RCMedy Sleep Medicine

IntakeQUEST

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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** (**If yes**, visits are **Self Pay**) O **No**

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

Referring Provider: ______________________ Primary Care Provider (PCP): ______________________

Address: ______________________ Phone: __________ 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:

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

Duration of Symptoms: ______________ months / years

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

Daytime Sleepiness:

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

Duration of Symptoms: ______________ months / years

- I am sleepy during the day, struggling to stay awake
- I have fallen asleep while driving
- I have fallen asleep during conversations
- I have had auto accidents due to falling asleep while driving
- I have had injuries as the result of sleepiness

- I have had “blackouts” or periods when I am unable to remember what just happened
- I have slept for several days at a time, or at least I have been overwhelmingly sleepy for that long
- 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
- I have had the inability to move (paralyzed) while falling asleep or when waking up
- I get sudden muscular weakness when laughing, angry or in situations of strong emotions
- I need “something” to help me stay awake during the day, I use ______________________________

Past Sleep Evaluation and/or Treatment:

- I have had a previous sleep disorder evaluation
- I have a family member with sleep apnea
- I have had surgical treatment for a sleep disorder
- I wear oxygen at night

Please see Page 2 for additional Past Sleep Evaluation and/or Treatment Questions

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Ht: __________ Wt: __________ HR: __________ O2 Sat: __________ BP: _______ /_______ Neck: ______________

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In your past, have you been **tested** for sleep disordered breathing, snoring or sleep apnea: ☐ **Yes** ☐ **No**

If No, skip to page 3 of your Intake Questionnaire.

If Yes, in your past, have you been **diagnosed** with any of the following:

☐ **Sleep Apnea** ☐ **Obstructive Sleep Apnea** ☐ **OSA** ☐ **Central Sleep Apnea**

In your past, if you have been **diagnosed with any of the above, please fill out this additional page of your Intake Questionnaire to the best of your ability and research:**

Year first diagnosed ____

Type of study: ☐ **Home Study (HST)** ☐ **In-Lab Study (PSG)**

If In-Lab, did you wear PAP: ☐ **Yes** ☐ **No**

If Yes, did you wear PAP all night: ☐ **Yes** ☐ **No (only wore PAP for part of the night)**

Where was sleep study performed____ (list state if not Great KC area)

Were you prescribed PAP _____________________ If so, are you still using PAP_____________________

How often do you use PAP: ☐ **nightly** ☐ **most nights** ☐ **occasionally** ☐ **rarely** ☐ **never**

PAP pressure settings: ☐ **CPAP ____________** ☐ **BIPAP ____________** ☐ **ASV ____________**

Type of PAP mask used: ☐ **Pillow (mask inserts in nose)** ☐ **Nasal (mask covers nose)** ☐ **Full Face (air enters nose and mouth)**

DME Provider (who supplies PAP equipment) ____________________ Age of current PAP machine ___________

***** Please bring with you a copy of your latest sleep study is less than 5 years old *****

What are your current needs from a Sleep Medicine Provider:

____

____

If diagnosed with OSA in past but not currently on treatment, please explain why:

____

____

____

____

Thank you for allowing us to participate your sleep medicine care.

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Date_________Location:__________________AHI: ____SUP:____REM:____O2 Nadir:______PAP setting___________

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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

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

- 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 ____

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

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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Witnessed Observations QUESTIONNAIRE

Patient's name: ____ Date of Birth: _______________Date: _______________

If you have a bed partner or someone who has witnessed your sleep behaviors, 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.

____
____

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☐ Snoring – R06.83	☐ Fragmented sleep – G47.8	☐ Heart Disease – I51.9	☐ ⇓ Memory– R41.3	☐ 95806 HST
☐ OSA - G47.33	☐ Fatigue – R53.83	☐ Palpitations – R00.2	☐ Depression – F33.8	☐ 95810 DX ONLY
☐ CSA - G47.31	☐ Insomnia – G47.09	☐ Arrhythmia – I49.9	☐ Anxiety – F41.1	☐ 95811 SPLIT NIGHT
☐ EDS – G47.13	☐ Inadeq Sleep Hyg – Z72.821	☐ HTN – I10	☐ ADHD – F90.9	☐ 95811 1ST TX CPAP
☐ Hypoxia – G47.36	☐ Insuff Sleep – F51.12	☐ T2DM – E11.9	☐ Bipolar – F31.9	☐ 95811 Reattempt
☐ Hypoxemia – R09.02	☐ Shiftwork – G47.26	☐ GERD – K21.9	_____________	☐ 95811 RE TX CPAP
☐ RLS – G25.81	☐ Narcolep; cata – G47.411	☐ ⇑ Hb – R71.8	☐ Obesity – E66.9	☐ 95811 RE TX BIPAP
☐ PLMD – G47.61	☐ Narcolep; no cata – G47.419	☐ ⇑ Tonsils – J35	☐ Morb Obesity – E66.01	☐ 95811 RE TX ASV
☐ Parasomnia – G47.59		☐ COPD – J44.9		☐ 99215 DSOV
☐ RBD – G47.52				☐ PAP Order
				☐ DME Switch
				☐ 7-Night Noc Ox
				☐ Dr L ☐ PCP
				☐ Fe++ ☐ Rx
				☐ DDS ☐ ENT
				☐ Sleep Logs
				☐ Refer: Insomnia
				☐ Refer: Hypersomnia

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