asleep easily when sitting quietly?
	28	Do you have a sore throat or dry mouth when you wake up?
Narcolepsy/Excessive Sleepiness		
	29	Do you frequently lose muscle tone during intense emotions?
	30	Do you experience the feeling that you are in a fog?
	31	Do you experience frequent vivid dreams?

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	32	Do you have to take multiple naps during the daytime?
	33	When taking daytime naps do you find that they are unusually refreshing?
	34	Are you able to easily fall asleep in public, social settings or special events?
	35	Do you feel that your sleepiness is often affecting your work?
	36	Shortly after falling asleep or during naps do you dream?
	37	Do you have unusual "sleep attacks" during the daytime?
	38	Were you ever diagnosed with narcolepsy?
	39	Were you ever diagnosed with hypersomnia?
	40	At times have you experienced brief loss of your ability to move upon falling asleep?
	41	At times have you experienced brief loss of your ability to move upon awakening from asleep?
Periodic Limb Movement Disorder/Restless leg Syndrome		
	42	Do you wake tired and feel tired during the day even after sleeping at night?
	43	Have you ever been diagnosed with restless legs syndrome?
	44	Do you experience muscle tension in your legs other than when exercising?
	45	Have you or others noticed that during sleep your legs or other body parts jerk?
	46	Has your bed partner ever stated that you kick in your sleep?
	47	Do you experience aches, creeping or crawling sensations in your legs before going to sleep?
	48	During the night do you experience leg pains or cramps?
	49	At night do you have "jumpy" legs that cause you to move your legs to feel comfortable?
REM sleep behavior disorder (RBD)		
	50	Do you act out in your dreams?
	51	Do you have violent behavior while asleep?
	52	Do you have a personal history of Parkinson's Disease?
	53	Do you have tremors during the daytime?
	54	Do you have body rigidity during the daytime?
	55	Are you slow to move in the daytime?
	56	Were you ever diagnosed with a REM sleep behavior disorder (RBD)?
Shift Work Disorder		
	57	Does your work schedule interfere with your sleep?
	58	Are you a shift worker?
	59	As a result of your shift work, do you feel that it is affecting your sleep?
	60	What type of shift do you work?
		☐ Days ☐ Evenings ☐ Overnight ☐ Alternating Shifts
	61	How long have you been on your current shift?
		☐ <1 Year ☐ 2-5 Years ☐ 5-10 Years ☐ >10 Years
	62	Do you feel sleepy during the daytime as a result of your shift work?
	63	Were you ever diagnosed with shift work disorder?

Section Questions

If the patient shows symptoms in three or more questions in a section results are as follows:

- **1-11 Insomnia:** A persistent inability to fall asleep or stay asleep.
- **12-28 Sleep Apnea:** A potentially serious disorder which causes you to stop breathing repeatedly, often hundreds of times in the night during your sleep.
- **29-41 Narcolepsy:** A lifelong disorder characterized by uncontrollable sleep attacks during the day.
- **42-49 Periodic Limb Movement Disorder:** Uncontrollable leg or arm jerks during sleep **OR** **Restless Leg Syndrome:** Uncontrollable feelings in the legs at night.
- **50-56 REM Sleep Behavior Disorder:** Paralysis that normally occurs during REM sleep is incomplete or absent, allowing the person to "act out" his or her dream, characterized by the acting out of dreams that are vivid, intense, and violent.
- **57-63 Shift Work Disorder:** Circadian rhythm sleep disorder characterized by insomnia and excessive sleepiness affecting people whose work hours overlap with the typical sleep period.

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Additional Sleep History, Habits and Driving History

Sleep Related: Evaluations and History

Have you ever had a sleep study? ☐ No ☐ Yes, When and Where?

If Yes, Please clarify what type of sleep study was performed?

☐ Polysomnography (PSG) Sleep Study of Snoring/Sleep Apnea
☐ Multiple Sleep Latency Test (MSLT) Sleep Study of Excessive Sleepiness/Narcolepsy
☐ Other: _____

Do you have a copy of the sleep study results? ☐ Yes ☐ No
Can you obtain a copy of the results? ☐ Yes ☐ No

Are you currently using a CPAP or BiPAP? ☐ Yes ☐ No

If so, what pressure? _____ How long has it been used? _____

If you stopped using your CPAP or BiPAP machine, why did you stop? _____

Are you being followed by a sleep specialist? ☐ Yes ☐ No

Are you using outdated equipment and/or supplies for snoring or obstructive sleep apnea (OSA)? ☐ Yes ☐ No

Have you ever had any surgery for sleep apnea? ☐ Yes ☐ No

If yes, what type of surgery? _____

Do you use oxygen at home? ☐ No ☐ Yes, Liters per minute (LPM)? _____

Sleep Related Habits: Bedtime

Bedtime on Weekdays: _____ ☐ am ☐ pm Bedtime on Weekends: _____ ☐ am ☐ pm	Wake-Up Time on Weekdays: _____ ☐ am ☐ pm Wake-Up Time on Weekends: _____ ☐ am ☐ pm
On average how many hours do you sleep a night? _____ Hours	Do you take any naps? ☐ Yes ☐ No How long are your naps? ☐ 15 Minutes ☐ 30 Minutes ☐ 45 Minutes ☐ 60 Minutes ☐ >60 Minutes

Do you feel refreshed after a nap? ☐ Yes ☐ No
Do you have a bed partner? ☐ Yes ☐ No
Do you think that your bed partner's habits are affecting your sleep? ☐ Yes ☐ No
Do you watch television in your bedroom? ☐ Yes ☐ No
Do you read in bed? ☐ Yes ☐ No
Do you eat in bed? ☐ Yes ☐ No
Do you eat in bed while asleep? ☐ Yes ☐ No
Do you have a hard time trying to relax? ☐ Yes ☐ No
Do you grind your teeth while sleeping? ☐ Yes ☐ No
Do you act out dreams? ☐ Yes ☐ No
Do you have nightmares and/or night terrors? ☐ Yes ☐ No
Do you walk while sleeping? ☐ Yes ☐ No
Do you talk while sleeping? ☐ Yes ☐ No
Do you toss and turn at night? ☐ Yes ☐ No

Sleep Related Habits: Bedroom Environment

Is your bedroom cool enough? ☐ Yes ☐ No
Is your bedroom noise proof? ☐ Yes ☐ No
Is your bedroom completely dark? ☐ Yes ☐ No
Are there any distractions in your bedroom? ☐ Yes ☐ No
Do you have a visible clock in your bedroom? ☐ Yes ☐ No
Do you think your bed partners' habits are affecting your sleep? ☐ Yes ☐ No

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Sleep Related Habits: Psychiatric Conditions
Do you suffer from excessive worry, anxiety or phobias? ☐ Yes ☐ No Do you suffer from depression? ☐ Yes ☐ No Do you have any medical problems that may affect your sleep? ☐ Yes ☐ No Do you have racing thoughts while in bed? ☐ Yes ☐ No Do you have bipolar disorder? ☐ Yes ☐ No Do you have schizophrenia or other type of psychosis? ☐ Yes ☐ No If you have a mental illness are you currently followed by a mental or medical health professional? ☐ Yes ☐ No ☐ N/A Do you feel that your mental illness is under good control? ☐ Yes ☐ No ☐ N/A

Social History: Tobacco Use
Are you a current tobacco user? ☐ Yes ☐ No Have you ever used any tobacco products? ☐ Yes ☐ No If yes, please mark each tobacco product: ☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe or Cigars ☐ Electronic Vape Pen ☐ Other: _____ If smoking please tell us how many packs daily: ☐ <1 Pack ☐ 1-2 Packs ☐ >2 Packs How long have you been using tobacco products? ☐ <1 Year ☐ 1-3 Years ☐ 3-5 Years ☐ >5 Years How long before bed do you use tobacco products? _____ If no longer using tobacco how long has it been since you quit? ☐ <1 Year ☐ 1-3 Years ☐ 3-5 Years ☐ >5 Years
Social History: Caffeine Use
Do you currently drink caffeinated beverages? ☐ Yes ☐ No If yes, please mark each caffeinated beverage that applies: ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Other: _____ How many caffeinated beverages do you consume daily? ☐ 1 beverage ☐ 2-3 beverages ☐ >3 beverages What time of the day do you typically consume your last caffeinated beverage? ☐ Morning ☐ Noon-3:00 pm ☐ 3:00 pm-6:00 pm ☐ >6:00 pm
Social History: Alcohol Use
Do you drink alcohol? ☐ Yes ☐ No If yes, please mark each type of alcohol that applies: ☐ Beer ☐ Wine ☐ Whiskey ☐ Vodka ☐ Tequila ☐Rum ☐ Gin ☐ Cognac ☐ Other: _____ How often did you consume an alcoholic beverage in the past year? ☐ Never ☐ Monthly or Less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week ☐ Daily On a typical day of consuming alcohol over the past year, how many drinks did you consume in that day? ☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ >10 drinks Over the past year how often did you consume 6 or more alcoholic beverages on one occasion? ☐ Never ☐ <1 Month ☐ Monthly ☐ Weekly ☐ Daily or nearly every day Do you use alcohol as a sleep aid? ☐ Yes ☐ No

Social History: Drug Use
Do you or have you used recreational drugs (drugs taken for any reason other than medical) in the last year? ☐ Yes ☐ No If yes, please mark each type of recreational drug that applies: ☐ Marijuana ☐ Methamphetamine ☐ Cocaine ☐ Prescription Opiates ☐ Ecstasy ☐ Crack ☐ PCP ☐ Ketamine ☐ LSD ☐ Other: _____ How frequently do you use recreational drugs? ☐ Never ☐ Monthly or Less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week ☐ Daily If using marijuana, do you currently have a medical marijuana card? ☐ Yes ☐ No

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Social History: Lifestyle, Work, Driving

Do you exercise? ☐ Yes ☐ No
If yes, how often do you exercise? ☐ Daily ☐ 1-2 times weekly ☐ 3-5 times weekly
Is the time you exercise close to when you are going to bed? ☐ Yes ☐ No

Social History: Driving History

Do you drive? ☐ Yes ☐ No
Does your work require you to drive? ☐ Yes ☐ No
Do you have a commercial driver's license? ☐ Yes ☐ No
How frequently do you feel sleepy while driving? ☐ Never ☐ Sometimes ☐ Often ☐ Always
Have you had any accidents or near missed accidents while driving due to being sleepy? ☐ Yes ☐ No

Family Medical History: Biological Parent(s)

Parent	Status	Age at Death	Cause of Death
Mother	☐ Living ☐ Deceased ☐ Unknown		
Father	☐ Living ☐ Deceased ☐ Unknown		

Family Medical History: Medical Conditions

Please mark below any of your immediate blood related family (not to include spouse or in-laws) that has ever had the following conditions. If marked, please indicate the family member.

	Medical Condition	Family Member		Medical Condition	Family Member
☐	Narcolepsy		☐	Hypertension (High BP)	
☐	Snoring		☐	Hypotension (Low BP)	
☐	Obstructive Sleep Apnea (OSA)		☐	Congestive Heart Failure (CHF)	
☐	Insomnia (trouble falling or staying asleep)		☐	Coronary Artery Disease (CAD)	
☐	Restless Leg Syndrome		☐	High Cholesterol	
☐	Sleep Walking		☐	Heart Disease	
☐	Dementia		☐	Early Cardiac Death (<65 years old)	
☐	Depression		☐	Stroke or Transient Ischemic Attack (TIA)	
☐	Bipolar Disorder		☐	Epilepsy	
☐	Schizophrenia		☐	Seizure Disorder	
☐	Other Psychotic Disorder		☐	Alcohol Abuse	
☐	Parkinson's Disease		☐	Drug Abuse	
☐	Diabetes Mellitus		☐	Obesity	
☐	Cancer: ☐ Skin ☐ Lung ☐ Prostate ☐ Breast ☐ Colon ☐ Kidney ☐ Bladder ☐ Non-Hodgkin's Lymphoma ☐ Thyroid ☐ Cervical ☐ Endometrial ☐ Ovarian ☐ Pancreatic ☐ Other: _____		☐	Other Condition(s): _____ _____ _____ _____ _____ _____	

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Personal Medical History: Tell us about any other medical conditions that you have or have had in the past.
Please mark all applicable medical conditions below:

	Obstructive Sleep Apnea (OSA)		Parkinson's Disease		Heart Disease
	Insomnia		Excessive Daytime Sleepiness		High Cholesterol
	Narcolepsy		Bipolar Disorder		Coronary Artery Disease
	Restless Leg Syndrome		Uncontrolled Schizophrenia		Hypertension (High BP)
	Rapid Eye Movement (REM)		Epilepsy		Hypotension (Low BP)
	Obesity		Seizure Disorder		Congestive Heart Failure (CHF)
	Depression		Panic Attacks/Anxiety		Dementia
	Chronic Neck Pain		Pneumonia		Cardiac Arrhythmia
	Chronic Pain		Asthma		Cardiac Pacemaker
	Head Trauma		Memory Loss		Shortness of Breath (SOB)
	Migraines		Hiatal Hernia		Pulmonary Embolism
	Stroke or Transient Ischemic Attack (TIA)		Benign Prostatic Hyperplasia		Ischemic Heart Disease
	Diabetes Mellitus		Gout		Pneumonia
	Fibromyalgia		Allergic Rhinitis		Respiratory Failure
	Lupus		Anemia		Grinding Teeth
	Menopause		Drug Abuse		Chronic Kidney Disease
	Decreased Sex Drive		Liver Disease		Multiple Sclerosis (MS)
	Frequent Sinus Infections		Ulcer Disease		Aneurysm
	Latex Allergy		Herniated Discs		Claustrophobia
	Cancer (Please list type): ☐ Skin ☐ Lung ☐ Prostate ☐ Breast ☐ Colon ☐ Kidney ☐ Bladder ☐ Non-Hodgkin's Lymphoma ☐ Thyroid ☐ Cervical ☐ Endometrial ☐ Ovarian ☐ Pancreatic ☐ Other:		Thyroid Disease/Disorder: ☐ Hypothyroidism ☐ Goiter ☐ Hyperthyroidism ☐ Nodules ☐ Parathyroid ☐ Other:		Chronic Obstructive Pulmonary Disease (COPD)/Emphysema Do you use oxygen? ☐ Yes ☐ No _____ LPM
	Gastro-Esophageal Reflux Disease (GERD)/Heartburn		Arthritis: ☐ Rheumatoid ☐ Osteoarthritis		Metal Implants

Please list any other medical conditions that you have been diagnosed with:

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Surgical History: Sleep Related
Have you ever had any surgeries and/or procedures that relate to sleep? ☐ Yes ☐ No If yes, please mark all that apply: ☐ Tonsillectomy ☐ Adenoidectomy ☐ Tracheostomy ☐ Uvulopalatopharyngoplasty (UPPP) ☐ Hypoglossal Nerve Stimulation ☐ Maxillomandibular Advancement (MMA) ☐ Septoplasty and Turbinate Reduction ☐ Palatal Implant Hyoid Suspension ☐ Radiofrequency Volumetric Tissue Reduction (RFVTR) ☐ Midline Glossectomy and Base of Tongue Reduction ☐ Genioglossus Advancement (GGA) ☐ Anterior Inferior Mandibular Osteotomy (AIMO) ☐ Jaw Surgery ☐ Neck Surgery ☐ Other: _____

Past Surgical History: Please list any past surgeries or procedures that you have had:	
Name of Surgery or Procedure	**Date Performed**

Allergies: Please list any allergies that you may have.	
Allergy:	**Reaction:**

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Current Medications: Please list **ALL** current medications you are already taking (including non-prescription medications, vitamins, supplements and birth control pills). You may attach a list if you have one.			
Medication Name	**Dosage/Frequency**	**Years Taken**	**Reason for Medication**

SLEEP CLINIC
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Standard Sleepiness Scale & Obstructive Sleep Apnea Screening

Patient Name: _____ **Date:** _____ **MR#:** _____

The EP WORTH Sleepiness Scale (attached):

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 = No chance of dozing	**2 = Moderate chance of dozing**
1 = Slight chance of dozing	**3 = High chance of dozing**

Situation	**Chance of Dozing Score**			
Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting inactive in a public place (e.g. a theater or a meeting)	**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 when the circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after a lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**
TOTAL				

STOP-BANG Sleep Apnea Questionnaire:

Please answer the questions below to help us see if you might have sleep apnea. This is when your breathing pauses sometimes while you are sleeping. Each "Yes" is worth one point.

STOP	**Yes**	**No**
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors)?		
Do you feel **T**IRED, fatigued, or sleepy during daytime?		
Has anyone **O**BSERVED you stop breathing during your sleep?		
Do you have or are you being treated for high blood **P**RESSURE?		
BANG		
BMI more than 35kg/m2?		
AGE over 50 years old?		
NECK circumference > 16 inches (40 cm)?		
Gender: Are you male?		
Total Score		

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What do my scores mean?

The EP WORTH Sleepiness Scale Scoring:

- If your score is below 9 you have a healthy level of daytime sleepiness in comparison to the general population.
- If your score is between 10 and 18 you have an excessive level of daytime sleepiness compared to the general population which requires further attention. You should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene.
- If your score is 18 or above you have a very high level of excessive daytime sleepiness.

STOP-BANG Sleep Apnea Questionnaire Scoring:

- Yes to 0-2 questions **low risk** for OSA
- Yes to 3-4 questions **intermediate risk** for OSA
- Yes to 5-8 questions **high risk** for OSA

OR

- Yes to 2 or more of 4 STOP questions + male gender
- Yes to 2 or more of 4 STOP questions + BMI > 35kg/m2
- Yes to 2 or more of 4 STOP questions + neck circumference 17 inches/43 cm in male
- Yes to 2 or more of 4 STOP questions + neck circumference 16 inches/41 cm in female

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Sleep Deprived or Drowsy Driving Acknowledgement

Driving sleep deprived or drowsy is a combination of sleepiness and fatigue but can also occur due to untreated sleep disorders, medications, drinking alcohol, and shift work. Often it occurs when the driver is too tired to remain alert while operating a motor vehicle. Drowsy drivers' cognitive abilities may be impaired, causing reduced coordination and judgment similar to the affect of alcohol; making it just as dangerous as drinking and driving. Due to the severity of consequences that occur while driving drowsy, Sleep Clinic of America feels obligated to inform you of the potential increased risks of vehicular accidents as well as injuries to the driver and others. Drivers must know the warning signs of drowsy driving that include:

- Frequent blinking or yawning
- Missing turns or exits
- Forgetting past few miles driven
- Drifting from one lane to another
- Hitting the rumble strips in the center and sides of the road

The only true way to address driving drowsy is to sleep. If you feel that you are becoming drowsy while driving then you should immediately pull over on the roadside. Please know that while caffeine may make the driver feel alert it is only for a brief amount of time. Turning up the radio, singing, rolling the windows down, getting out of the car to walk, etc. are **NOT** effective ways to deter drowsiness. The options that a drowsy driver has while on the roadside are to:

- Take a nap until rested enough to drive
- Call a friend or family member to come to pick you up
- Call a form of public transportation such as a cab to come pick you up

Drowsy driving can be prevented by developing good sleeping habits such as keeping to a sleep schedule and getting adequate sleep (at least 7 hours). Drivers should avoid any medications that cause drowsiness and should not consume alcohol prior to driving. Under no circumstances should a driver drive drowsy as it is a matter of personal and public safety.

By signing below I acknowledge that I have been made aware of the consequences of driving a motor vehicle sleep deprived or drowsy.

_____ _____ _____

Signature of Patient/Guardian | Relationship to patient | MR #

_____ _____

Printed Name of Patient/Guardian | Today's Date

SLEEP CLINIC
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Bed Partner/Witness Screening Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Bed Partner/Witness Name: _____ Relationship to Patient: _____

How often have you observed the patient's sleep? ☐ Never ☐ Once or Twice ☐ Often ☐ Every Night

Have you noticed the patient fall asleep during normal daytime activities or in other situations that may pose danger (i.e. driving)? ☐ Yes ☐ No If yes, please explain:

_____

_____

_____

Below please check all applicable behaviors that have been observed by **you** while the patient is sleeping.

While the patient sleeps I have observed:	
☐ Snoring	☐ Teeth grinding
☐ Choking	☐ Tongue biting
☐ Gagging	☐ Acting out dreams
☐ Kicking legs or feet	☐ Night terrors
☐ Pausing breathing	☐ Violent behavior while asleep
☐ Tossing and turning	☐ Sitting up in the bed but still asleep
☐ Sleep walking	☐ Body very rigid and/or shaking
☐ Sleep talking	☐ Other:
☐ Sleep eating	
☐ Head rocking or banging	

How long have you noticed the sleep behavior(s) that you checked above?
☐ Weeks ☐< 3 Months ☐ 3-6 Months ☐ 6-12 Months ☐ 1-2 Years ☐ 3+ Years ☐ Other: _____

Please describe the checked behavior(s) in more detail. Include a description of the behavior, when it occurs during the night, frequency during the night, and how often it occurs (every night, 4 times a week, etc.).

_____

_____

_____

_____

_____ _____

Signature of Bed Partner/Witness Date

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Sleep Diary

Patient Name: _____ Date: _____ MR#: _____

A sleep diary can help you see abnormalities in your own sleep habits, such as irregular or inconsistent bed times, or daytime naps, that may affect the sleep schedule at night.

Please fill out as much as possible, including naps and bring with you at time of initial sleep study

Day	Date	Time in Bed	Out of bed	Total TIB	Time Asleep	Time Awake	TST	S.E.
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								

Abbreviations Key for Sleep Diary:

- **Time in bed:** The final time of day you got in bed to go to sleep
- **Time out of bed:** The time of day you got out of bed for the last time in the morning
- **Total TIB:** The total time in minutes you spent in bed during the night. This equals the time out of bed minus the time in bed.
- **Time asleep:** The estimated time of day you fell asleep for the first time.
- **Time awake:** The estimated time of day you awoke for the last time in the morning.
- **TST (Total sleep time):** The estimated total amount of time (in minutes) you actually slept.
- **S.E. (Estimated sleep efficiency):** This is calculated by dividing the TST by the TIB. A sleep efficiency of >90% is considered normal.