RCMedy Sleep Medicine

Phone: (913) 777-0077
Secure Fax: (877) 796-6309
Carole Guillaume, MD, FAASM
Leah Luckeroth, MD

IntakeQUEST

INTAKE FORM AND SLEEP QUESTIONNAIRE

Name: _____ Date of Birth: _____ Date: _____

Address: _____

Primary Phone: (_____) _____ Secondary Phone: (____) _____

Insurance Company: _____

Do you have insurance through the Affordable Care Act (commonly called Obama Care)? O Yes O No

How did you find out about us? [ ] My doctor [ ] My friend [ ] My family [ ] My insurance [ ] Your website [ ] Advertisement

Referring Provider:_____
Address:_____Phone:_____

Primary Care Provider (PCP):_____
Address:_____Phone:_____

What is your height? _____ Feet _____ Inches Gender: Male Female

What is your weight today? _____ Weight one year ago? _____ Weight five years ago? _____

My Main Sleep Complaint (please explain): _____

_____

Reason your doctor sent you to our office (please explain): _____

_____

In the past 12 months have you had: Physical Exam by PCP YES NO **Complete Blood Count** YES NO **Thyroid Test** YES NO

Please check all of the following statements that are true about your sleep:

Breathing Problems:

- o I have been told that I snore
- o I have been awakened by my own snoring
- o I have been told I stop breathing during sleep
- o I sweat a great deal at night

Duration of Symptoms: _____ months / years

- o I wake up at night choking, smothering or gasping for air
- o My snoring / breathing is worse if I fall asleep after alcohol
- o My snoring / breathing is worse if I sleep on my back
- o My heart pounds / beats rapidly or beats irregularly at night

Daytime Sleepiness:

- o I take daytime naps
- o I fall asleep while watching TV
- o I fall asleep in sedentary situations
- o I performed poorly at work due to sleepiness
- o I performed poorly at school due to sleepiness

Duration of Symptoms: _____ months / years

- o I am sleepy during the day, struggling to stay awake
- o I have fallen asleep while driving
- o I have fallen asleep during conversations
- o I have had auto accidents due to falling asleep while driving
- o I have had injuries as the result of sleepiness
- o I have had "blackouts" or periods when I am unable to remember what just happened
- o I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long
- o I see dream-like images (hallucinations) either just before, just after a daytime nap or as I wake up in the morning, even though I am not asleep
- o I have had the inability to move (paralyzed) while falling asleep or when waking up
- o I get sudden muscular weakness when laughing, angry or in situations of strong emotions
- o I need "something" to help me stay awake during the day, I use _____

Past Sleep Evaluation and/or Treatment:

- o I have had a previous sleep disorder evaluation
- o I have been prescribed PAP for home use
- o I wear oxygen at night

Duration of Symptoms: _____ months / years

- o I have had a previous overnight sleep study
- o I have had surgical treatment for a sleep disorder
- o I have a family member with sleep apnea
- o Please list 1) Date of Prior Sleep Study 2) Diagnosis 3) Treatment 4) Sleep Lab Name:

_____

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Restlessness Problems:

- I am a restless sleeper
- I wake up often during the night
- I have talked in my sleep as an adult
- I have walked in my sleep as an adult
- I grind my teeth in my sleep

Duration of Symptoms: _____ months / years

- I have a difficult time falling back to sleep after I awaken
- I typically wake up from sleep to go to the restroom
- I have been told that I kick/jerk my legs/arms during sleep
- I sometimes act out my dreams
- I have injured myself or another while acting out a dream

- **I have a strong urge to move my legs (restless leg symptoms) which I notice in the evenings, especially when I'm sitting in the evening or lying down to in bed** (*example: activities that bother me at night do not bother me during the day.*)
- **I have an unusual feeling my legs and I'm unable to resist moving them** (*the need to move is often accompanied by hard-to describe sensations. Some words used to describe these include: "creeping, itching, pulling, creepy-crawly, tugging or gnawing."*)
- **These symptoms start or become worse when I am resting** (*example: the longer I rest, the greater the chance the symptoms will occur and the more severe they are likely to be; it can occur as a passenger in a car, on an airplane, in a movie theatre, etc.*)
- **These symptoms get better when I move** (*example: the relief is complete or partial but generally starts very soon after starting an activity. Relief persists as long as the motor activity continues.*)

Other Sleep Problems:

- I have trouble falling asleep / insomnia
- My sleep is disturbed by sadness or depression
- I have a decreased desire / interest in sex
- I have a lot of nightmares (frightening dreams)
- I have racing thoughts when I try to fall asleep
- I have difficulty returning to sleep if I wake up during the night
- I wake up early in the morning, despite being tired, I am unable to return to sleep
- I need 'something' to help me get to sleep and/or stay asleep. I use _____

Duration of Symptoms: _____ months / years

- I have been unable to sleep at all for several days
- I have considered or attempted suicide
- I am unhappy about loving relationships in my life
- A family member has been hospitalized for a psychiatric illness
- I use alcohol to cope with stress

Sleep Habits:

- I usually watch TV in bed prior to sleep
- I usually read in bed prior to sleep
- I eat a snack at bedtime
- I work a rotating shift or I am a shift worker
- I smoke prior to bedtime or when I awaken during the night
- I eat if I wake up during the night
- I often travel across two (2) or more time zones
- I drink alcohol in the evening time to help get to / stay asleep

Bedroom Habits:

- I sleep alone
- I share a bed with someone
- I share a dwelling but have separate bedrooms
- I share the bed with pets
- I have an uncomfortable bed or pillow
- I have an uncomfortable temperature in the bedroom
- I have a noisy bedroom or have too much light in the bedroom
- I have too many electrical devices in the bedroom

Sleep Pattern:

Typical bedtime _____ AM/PM

How many awakenings in the night? _____

Typical wake-up time _____ AM/PM

How many minutes to fall asleep _____

Do you fall back to sleep easily? YES / NO

Do you nap? YES / NO If yes, when / how long _____

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Epworth Sleepiness Scale

NOTE: Your answers below should be based on the worst you've felt in recent memory . . .

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

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Stopped for a few minutes in traffic while driving	_____
Sitting quietly after lunch (no alcohol)	_____
TOTAL (This is your Epworth Sleepiness score)	_____

Past Medical History:

- o Hypertension (high blood pressure)
- o Heart Disease
- o Pacemaker
- o Stroke
- o TIA "Light Stroke"
- o Diabetes
- o Cancer
- o Lung problems o COPD o Asthma
- o Reflux (GERD)
- o Stomach / Colon problems
- o Thyroid problems
- o Hepatitis/jaundice
- o Back or joint problems
- o Arthritis
- o Hearing impairment
- o Fibromyalgia
- o Blackouts
- o Seizures
- o Depression
- o Anxiety
- o Alcoholism
- o Chemical dependency or abuse
- o **Female**
- o Premenstrual syndrome
- o Menopause
- o **Male**
- o Prostate problems
- o Erectile dysfunction/impotence

List other past medical problems and dates:

_____ _____
_____ _____
_____ _____
_____ _____

Past Surgeries:

_____ _____
_____ _____
_____ _____

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Current Medications:

Medication	Dose	#per day	Medication	Dose	#per day
______________________	_______mg	_______	______________________	_______mg	_______
______________________	_______mg	_______	______________________	_______mg	_______
______________________	_______mg	_______	______________________	_______mg	_______
______________________	_______mg	_______	______________________	_______mg	_______
______________________	_______mg	_______	______________________	_______mg	_______

MEDICATION ALLERGIES: ____

Family History: Has an immediate blood relative **(Father/Mother/Sister/Brother/Child)** had any of the following?

	Relation		Relation
Cancer	______________________________	Stroke	______________________________
Diabetes	______________________________	Anxiety/Depression	______________________________
Hypertension	______________________________	Sleep Apnea	______________________________
Heart disease	______________________________	Narcolepsy	______________________________
Thyroid disease	______________________________	Other:	______________________________

Social History:

Marital Status: _______________________________________ Number of Children: ______________________________

Employment status (circle all that apply): Employed Unemployed Retired Student

Occupation: ____ My work hours are: ___________________________________

My job requires a DOT license: YES NO DOT anniversary: ____

Have you ever smoked? YES NO If yes, how long have you smoked? _______________ Years

How much? ____________ Packs per day Have you quit smoking? YES NO Year Quit _____________________

Do you drink alcohol? YES NO If yes, how much do you feel you drink? ___________ Drinks

How frequent? DAILY WEEKLY (_____ times per week) SOCIALLY What kind of alcohol? BEER LIQUOR WINE

Do you drink caffeine? YES NO Amount: ____

Check any of the following symptoms you have had in the past 12 months:

○ Frequent headaches	○ Frequent heartburn / indigestion
○ Morning headaches	○ Difficulty swallowing or food "sticking"
○ Fainting or passing out	○ Abdominal pain
○ Sudden loss of vision or strength	○ Frequent constipation
○ Inability to speak	○ Frequent diarrhea
○ Hearing loss or ringing in ear(s)	○ Rectal bleeding / black stools
○ Hoarseness for more than 2-4 weeks	○ Difficulty urinating / incontinence
○ Nosebleeds	○ Blood in urine
○ Cough for more than 2-4 weeks	○ Urinating more than 2 times per night
○ Coughing up blood	○ Pain in joints or bones
○ Shortness of breath or wheezing	○ Unusual bruising or bleeding
○ Swelling in feet or ankles	○ Epilepsy / seizures
○ Chest pain, tightness or pressure	○ Change in wart, mole or skin growth
○ Irregular or sudden, fast heartbeat	○ Weight loss of more than 5-10 lbs.

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BED PARTNER QUESTIONNAIRE

Patient's name: _____ Date of Birth: _____Date: _____

If you have a bed partner (or someone who observes you while sleeping), please have them complete this questionnaire.

Check any of the following behaviors that you have observed the patient doing **while asleep**:

○ Loud snoring	○ Bedwetting
○ Light snoring	○ Sitting up in bed while still asleep
○ Pauses in breathing	○ Head rocking or banging
○ Grinding teeth	○ Kicking or twitching of legs or feet
○ Sleep talking	○ Getting out of bed while still asleep
○ Sleepwalking	○ Biting tongue
○ Acting out of dreams	○ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above? _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

_____

_____

_____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

_____

_____

OFFICE USE ONLY

☐ Snoring – R06.83 ☐ OSA - G47.33 ☐ CSA - G47.31 ☐ EDS – G47.13 ☐ Hypoxia – G47.36 ☐ Hypoxemia – R09.02 ☐ RLS – G25.81 ☐ PLMD – G47.61 ☐ Parasomnia – G47.59 ☐ RBD – G47.52	☐ Insomnia – G47.09 ☐ Insomnia – G47.00 ☐ Sleep Hygiene – Z72.821 ☐ Insuff Sleep – F51.12 ☐ Shiftwork – G47.26 ☐ Narcolep; cata – G47.411 ☐ Narcolep; no cata – G47.419	☐ Palpitations – R00.2 ☐ Arrhythmia – I49.9 ☐ HTN – I10 ☐ T2DM – E11.9 ☐ GERD – K21.9 ☐ ⇑ Hb – R71.8 ☐ ⇑ Tonsils – J35 ☐ COPD – J44.9	☐ ⇓ Memory– R41.3 ☐ Depression – F33.8 ☐ Anxiety – F41.1 ☐ ADHD – F90.9 ☐ Bipolar – F31.9 _____ ☐ Obesity – E66.9 ☐ Morb Obesity – E66.01	☐ 95806 HST ☐ 95810 DX ONLY ☐ 95811 SPLIT NIGHT ☐ 95811 1ST.TX CPAP ☐ 95811 Re.Attempt ☐ 95811 RE.TX CPAP ☐ 95811 RE.TX BIPAP ☐ 95811 RE.TX ASV ☐ 99215 DSOV ☐ PAP Order ☐ DME Switch ☐ Dr L ☐ PCP ☐ Fe++ ☐ Rx ☐ DDS ☐ ENT

Weight: _____ Height: _____ Heart Rate / Pulse: _____ O2 Saturation: _____ BP: _____/_____

Patient Name _____ DOB: _____