NEW PATIENT FORM

It is important that you fill out this sleep questionnaire completely and as accurately as possible. Please answer each question. The questionnaire is a broad-based screening tool that will assist our staff and your treating sleep physician to provide excellent care to you. It may be helpful to consult with a family member or bed partner when answering these questions. All information contained in this questionnaire will become a part of your medical record and will be confidential.

Patient's Information:

Name: ________________________________ DOB: ________________ Age: ____________________

Home Address: ____ *(Include: City/St/Zip Code)*

Height: _______Weight: ________ Neck Size ________ Male: ☐ Female: ☐

Marital Status: (Please Circle) Married Single Divorced Widowed

Home Phone: (______) ________________ Cell: (______) ________________ Work: (______) _______________

Employer: ____

Occupation: ____________________________________

Relationship to Insured: (Please Circle) Self Spouse Child Other ___________________

Insured's Name (if other than patient) ___________________ Insured's SSN: ____________________DOB _________

Physician Information:

Primary Physician: _______________________ Referring Physician: _________________________________

Phone: (_____) __________________________ Phone: (______) ____________________________________

Specialty: _______________________________ Specialty: ____

Reason For Your Visit:

The reason for sleep evaluation?

____

____

____

How long have you had this problem? _______________Months _______________Years

State of Franklin
HEALTHCARE ASSOCIATES™

List other problems with your sleep (indicate duration in months/years):

a) ____

b) ____

c) ____

d) ____

Have you had a sleep problem diagnosed in the past? ☐ Yes | ☐ No

If yes, what was/were the problem(s) and what treatment(s) was/were recommended?

____

Did the treatment(s) help? ☐ Yes | ☐ No

Where was the diagnosis made? ____

Sleep Schedule:

Work Hours: ____________ Shift ☐ 1st ☐ 2nd ☐ 3rd ☐ Rotating

Bedtime	Wake time	Average amount of sleep per night
Weekday: ☐am ☐ pm	☐am ☐ pm	Hours:
Weekend: ☐am ☐ pm	☐am ☐ pm	Hours:

Do you wake up feeling rested? ☐ Yes | ☐ No

Do you currently use CPAP treatment at night? ☐ Yes | ☐ No Pressure: ______________________

How long does it take you to go to sleep? ____________hours ____________minutes

How many times a night do you wake up from sleep? _____________Do you fall back to sleep easily? __________

What wakes you from your sleep: ☐ Nothing ☐ Pain ☐ Need to empty bladder ☐ Noise ☐ Light ☐ Bedpartner ☐ Uncomfortable temperature ☐ Mattress ☐ Pets ☐ Unknown ☐ Other: ________________________

Do you nap? __________________________ If so, how many days per week? ________________________

State of Franklin HEALTHCARE ASSOCIATES™

AMERICAN ACADEMY OF SLEEP MEDICINE® WAKE SLEEP
ACCREDITED MEMBER CENTER

Sleep History:

Describe the problem you are experiencing with your sleep and when it first began:

☐ Yes | ☐ No Do you experience excessive daytime sleepiness? For how long? _______________

☐ Yes | ☐ No Are you a restless sleeper? For how long? _______________

☐ Yes | ☐ No Do you snore sleeping in all positions? For how long? _______________

☐ Yes | ☐ No Have you ever awakened gasping for breath? For how long? _______________

☐ Yes | ☐ No Do you have “tingly” legs and feel as if you have to move them? For how long? _______________

☐ Yes | ☐ No Do you kick your legs at night? For how long? _______________

☐ Yes | ☐ No Do you sleep better away from your own bed? (ie: vacation) For how long? _______________

☐ Yes | ☐ No Do you have pain that bothers you at night? For how long? _______________

☐ Yes | ☐ No Do you grind your teeth in your sleep? For how long? _______________

☐ Yes | ☐ No Do you sleep walk? For how long? _______________

☐ Yes | ☐ No Do you talk in your sleep? For how long? _______________

☐ Yes | ☐ No Have you ever experienced periods in which you feel paralyzed while you are going to sleep or waking up? For how long? _______________

☐ Yes | ☐ No Have you ever had a hallucination or dream-like mental images when falling asleep? For how long? _______________

☐ Yes | ☐ No Have you ever experienced sudden physical weakness during strong emotions? (ie: legs going limp while laughing or when angry) For how long? _______________

☐ Yes | ☐ No Have you ever had an automobile accident due to sleepiness? Date of Accident ____/____/______

Berlin Questionnaire:

Category 1 Questions	
2. Do you snore?	☐ Yes** ☐ No ☐ I don't know
3. How loud is your snoring?	☐ My snoring is as loud as breathing ☐ My snoring is as loud as talking ☐ My snoring is louder than talking** ☐ My snoring is very loud**
4. How frequently do your snore?	☐ Almost every day** ☐ 3-4 times per week** ☐ 1-2 times per week ☐ 1-2 times per month ☐ Never or almost never
5. Does your snoring bother other people?	☐ Yes **☐ No
6. How often have your breathing pauses been noticed?	☐ Almost every day** ☐ 3-4 times per week** ☐ 1-2 times per week ☐ 1-2 times per month ☐ Never or almost never
Category 2 Questions	
7. Are you tired after sleeping?	☐ Almost every day** ☐ 3-4 times per week** ☐ 1-2 times per week ☐ 1-2 times per month ☐ Never or almost never
8. Are you tired during wake time?	☐ Almost every day** ☐ 3-4 times per week** ☐ 1-2 times per week ☐ 1-2 times per month ☐ Never or almost never
9. How often do you nod off or fall asleep while driving?	☐ Almost every day** ☐ 3-4 times per week** ☐ 1-2 times per week ☐ 1-2 times per month ☐ Never or almost never
Category 3 Questions	
10. Do you have high blood pressure?	☐ Yes** ☐ No ☐ I don't know

Epworth Sleepiness Scale:

Please estimate your risk of falling asleep in the following situations, using the scale below

SITUATION	CHANCE OF DOZING
Sitting and Reading	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
Watching TV	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
Sitting inactive in a public place (e.g. theatre of meeting)	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
As a passenger in a car for an hour without a break	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
Lying down to rest in the afternoon when circumstances permit	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
Sitting and talking to someone	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
Sitting quietly after a lunch without alcohol	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
In a car, while stopped for a few minutes in traffic	☐ 0= None ☐ 1= Slight ☐ 2= Moderate ☐ 3= High
	TOTAL SCORE =________

State of Franklin
HEALTHCARE ASSOCIATES™

Medical History:

Review of Symptoms (Check all that apply to you)

General

□ Fatigue
□ Sleeping Problems
□ Weight loss
□ Weight gain

HEENT

□ Dry mucous membranes
□ Earache
□ Hay fever
□ Headache
□ Nasal congestion
□ Nosebleeds
□ Ringing in ears
□ Sinus pain
□ Sore throat
□ Stuffiness

Respiratory

□ Shortness of breath
□ Wheezing

Cardiovascular

□ Difficulty breathing lying down
□ Shortness of breath with activity
□ Palpitations

Gastrointestinal
□ Swallowing difficulties
□ Heartburn

Musculoskeletal

□ Back pain
□ Joint pain
□ Muscle stiffness
□ Leg cramping

Neurologic

□ Fainting
□ Seizures

Psychiatric

□ Depression
□ Memory Loss

Endocrine
□ Cold intolerance
□ Excessive sweating
□ Excessive urination
□ Heat intolerance

Past Medical History:

Past Medical History (Check all that apply to you)

☐ Diabetes ☐ High Blood Pressure ☐ Heart Attack/Angina ☐ Atrial Fibrillation

☐ Congestive Heart Failure ☐ Stroke ☐ Restless Legs Syndrome ☐ Sexual Problems

☐ COPD ☐ Pulmonary Hypertension ☐ Seizures

☐ Other ____

State of Franklin
HEALTHCARE ASSOCIATES™

Family History:

(Which blood relatives been *diagnosed* with the any of the following)

☐ Sleep Apnea – Relative(s): ________________________ ☐ Restless legs syndrome – Relative(s): _____________________

☐ Narcolepsy – Relative(s): _________________________ ☐ Sleepwalking – Relative(s): _____________________________

Social History:

I drink alcohol: ☐ Never ☐ Few times per year ☐ Few times per month ☐ Few times per week ☐ Daily

If you do drink, how many drinks do you usually have? ___________________________

If you currently use tobacco, how long have you used it? __________________________

If you used tobacco in the past, about when did you quit? __________________________

How many cups of caffeinated beverages do you drink per day? _____________________

How often do you drink caffeine within 2 hours of bedtime: ☐ Everyday ☐ Occasionally ☐ Rarely ☐ Never

Current Medications:

Pharmacy Name & Location: ____

Current Medications: (Include any sleep aids) – use the back of the page if necessary

________________________________ ______________________________ ____________________________

________________________________ _______________________________ ____________________________

________________________________ _______________________________ ____________________________

Currently or have used oxygen at home ☐ Yes | ☐ No DME Company: ____

Past Surgical History:

(Check all that apply to you)

☐ Jaw Surgery ☐ Nasal septoplasty ☐ Nasal Turbinate reduction

☐ Adenoids removed ☐ Thyroid Surgery ☐ Uvulopalatopharyngoplasty (UPPP or UP3)

☐ Heart Valve Surgery ☐ Coronary Artery Bypass Graft ☐ Pacemakers/ALCD Placement

☐ Cardiac Stent ☐ Weight loss surgery ☐ Tonsils removed

Patient Signature ____ Date ____/____/_________

State of Franklin HEALTHCARE ASSOCIATES™

AMERICAN ACADEMY OF SLEEP MEDICINE® WAKE SLEEP ACCREDITED MEMBER CENTER

Notice of Nondiscrimination

State of Franklin Healthcare Associates complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. State of Franklin Healthcare Associates does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

State of Franklin Healthcare Associates:

- Provides free aids and services to patients with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact the Office Manager.

If you believe that State of Franklin Healthcare Associates has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Vicki Moody
2528 Wesley Street, Suite 2
Johnson City, TN 37601
P: 423.794.2440
423-283.9730
vickimoody@sofha.net

or

Sandra Westelaken
2528 Wesley Street, Suite 1
Johnson City, TN 37601
P: 423.794.2435 F:
F: 423.794.1842
sandrawestelaken@sofha.net

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Vicki Moody or Sandra Westelaken are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F HHH Building
Washington, DC 20201
1-800-368-1019; 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html