



**Patient Medical and Sleep History Questionnaire**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City, State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Primary/Alternate Phone:** \_\_\_\_\_ **Emergency Contact/Number:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Neck Size:** \_\_\_\_\_

**Please circle: Male/Female**    **Race:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Please List all medications that you are currently taking.**


**Allergies** \_\_\_\_\_ **Pharmacy** \_\_\_\_\_

**Current symptoms or illnesses** \_\_\_\_\_

**Medical History (Have you ever been diagnosed with any of the following? Check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma                             | <input type="checkbox"/> Allergies                       |
| <input type="checkbox"/> Anxiety Disorder (anxiety attacks) | <input type="checkbox"/> Arthritis                       |
| <input type="checkbox"/> Chronic Fatigue Syndrome           | <input type="checkbox"/> COPD                            |
| <input type="checkbox"/> Depression                         | <input type="checkbox"/> Deviated Septum                 |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Emphysema                       |
| <input type="checkbox"/> Fibromyalgia                       | <input type="checkbox"/> GERD – Gastro Esophageal Reflux |
| <input type="checkbox"/> Gout                               | <input type="checkbox"/> Hyperthyroidism                 |
| <input type="checkbox"/> Hypothyroidism                     | <input type="checkbox"/> Irritable Bowel Syndrome        |
| <input type="checkbox"/> Kidney Failure                     | <input type="checkbox"/> Liver Disease                   |
| <input type="checkbox"/> Peptic Ulcer                       | <input type="checkbox"/> Seizures                        |
| <input type="checkbox"/> Menopause                          | <input type="checkbox"/> Prostate Disease                |
| <input type="checkbox"/> Cancer                             |  |

**Other:**

\_\_\_\_\_

\_\_\_\_\_

**Cardiovascular History (Have you ever been diagnosed with any of the following? Check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Angina  | <input type="checkbox"/> Arrhythmia                         |
| <input type="checkbox"/> Atrial Fibrillation                                     | <input type="checkbox"/> Balloon Angioplasty or Stents      |
| <input type="checkbox"/> Cardiac Surgery for Coronary Bypass                     | <input type="checkbox"/> Cortication of the Aorta           |
| <input type="checkbox"/> Congestive Heart Failure                                | <input type="checkbox"/> Coronary Artery Disease            |
| <input type="checkbox"/> Diastolic Dysfunction                                   | <input type="checkbox"/> Enlarged Heart                     |
| <input type="checkbox"/> Heart Attack – Myocardial Infarction                    | <input type="checkbox"/> High Cholesterol                   |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Hyperlipidemia                     |
| <input type="checkbox"/> Hypertension (High blood pressure treated or untreated) | <input type="checkbox"/> LVH – Left Ventricular Hypertrophy |
| <input type="checkbox"/> Internal Defibrillator                                  | <input type="checkbox"/> Nocturnal Ischemia                 |
| <input type="checkbox"/> Microalbuminuri   | <input type="checkbox"/> Peripheral Arterial Disease        |
| <input type="checkbox"/> Pacemaker   | <input type="checkbox"/> Ventricular Arrhythmia             |
| <input type="checkbox"/> Stroke or TIA   |   |
| <input type="checkbox"/> Cardiac Surgery for valve replacement                   |   |

List any other Cardiovascular Conditions that you have or have had in the past. \_\_\_\_\_

**Surgical History (Have you ever had any of the following surgical procedures? Check all that apply.)**

- |   |  |
|---|--|
| <input type="checkbox"/> Deviated Septum                | <input type="checkbox"/> Gastric Bypass          |
| <input type="checkbox"/> Hip Replacement                | <input type="checkbox"/> Herniated Disk Repair   |
| <input type="checkbox"/> Knee Replacement               | <input type="checkbox"/> Spinal Fusion           |
| <input type="checkbox"/> Tonsillectomy                  | <input type="checkbox"/> Repair of broken bone   |
| <input type="checkbox"/> UPPP                           | <input type="checkbox"/> Pacemaker               |
| <input type="checkbox"/> Defibrillator                  | <input type="checkbox"/> Lung transplant         |
| <input type="checkbox"/> Kidney Transplant              | <input type="checkbox"/> Heart Valve Replacement |
| <input type="checkbox"/> Coronary Bypass Surgery (CABG) |  |

Please list any other surgical procedures that you have had. \_\_\_\_\_

**Past Sleep Diagnosis - In the past have you been diagnosed with any of the following? Please check all that apply.**

- ☐ Sleep Apnea
- ☐ Periodic Limb Movement
- ☐ Insomnia
- ☐ Restless Legs Syndrome
- ☐ Narcolepsy
- ☐ Seizures

Have you had a sleep study preformed in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, where? \_\_\_\_\_

How long ago? \_\_\_\_\_

**Home Care:**

Do you currently have a CPAP machine in your home? \_\_\_\_\_ YES \_\_\_\_\_ NO

If so, how many hours per night are you wearing your CPAP mask? \_\_\_\_\_

Do you have oxygen in your home? \_\_\_\_\_ YES \_\_\_\_\_ NO

How many hours per day are you wearing oxygen? \_\_\_\_\_ During hours of sleep? \_\_\_\_\_ During daytime? \_\_\_\_\_

Do you require the use of any special equipment/devices such as a wheelchair or lift, etc.? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, explain \_\_\_\_\_

**Family History (Have any of your blood relatives ever been diagnosed with any of the following? Check all that apply.)**

- |   |   |
|---|---|
| <input type="checkbox"/> Premature Cardiovascular Death (died from heart disease when they were younger than 70 years of age) |   |
| <input type="checkbox"/> Stroke or TIA  | <input type="checkbox"/> Arrhythmia               |
| <input type="checkbox"/> Sudden Cardiac Death   | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Heart Attack   | <input type="checkbox"/> Obstructive Sleep Apnea  |
| <input type="checkbox"/> Coronary Artery disease  | <input type="checkbox"/> Died in their sleep      |
| <input type="checkbox"/> Narcolepsy   |   |

**Current Sleep Schedule:****During the Week**

What time do you normally go to bed on weeknights? \_\_\_\_\_

What time do you normally get out of bed on weekdays? \_\_\_\_\_

Do you nap on weekdays? \_\_\_\_\_ What time do you nap? \_\_\_\_\_

How long are your naps? \_\_\_\_\_

**On Weekends**

What time do you normally go to bed on weekends? \_\_\_\_\_

What time do you get out of bed on weekends? \_\_\_\_\_

Do you nap on weekends? \_\_\_\_\_ What time do you nap? \_\_\_\_\_

How long are your naps? \_\_\_\_\_

**Sleep Habits**

Do you watch television in bed prior to going to sleep? \_\_\_\_\_

How long is the television left on? \_\_\_\_\_ hrs. \_\_\_\_\_ all night

Do you read in bed prior to sleeping? \_\_\_\_\_

How long do you read in bed prior to turning the lights off? \_\_\_\_\_

**Generally speaking, your challenges with going to sleep at night are related to. (Check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Temperature in bedroom.  | <input type="checkbox"/> Noise             |
| <input type="checkbox"/> Assisting others   | <input type="checkbox"/> Telephone         |
| <input type="checkbox"/> Pets   | <input type="checkbox"/> Uncomfortable Bed |
| <input type="checkbox"/> Pain or discomfort   |  |
| <input type="checkbox"/> Restless Legs (creepy crawly feelings in your legs)                              |  |
| <input type="checkbox"/> Thoughts running through your mind   |  |
| <input type="checkbox"/> Inability to settle down   |  |
| <input type="checkbox"/> Going to bed prior to being sleepy   |  |
| <input type="checkbox"/> Anxiety  |  |
| <input type="checkbox"/> Fear of not being able to go to sleep or not being able to get enough sleep      |  |
| <input type="checkbox"/> Bed Partner Activities (snoring, reading, lights on, TV on, restless sleep, etc) |  |



**During the night your sleep is disturbed by? (Check all that apply)**

- ☐ Noise
- ☐ Others requiring your assistance (pets or people)
- ☐ Difficulty breathing or shortness of breath (especially when lying flat)
- ☐ Chest pain
- ☐ Leg cramps
- ☐ Other leg discomfort
- ☐ Pain or discomfort
- ☐ Need to go to the bathroom
- ☐ Hunger
- ☐ Thirst
- ☐ Unusual movements (such as sleep walking or sleep eating)
- ☐ Abdominal pain or gas
- ☐ Back or joint or muscle pain
- ☐ Difficulty breathing through your nose

Please list any other disturbances that you experience. \_\_\_\_\_

**Have you ever been told or are you aware that you do any of the following? (Check all that apply)**

- ☐ Talk in your sleep
- ☐ Walk in your sleep
- ☐ Physically act out your dreams during sleep?
- ☐ Have you ever awakened to find that you had eaten after going to sleep with no memory of having gotten up to eat.?
- ☐ While sleeping, awake to find that you are in a different location other than where you went to sleep.
- ☐ Snore
- ☐ Stop Breathing
- ☐ Move your legs or arms repeatedly in sleep
- ☐ Sweat excessively
- ☐ Kick or move frequently
- ☐ Have tingling in your arms or legs.
- ☐ Grind your teeth when sleeping?
- ☐ Nightmares or scary dreams

When going to sleep or waking from sleep, do you ever experience a feeling of paralysis? \_\_\_\_\_

Have you ever experienced a loss of muscle tone or muscle weakness when experiencing strong emotions such as surprise, happiness, fear or sadness? \_\_\_\_\_

Do you experience vivid dream like sequences that happen when you are awake? \_\_\_\_\_

Do you experience uncontrollable urges to take brief naps? \_\_\_\_\_

## **Work History:**

Do you work? \_\_\_\_\_ What type of work do you do? \_\_\_\_\_

What time do you go to work? \_\_\_\_\_ What time do you leave work? \_\_\_\_\_

Do you experience difficulty doing your job because of sleepiness? \_\_\_\_\_

Do you experience difficulty driving because of sleepiness? \_\_\_\_\_

## **Social Activities**

Do you smoke cigarettes or cigars? \_\_\_\_\_ Did you in the past? \_\_\_\_\_

Have you quit smoking? \_\_\_\_\_ How long ago? \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ How many a day? \_\_\_\_\_

Do you use any recreational drugs? If so, please explain \_\_\_\_\_

How much caffeine do you consume in an average day? \_\_\_\_\_

How much caffeine do you consume after 2 pm? \_\_\_\_\_ (caffeine includes chocolate, coffee, tea, soda, some diet/stimulant products)

Do you exercise daily? \_\_\_\_\_

If so please describe type, frequency and at what time of the day. \_\_\_\_\_

## **General Questions**

Do you wear dentures? \_\_\_\_\_ partial \_\_\_\_\_ complete \_\_\_\_\_

Do you sleep in a bed or a recliner? \_\_\_\_\_

Do you require assistance to get in and out of bed at night? \_\_\_\_\_

Do you use oxygen when sleeping? \_\_\_\_\_ How much oxygen do you use? \_\_\_\_\_

When is your sleep most disrupted? < first part of the night < middle of the night < early morning

Do you wake-up too early? \_\_\_\_\_ Do you feel that you get enough sleep? \_\_\_\_\_

Do you have difficulty concentrating because you are sleepy or tired? \_\_\_\_\_

Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired? \_\_\_\_\_

Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired? \_\_\_\_\_

Do you have difficulty completing errands because you are too sleepy or tired to drive? \_\_\_\_\_

## Epworth Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation:

- 0 = would *never* doze or sleep.  
1 = *slight* chance of dozing or sleeping  
2 = *moderate* chance of dozing or sleeping  
3 = *high* chance of dozing or sleeping

<b>Situation</b>	<b>Chance of Dozing or Sleeping</b>			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Stopped for a few minutes in traffic while driving	0	1	2	3
<b>Total score</b>				

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### **SLEEP CENTER USE ONLY**

#### **Clinical Indications:**

- |  |   |
|--|---|
| <input type="checkbox"/> Daytime Sleepiness            | <input type="checkbox"/> Overweight/Obese     |
| <input type="checkbox"/> Observed apnea episodes       | <input type="checkbox"/> Cognitive difficulty |
| <input type="checkbox"/> Awakening, gasping or choking | <input type="checkbox"/> Fatigue              |
| <input type="checkbox"/> Headaches                     | <input type="checkbox"/> Restless legs        |
| <input type="checkbox"/> Loud Snoring                  | <input type="checkbox"/> Irritability         |
| <input type="checkbox"/> Hypertension                  | <input type="checkbox"/> History of Stroke    |
| <input type="checkbox"/> Cardiac Disease               | <input type="checkbox"/> Other: _____         |

#### **Suspected Diagnosis**

- ☐ Sleep Apnea    ☐ Insomnia    ☐ RLS/PLMD    ☐ Other: \_\_\_\_\_

#### **Notes:**

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SLEEP STAFF SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Date: \_\_\_\_\_



1113 Christine Ave., Anniston, AL 36207  
256-770-4813

**AUTHORIZATION FOR MEDICAL TREATMENT:** The undersigned has been informed of the treatment procedures considered necessary for the patient and that the treatment/procedures will be directed by a physician and performed by employees of Southern Sleep Diagnostics. The undersigned understands that no guarantee or assurance has been made as to the results that may be obtained from treatment. Authorization is hereby granted for treatment.

**INFORMATION PRIVACY:** Southern Sleep Diagnostics will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, copies available upon request. The undersigned acknowledges receipt of this information.

**RELEASE OF INFORMATION:** Southern Sleep Diagnostics is hereby authorized to disclose all or part of my information regarding medical condition, treatment and prognosis to insurance carriers, other treating physicians, etc. I agree that Southern Sleep Diagnostics may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payor for treatment purposes. I also authorize Southern Sleep Diagnostics to utilize medical information attained during the course of my treatment in medical research and education programs, provided my name and likeness are not revealed and my privacy is protected. **I give Southern Sleep Diagnostics authorization to release my information to the following individuals (you may leave blank):**

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS:** In the event the undersigned is entitled to benefits of any kind whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Southern Sleep Diagnostics for application on their patient's bill. The undersigned, and/or patient agrees to be responsible for charges not covered by the assignment, including deductibles and co-payments prescribed by law.

**FINANCIAL AGREEMENT:** The undersigned agrees that in consideration for the services to be rendered to the patient, he-she individually agrees to be totally responsible for all charges for services such as DURABLE MEDICAL SUPPLIES or any other non-covered charges. The undersigned agrees to assign payment for the unpaid charges from services provided by specialist and by physicians from whom Southern Sleep Diagnostics is authorized to bill. I, the undersigned, accept the fee(s) charged as a legal and lawful debt. I understand the fee(s) charged are due at time of service. Should it become necessary to forward my account for collection, I agree to pay all monies due, including a **33.3 %** collection fee, attorney fees, and/or court costs, if such be necessary. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state. All delinquent balances shall bear interest at the legal rate.

**MEDICARE AUTHORIZATION:** I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare Services (CMS) or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Regulations pertaining to Medicare assignment of benefits also apply.

**MISCELLANEOUS PROVISIONS:** I consent to receive calls, e-mails, and/or text messages regarding my healthcare information and other healthcare-related services at the phone number(s) given. I understand I may be charged for calls to my wireless phone by my wireless carrier, and that calls may be generated by an automated dialing system. I further understand I may revoke this consent at any time by notifying my healthcare provider in writing. I understand that under no circumstances will Southern Sleep Diagnostics be liable for property of patients.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT TO EXECUTE THE ABOVE AND ACCEPTS THE TERMS THEREOF.**

Southern Sleep Diagnostics complies with applicable Federal Civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

\_\_\_\_\_  
Patient's signature if over 14 years old

\_\_\_\_\_  
Signature of Parent/Responsible party

\_\_\_\_\_  
Date and time of signing

\_\_\_\_\_  
Relationship to Patient

## RELEASE OF INFORMATION REQUEST

Southern Sleep Diagnostics  
1113 Christine Ave., Anniston, AL 36207  
Ph# 256-770-4813 Fax # 256-770-4807

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The person named above hereby authorizes Southern Sleep Diagnostics to:

- ☐ Request health information from
- ☐ Send health information to

The person named above authorizes information to be requested or released by representatives of:

Name of Person, Provider, or Facility: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Scope:

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): \_\_\_\_\_
- ☐ All information regarding care received by patient between the dates of \_\_\_\_\_ and \_\_\_\_\_.
- ☐ Other information (specify): \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

**If not signed by the patient, indicate relationship of authorizing person to patient:**

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual

**The above named patient has the following rights:**

1. I understand I may revoke this authorization in writing at any time except to the extent where information has previously been disclosed.
2. I understand this consent may include disclosure of records related to treatment of : (Please initial each)  
\_\_\_\_Alcohol and/or Drug Abuse \_\_\_\_Psychiatric \_\_\_\_Sexually Transmitted Disease \_\_\_\_ HIV/AIDS
3. I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by and may no longer be protected by Federal Law.
4. I understand this authorization will expire upon completion of the request information.
5. I understand my health care and the payment for my health care will not be affected if I do not sign this form.
6. I understand I may receive a copy of this form upon my request.





### HIPPA EMAIL CONSENT

**Please read if you intend to request medical documents via email.**

Under HIPPA (*Health Insurance Portability and Accountability Act*):

- \* HIPPA is a law passed in 1996 to maintain privacy and security protections for patients' health information.
- \* Information stored in our computer system is encrypted. **However, most email services** (ex. Yahoo, Gmail, Hotmail, etc.) **are not encrypted**. Therefore, information passed via email (to or from our office from your personal email account) also may not be encrypted.
- \* **It is possible that information sent through non-encrypted channels may be accessed by a third party** since it is transmitted via the internet, **OR** a third party which gains access to your email account may gain access to the information.
- \* HIPPA guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient consents to still receive private health information via email, then a healthcare provider may send that patient medical information via unencrypted email.

- This guideline is viewable on page 5634 of the HIPPA PDF at:

US Department of Health and Human Services -  
<http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf>

**YES** - I understand the risks of unencrypted email and **give permission** for Southern Sleep Diagnostics to email my personal health information via unencrypted email:

Patient/representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email address: \_\_\_\_\_

**NO** - I understand the risks of unencrypted email and **DO NOT give permission** for Southern Sleep Diagnostics to email my personal health information via unencrypted email:

Patient/representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Southern Sleep Diagnostics  
1113 Christine Ave  
Anniston, AL 36207  
Phone: 256-770-4813  
Fax: 256-770-4807



## **Ownership Disclosure**

I understand that Fred A. McLeod, M.D., Jenn McLeod, CRNP, PhD, and Jerry Crocker, RPSGT, have an ownership interest in Southern Sleep Diagnostics..

I understand that I always have a choice in which medical facility, hospital, sleep center or DME company that I choose to, have my testing or treatment with, or to make purchases from.

I understand that any choice I make will not alter the care that I receive at Southern Head and Neck Surgery.

I understand that I am always free to choose from the available options for any of my recommended care.

\_\_\_\_\_

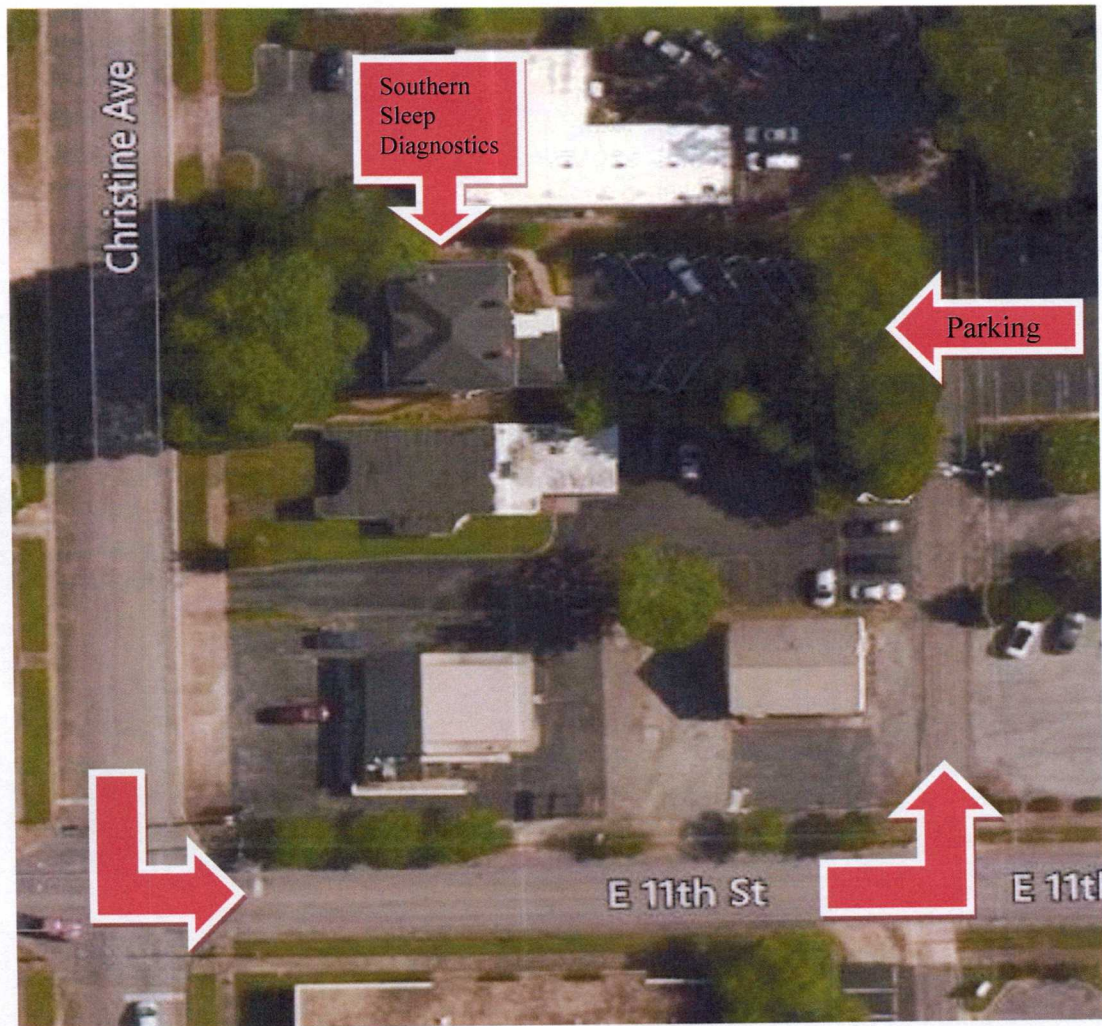
Authorized Signature

\_\_\_\_\_

Date



Southern Sleep Diagnostics parking located at the back of the building



Front



Parking in Back