Piñon Healthcare

PERSONAL INFORMATION

Patient Name: _____ Date: _____

Birth Date: _____ Primary Care Provider: _____

Height: _____ Weight (lbs): _____

When was the last sleep study you had performed? _____ (mm/yy) or N/A

Where did you have your sleep study performed? _____

SLEEP- WAKE SCHEDULE

Would you describe yourself as a morning person or a night person? _____

What time do you go to sleep on WEEKDAYS? _____

What time do you wake up on WEEKDAYS? _____

Do you use an alarm on WEEKDAYS? _____

How many minutes does it take you to fall asleep? _____

Do you have difficulty falling asleep? _____

What time do you go to sleep on WEEKENDS? _____

What time do you wake up on WEEKENDS? _____

Do you use an alarm on WEEKENDS? _____

How many times do you nap during the day? _____

How many minutes do you nap for? _____

Do you feel refreshed after you nap? _____

How many inadvertent naps during the day? _____

How many times do you awaken during the night? _____

How long are you awake in the night before going back to sleep? _____

What do you awaken to in the night? (please circle one of the following below)

Urination Night terrors Screen use and noise Gasping Other

Do you watch TV, read, use cell phone, etc. in bed?

Do you do shift work?

SLEEP COMPLAINTS

Do you snore? _____

Do you have difficult or labored breathing? _____

Do you have morning headaches or confusion? _____

Do you have a coexisting lung disease? _____

Do you have a coexisting heart disease? _____

Do you have a bed partner? _____

Does your bed partner sleep separately because of snoring? _____

When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feelings in your legs that can be relieved by walking or movement? _____

Do you have involuntary periodic limb movement? _____

Do you have sudden episodes of muscle weakness accompanied by full conscious awareness after emotions such as laughing, crying, or terror? _____

SLEEP BEHAVIORS - Check any that apply

☐ Sleep Paralysis ☐ Hallucinations

☐ Leg Symptoms/Movements ☐ Motor Restlessness

☐ Night Terrors ☐ Teeth Grinding/Clenching

☐ Automatic Behaviors

OTHER SUBJECTIVE COMPLAINTS

Do you have anxiety? _____

Do you experience pain or discomfort at night? _____

Do you wake up with your heart pounding or racing? _____

Do you have GERD or aspiration? _____

MEDICATIONS:

Please list any current medications you are taking below

Please list any drug allergies you have below

PAST MEDICAL HISTORY

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Benign Prostatic Hyperplasia
☐ Bipolar Disorder
☐ Blood Clot
☐ Cancer
☐ Chronic Fatigue
☐ Congestive Heart Failure
☐ COPD / Breathing problems
☐ Coronary Artery Disease
☐ Cataracts
☐ Dementia / Memory Loss
☐ Depression
☐ Diabetes
☐ Diverticulosis
☐ Eating Disorder
☐ Emphysema
☐ Fibromyalgia
☐ Urinary Tract Infections
☐ Glaucoma
☐ Gout
☐ Heart Attack
☐ Heart Disease
☐ Heartburn/ Gastric Reflux
☐ Hepatitis
☐ High Cholesterol
☐ HIV
☐ Hypertension
☐ Kidney Disease
☐ Kidney Stones
☐ Leg / Foot Ulcers
☐ Liver Disease
☐ Obesity
☐ Osteoporosis
☐ Pneumonia
☐ Seizures
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Ulcers
☐ None

Do you need oxygen supplement at night? _____

PAST SURGICAL HISTORY

Enter the date in the blank space after surgical procedure:

☐ Cardiac Bypass Surgery _____
☐ Tonsillectomy _____
☐ Appendectomy _____
☐ Skin Lesions Removed _____
☐ Cholecystectomy _____
☐ Hernia Repair _____
☐ None

CHEMICAL HISTORY

Tobacco use: Never Smoker Current Smoker Former Smoker (Quit Date): _____

Do you use caffeine? Never Once per day Multiple times per day

Last caffeine intake is usually before _____

Do you take supplements for wakefulness? _____

Do you drink alcohol? Never Occasionally Daily

Do you use recreational drugs? _____

FAMILY HISTORY

Condition	Mother	Father	Sister	Brother	Daughter	Son
Arthritis						
Asthma						
Dementia						
Depression						
Diabetes I						
Diabetes II						
Heart Disease						
Hypertension						
High Cholesterol						
Kidney Disease						
Obesity						
Osteoporosis						
Stroke						
Substance Abuse						
Cancer						

Sleep Family History:

Restless Leg Syndrome _____ Obstructive Sleep Apnea _____

Insomnia _____ Parasomnia _____

REVIEW OF SYSTEMS:

Have you had any weight gain/loss, fever, chills, sweats or night sweats, or dug allergies? _____

Have you had any changes in vision, blind spots, or double vision? _____

Have you had ear pain, sore throat, sinus pain, post-nasal drip, runny nose, bloody nose? _____

Have you had fast heartbeats or fluttering in chest, chest pain or pressure, breathlessness when lying flat, or swollen legs or feet? _____

Have you had headaches, weakness or numbness in the arms or legs? _____

Have you had any new rashes, new moles or change in mole(s)? _____

Have you had shortness of breath at rest, shortness of breath with activity, dry cough, productive cough, coughing up blood, wheezing or whistling when breathing? _____

Have you had nausea or vomiting, loose or watery stools, fat or grease in stools, constipation, abdominal pain, bowel movements black in color or blood noted? _____

Have you had pain during urination, blood in urine, urinating more frequently than usual, irregular menstrual periods? _____

Have you had muscle pain, bone or joint pain, swollen joints? _____

Have you had increased thirst or urination, diabetes? _____

Do you have swollen lymph nodes, lumps or bumps in the breast, or nipple discharge? _____

Piñon Healthcare

Patient Consent for Treatment

I voluntarily consent to any and all health care treatment and diagnostic procedures provided by Pinon Healthcare and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other health care professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Pinon Healthcare.

I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the Pinon Healthcare Notice of Privacy Practices.

I authorize payment of medical benefits to Pinon Healthcare providers or their designee for services rendered.

I acknowledge I have received a copy of the Notice of Privacy Practice.

Print Name _____

Signature _____ Date: _____

ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Piñon Healthcare Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Name/Relationship if signed by other than patient

_____ _____

Signature Date

Piñon Healthcare

Authorization to Assign Benefits to Provider

I hereby request payment of my authorized Medicare or other carrier benefits to be made on my behalf to Piñon Healthcare for products and services that they have provided me. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to release to the Health Care Financing Administration, any other insurer and/or their agents any information needed to determine these benefits. Piñon Healthcare bills third party payers as a courtesy when appropriate. I understand that I am fully responsible for all deductibles, coinsurance and disallowed items.
Also, I understand that a particular item or services, although it would otherwise be covered, if not "reasonable and necessary" under Medicare standards, Medicare will deny payment.

Patient Signature: _____ Date: _____

If signed by caregiver or other, please list relationship (IE Husband, Wife, RN, etc.)

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EPWORTH SLEEPINESS SCALE FORM

NAME_____ DOB: _____ DATE: _____

This test is a list of eight situations in which you rate your tendency to become sleepy

Instructions: Be as truthful as possible

Write down the number corresponding to your choice in the right-hand column. Total your score below.

No chance of dozing = 0

Slight chance of dozing = 1

Moderate chance of dozing = 2

High chance of dozing = 3

SITUATION	SCORE
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 _____