

SLEEP LINK - SOUTHWEST

Patient Questionnaire

Name: _____ Age: _____ Marital Status: _____
Date of Birth: _____ SS#: _____ Home Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Work Phone: _____
Employer Address: _____
Occupation _____
Do you drive a truck, bus or operate heavy equipment? _____ Pilot? _____

Primary Insurance: _____ Group #: _____
Claim Address: _____
Insured's Name: _____ Phone #: _____
Policy #: _____
Secondary Insurance: _____ Group #: _____
Claim Address: _____
Insured's Name: _____ Phone #: _____
Policy #: _____
Doctor's Full Name: _____

Height: _____ Weight: _____ Sex: _____
Do you currently exercise at least 20 minutes a day, 3 days a week?
___Yes___No
Have you gained weight during the past 3 to 6 months?
___Yes How much? _____ ___No

Normal Bedtime: _____am/pm Normal Wake-up Time: _____am/pm
Does your sleep schedule change as a result of work, family, or social responsibilities?
___Yes ___No
Do you nap during the day? ___Yes ___No If Yes, when: ___Daily ___Weekends
Comments: _____
Are these naps refreshing? ___Yes ___No
Do you routinely have difficulty falling asleep? ___Yes___No
When lying in bed, do you find yourself thinking about various daytime activities or do thoughts race through your mind? ___Yes ___No
Current Medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Questions	Never	Rarely	Sometimes	Frequently	Most of the time	Always
I am sleepy during the day, even though I slept through the night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am tired during the day, even though I slept through the night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I awaken at least once during the night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I require a nap to remain awake during the evening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fall asleep when watching TV in the evening, though I try to stay awake.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fall asleep during routine situations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fall asleep while driving.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have difficulty concentrating or making decisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I sweat at night while asleep without being hot.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wake up during the night to urinate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I notice puffiness in my ankles, feet, or hands at night.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wake up in the morning with headaches.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am hoarse or have a dry, sore throat when I wake up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been told that I snore loudly when sleeping on my back.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been told that I snore loudly even when sleeping on my side.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	Neve				Most	

Questions	r	Rarely	Sometimes	Frequently	of the time	Always
My snoring affects the sleep of others.						
I have been told that I stop breathing while sleeping.						
I wake up gasping for breath.						
I wake up short of breath.						
I am short of breath during periods of inactivity.						
I am short of breath during periods of exertion.						
I often sleep better when reclining or not sleeping flat.						
I kick or twitch my legs at night prior to falling asleep.						
I have been told I kick or twitch my legs or arms when sleeping.						
I have "aching" or "crawling" sensations in my legs when relaxing at night.						
I wake up with heartburn.						
When surprised, angered, or excited, I feel like I am going to "black out" or buckle at my knees.						
I wake up and am too tired to move.						
I wake up and cannot move, as if I were paralyzed.						
I experience vivid, life-like scenes when I am tired.						
I have been told I grind or clench my teeth while sleeping.						
I talk in my sleep.						
I walk in my sleep.						

Please circle the appropriate responses:

I use oxygen at night.	Yes/No	I have high blood pressure.	Yes/No
I currently use CPAP at night.	Yes/No	I have an irregular heart beat.	Yes/No
I use sleep medications.	Yes/No	I have had a heart attack.	Yes/No
I currently smoke.	Yes/No	I have diabetes.	Yes/No
I have smoked in the past.	Yes/No	I have lung disease or asthma.	Yes/No
I drink alcohol prior to bedtime.	Yes/No	I have had a stroke or TIA.	Yes/No
I have had a tonsillectomy.	Yes/No	I have chest pain at night.	Yes/No
I have had lung surgery.	Yes/No	I have fibromyalgia.	Yes/No
I currently use a mouth guard.	Yes/No	I have seizures.	Yes/No
I have had an abnormal chest X-Ray.	Yes/No	I have been exposed to excessive amounts of dust.	Yes/No
I have been exposed to fumes or chemicals at work.	Yes/No		

EPSWORTH SLEEPINESS SCALE

In contrast to feeling tired, are you likely to dose off or fall asleep in the following situations:

Please choose the most appropriate number for each situation:

0=Never	1=Slight Chance	2=Moderate Chance	3=High Chance
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- Sitting and reading _____
- Watching television _____
- Sitting inactive in a public place (i.e. Theater) _____
- As a passenger in a car for an hour without a break _____
- Lying down to rest in the afternoon _____
- Sitting and talking to someone _____
- Sitting quietly after a lunch without alcohol _____
- In a car while stopped briefly in traffic _____

Sleep LINK - SOUTHWEST

1902 Ave. G NW, Suite I-1

Childress, TX 79201

(940) 937-0400

(940) 937-0401 Fax

**INSURANCE AUTHORIZATION
&
AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

Patient Name: _____

Insurance ID: _____

I request that payment of authorized insurance benefits be made to Sleep Link on my behalf for any services furnished to me by the lab.

I authorize any holder of medical information about me to release to the health care financing department, and it's agents, any information necessary to determine the benefits for related services.

I authorize Sleep Link to obtain my personal medical/health records for the sole purpose of gaining information requested by my insurance carrier to file services rendered.

If for any reason my insurance denies payment for services rendered, I agree to be personally and fully responsible for payment.

Lifetime Signature: _____

Sleep LINK - SOUTHWEST

1902 Ave. G NW, Suite I-1
Childress, TX 79201
(940) 937-0400
(940) 937-0401 Fax

Consent Form

This consent is for *Sleep Link*.

Please provide your signature below to indicate that you have read the above consent and have reviewed the Notice of Information Practices.

Signature of Patient or Legal Representative

Witness

Date

Effective Date

Authorized persons: _____

The purpose of this consent form is to inform you, the patient, how your personal health information is used and/or disclosed by this provider or organization. We want you to be fully aware of what we do with your information so that you can provide us with your consent in order for us to treat your health care needs, receive payment for services rendered, and allow administrative and other types of health care operations to happen, which are part of normal business activities of this provider or organization.

Your consent

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis/es and other health information to my bill(s).

- A means by which my health plan or health insurance company can verify that services billed were actually provided.
- A tool for routine health care operations in this organization, such as ensuring that we have quality processes and programs in place and making sure that the professionals who provide your care are competent to do so.

I understand that:

- I have been provided with a Notice of Information Practices that provides specific examples and descriptions of how my personal health information is used and disclosed by *Sleep Link*
- I have the right to review the Notice of Information Practices prior to signing this consent;
- *Sleep Link* can change its Notice of Information Practices but must notify me of those changes before they are put into practice and will mail me a copy of the new Notice to the address that I have provided;
- I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations and that *Sleep Link* is not required to agree to those restrictions;
- Any restrictions to which *Sleep Link* agrees to will be respected.
- I may revoke this consent in writing at any time. Further, I am aware that *Sleep Link* can proceed with uses and disclosures that pertain to treatment, payment, or healthcare issues that took place before the consent was revoked.

To request a restriction on the use and disclose of your personal health information related to your treatment, payment for service, or for the health care operations of *Sleep Link* please do so after reading the Notice of Information Practices. You may use this consent form to request a restriction.

I request the following restrictions to the use or disclosure of my health information:

<p>For provider use only:</p> <p>Restriction is</p> <p><input type="checkbox"/> Accepted</p> <p><input type="checkbox"/> Denied</p> <p>Reason denied:</p> <p>Patient is notified?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
