Patient Registration (please print)

Name:_____SSN:_____Marital Status: M S W D

Race:_____Ethnicity:_____

Address:_____City:_____State:_____Zip:_____

DOB:_____Home Phone:_____Cell Phone:_____

E-Mail:_____

Employer:_____Work Phone:_____

_____

Bill To *(patient is responsible party unless patient is under 18 years old)* Same as above Y or N

Responsible Party:_____Relationship to Patient:_____

Address:_____City:_____State:_____Zip:_____

DOB:_____SSN:_____Home Phone:_____Cell Phone:_____

Insurance Information

Primary Insurance:_____Policy #_____Group #_____

Address:_____City:_____State:_____Zip:_____

Subscriber Name:_____SSN:_____DOB:_____

Secondary Insurance:_____Policy #_____Group #_____

Address:_____City:_____State:_____Zip:_____

Subscriber Name:_____SSN:_____DOB:_____

Emergency Contact:_____Phone:_____Relation to Patient:_____

Your Pharmacy Name:_____City/State:_____Phone:_____

Primary Care Provider:_____Phone:_____

It is the responsibility of the patient to be aware of health insurance benefits including, but not limited to, co-pays, deductibles, and network participation.
Assignment of Insurance Benefits:

I, the undersigned hereby authorize the release of any information relating to claims for benefits submitted on behalf of myself and/or dependents. I agree that my signature on this document authorizes my physician and/or his employees to submit claims for benefits for services rendered without obtaining my signature on each claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though I had personally signed the claim.

I, the undersigned hereby authorize the above-named insurance company (s) to pay and hereby assign directly to Iowa Sleep all benefits, if any, for services rendered by staff at Iowa Sleep. I further acknowledge that any insurance benefits when received by and paid to Iowa Sleep will be credited to my account, in accordance with the above said assignment.

I, the undersigned agree to be responsible for any/all balance that insurance does not pay.

Authorized signature of subscriber:_____Date:_____

Parent signature (if minor):_____Date:_____

Iowa Sleep

Name: _____

Date of Birth: _____

New Patient Adult Sleep Medicine Questionnaire

Epworth Sleepiness Scale				
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the scale below to choose the most appropriate number for each situation. 0 = would **never** doze 1 = **slight** chance 2 = **moderate** chance 3 = **high** chance				
Situation:	**Chance of Dozing**			
	0	**1**	**2**	**3**
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g., movie theater or 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 lunch without alcohol				
In a car while stopped for a few minutes in traffic				

In your own words, please describe the main reason for coming to clinic today:

_____

Have you had a sleep study or sleep evaluation before? If so, specify when and where:

_____

Symptom Checklist

Fatigue/Sleepiness	**Yes**	**No**
I feel tired or fatigued during the day.		
I struggle to stay awake during the day.		
I wake up feeling refreshed.		
I have fallen asleep while driving.		
I have difficulty with memory or concentration		
Sleep-Disordered Breathing		
I snore or have been told I snore.		
I have experienced choking, shortness of breath, or gasping during sleep		
I have been told that others have seen me choking or gasping during sleep		
How much weight have you gained in the last year? _____		
I sometimes wake up with a headache.		
I struggle with nasal congestion.		
I experience leg swelling.		
I wake at night to urinate.		
Someone in my family has sleep apnea.		
Movement Disorders		
I have restlessness or discomfort in my legs at night.		
I have a history of sleep walking, sleep talking, sleep eating, or acting out in my dreams		
I clench or grind my teeth at night.		
I have regular nightmares.		

Name: _____

Date of Birth: _____

Sleep Hygiene	Yes	No
My bedtime is _____. My wake time is _____. I sleep_____ hours per night.		
I struggle to fall asleep. If yes, about how long before you fall asleep? _____		
I have or currently use medications to help me sleep. Please list what you have/are taking:		
I wake multiple times during the night. How many times? _____ If yes, list the reasons that wake you up:		
I nap intentionally or accidentally fall asleep during the day.		
I sleep in my bed at night.		
I watch television or use electronics in bed.		
I sleep with pets.		
I work in my bedroom.		
My bedroom is noisy or uncomfortable.		
Excessive Daytime Sleepiness (EDS)		
I have felt paralyzed while waking up or falling asleep.		
I have felt weakness in my face or knees when laughing or experiencing strong emotion		
I experience dream like hallucinations while falling asleep or waking up.		
I have a history of depression.		
I have a history of severe head trauma		
I have chronic pain. What medications do you use for pain?		

Past Medical History

Mark all that apply:

- o Allergies
- o Anemia
- o Anxiety
- o Asthma
- o Atrial Fibrillation
- o Blood clots
- o Cancer, type: _____
- o COPD
- o CHF
- o Depression
- o Dementia
- o Diabetes
- o GERD
- o Heart attack or heart disease
- o High cholesterol
- o High blood pressure
- o Migraine headaches
- o Narcolepsy
- o Parkinson's disease
- o Renal disease
- o Restless leg syndrome
- o Seizure disorder
- o Sleep Apnea
- o Thyroid disorder
- o Other (*specify*): _____

_____

Social History

Circle one answer per following questions:

1) Do you use chewing tobacco, cigars, or cigarettes? Yes, currently No, I quit _____ (year) Never

2) Do you alcohol? Yes, frequency: _____times/week, _____drinks/episode No

3) Do you drink caffeine? Coffee, tea, or soda: _____ drinks/day

4) Marital status: Married Single Divorced Widowed other: _____

5) Are you employed? ___Yes ____No

6) What is your occupation? _____

Name: _____

Date of Birth: _____

Past Surgical History

Mark all that apply:

- o Angiography with stent
- o Appendectomy
- o Back surgery
- o CABG
- o Cardiac pacemaker
- o Gastric bypass/sleeve
- o Hernia repair
- o Hip replacement
- o Knee replacement
- o Knee arthroscopy
- o Shoulder arthroscopy
- o Sinus Surgery
- o Septoplasty
- o Thyroidectomy
- o Tonsillectomy
- o Uvuloplasty
- o Other (*specify*): _____

Family History

List health problems for each:

Mother: _____ Deceased: yes / no

Father: _____ Deceased: yes / no

Siblings: _____

Review of Systems

Please mark yes **ONLY** to those symptoms you have experienced in the **last 2 weeks**.

Pulmonary	**Yes**	**Constitutional**	**Yes**	**Renal**	**Yes**
Shortness of breath at rest		Fever		Blood in urine	
Shortness of breath with exercise		Night Sweats		Frequent urination at night	
Frequent Cough		Chills		Painful urination	
Waking up at night short of breath		Weight loss			
Wheezing				**ENT**	
Blood clots		**Gastrointestinal**		Frequent sore throat	
		Trouble swallowing		Sinus infections	
Hematology/Oncologic		Heartburn		Hay fever	
Anemia		Abdominal pain		Dry Mouth	
Bleeding tendency		Nausea			
		Vomiting		**Musculoskeletal**	
Psychiatric				Muscle weakness	
Depression		**Neurologic**		Joint pain	
Anxiety		Migraines or headaches		Joint swelling	
Poor Sleep		Numbness or tingling			
Snoring		Dizziness		**Cardiac**	
Morning headaches		Imbalance/unsteadiness		Chest pain	
Sleep during the day		Vertigo		Leg swelling	
Panic attacks				Heart racing or thumping	
				Sleeping on 2+ pillows	

Fall Risk: Have you fallen in the last year? ☐ No ☐ Yes Number of falls/past year _____

Do you have problems with walking or balance? ☐ No ☐ Yes

Depression Screening: Over the last 2 weeks, how often have you been bothered by the following:

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless?	☐	☐	☐	☐

Current Medication / Allergy List

In order for us to provide you with the highest quality of care, we ask that you provide us with current medication (including any over the counter and herbal medicines), and allergy list.

Please complete the following:

Medication Name	Strength/Dose	How Often (Directions)

ALLERGIES:

_____

_____

_____

_____

Thank you for your cooperation!

Patient Initials: _____