PAIIENT DEMOGRAPHIC SHEET

LAST NAME____________________ FIRST NAME________________ MI______

SEX________ DOB________________ MARITAL STATUS________________

ADDRESS________________ City________________ STATE______ ZIP________

HOME PHONE ____________ WORK PHONE____________ CELL PHONE________

EMAIL____________________ SS__________________________

DRIVERS LICENSE________________ EMPLOYER____________ OCCUPATION________

REFFERIG PHYSICIAN________________ PHONE: ________________ FAX__________

DRUG ALLERGIES:

____

PHARMACY INFORMATION:

NAME OF PHARMACY ____

Phone Number: (______)__________-____________ ZIP: ________________________

PRIMARY INSURANCE

INSURED'S NAME____________________ RELATION TO PATIENT ________________

ADDRESS________________________ HOME PHONE:____________________

CITY, STATE, ZIP________________________ WORK PHONE____________________

SS#__________________ DOB____________ EMPLOYER ________________

SECONDARY INSURANCE

INSURED 'S NAME________________________ RELATION TO PATIETN ____________

ADDRESS #________________________ HOME #____________________

POLICY #________________________ GROUP#________________ DOB____________

I authorize Dr. Kris Bhat to release medical records to insurance for payment and for services and to the referring or primary care physician or other health care providers. I authorize and assign insurance benefits to Kris Bhat, M.D. for services rendered. I am responsible for all deductibles, coinsurances, co pays and referrals when needed. <u>If needing a sleep study and you do not show or call to cancel, you will pay $150. New patient no show fee is 50.00 and fu is 25.00</u>

SIGNATURE______________________________ DATE____________________

MINORS NAME______________________________ DATE____________________

WITNESS______________________________ DATE ____________________

Sleep Diagnostic Center
Kris Bhat, M.D., D.ABSM

SLEEP INTERVIEW QUESTIONNAIRE

Date: ________________

1. Name: Last __________________First ________________MI: _____Male/Female
2. DOB: ___/___/______Age: ____ Marital Status______ Occupation: ____________
3. SSN: _____/_____/_______ Referring Physician: _________________________

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits.

Section I: Main Complaint

4. What is your main sleep Complaint? ______________________________________
5. How long has this been a problem? __________________________________
6. Were there any events (weight gain, stress, illness, etc.) associated with the onset of your complaints____
7. Have you had a sleep study or home screen? ____How long ago? ___ ___Where? _____
8. Have you ever used nasal CPAP or BiPAP? No ___ Yes ___
   If so, how long? __________ Pressure setting_______ Mask__________

Section II: History of Sleep/Wake Disorder

Epworth Sleepiness Scale (ESS):

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. Use this scale to choose the most appropriate number for each situation:

0 = would never doze — 1 = slight chance of dozing
2 = moderate chance of dozing — 3 = high chance of dozing

Situation	Chance of dozing			
1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (e.g. meeting, theater)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
8. In a car, while stopped in traffic	0	1	2	3
			Total: _____	

Do you fall asleep or become sleepy when:	Never	Sometimes	Often	Always
1. Driving?	0	1	2	3
2. At work?	0	1	2	3
3. Do you take intentional naps?	0	1	2	3
4. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	0	1	2	3
5. Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3
6. Do you feel unable to move (paralyzed) when falling asleep?	0	1	2	3
7. Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep that is relieved by moving or getting out of bed and walking?	0	1	2	3
8. How would you rate your overall sleepiness?	None	Mild	Moderate	Severe

While asleep do you:	Never	Sometimes	Often	Always
9. Snore?	0	1	2	3
10. Hold your breath? Or have you been told to stop breathing?	0	1	2	3
11. Toss and turn or have restless sleep?	0	1	2	3
12. Suddenly awaken choking or gasping for breath?	0	1	2	3
13. Awaken with heartburn or acid reflux? (acid reflux in mouth)	0	1	2	3
14. Walk or talk in your sleep? (circle appropriate event)	0	1	2	3
15. Have nightmares?	0	1	2	3
16. Grind your teeth?	0	1	2	3
17. Have leg or arm jerks, twitches, or kicks?	0	1	2	3
18. Move about or engage in aggressive behaviors while asleep or awakening from sleep?	0	1	2	3
19. Wake up with a dry mouth?	0	1	2	3
20. Wake up with headaches?	0	1	2	3
21. Do you think you need a sleeping pill, either prescription drug or over-the-counter sleeping aids in order to fall asleep?	0	1	2	3
22. Do you consume wine or another alcoholic beverage in order to fall asleep?	0	1	2	3
23. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks?	0	1	2	3
24. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep?	0	1	2	3
25. Do you dread getting into bed because you think you will "never" sleep or return to sleep?	0	1	2	3

Section III: Sleep Habits

26. What time do you go to bed on weekdays? ________________________ weekends?____________

27. How long does it take you to fall asleep? ____

28. What percentage do you sleep on your Back____% Stomach____% Left/Right side____/____%

29. a). How often do you awaken at night? ____

b). How long do you stay awake? ____

c). What reason? (bathroom, etc.) ____

31. How many hours of sleep do you get in a typical night? ______________________________

32. How do you feel in the morning?

Very sleepy? ________ Sleepy, but wake up soon ______Wide awake, ready to go _____

33. When do you function best?				
	Morning:	Best	Medium	Worst
	Afternoon:	Best	Medium	Worst
	Evening:	Best	Medium	Worst

Section IV: Medical History

1. Please outline your medical history: Do you have or have ever been told you have:

- ☐High Blood Pressure
- ☐ Sinus Problems
- ☐ Diabetes
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Migraine or Frequent Headaches
- ☐ Elevated Cholesterol
- ☐ Obesity
- ☐ Stroke
- ☐ GI Disease
- ☐ Cancer
- ☐ Frequent nighttime urination
- ☐ Depression and/or Anxiety
- ☐ Liver Disease
- ☐ Seizures or Epilepsy
- ☐ Dementia (Alzheimer's)
- ☐ Abnormal behavior during sleep
- ☐ Prior History of Sleep Apnea
- ☐ Prior History of Restless Legs

1. Past Medical or Surgical History (include within the past five years)

Problem | Date of Onset | Treatment | Resolved/Current

____
____
____
____
____

2. List prescription and over-the-counter medications/drugs you are taking or recently have taken:

Name | Dosage | How often | Reason

____
____
____
____
____
____
____
____
____

3. Your weight? ____________ Your Height? __________
4. Do you smoke? ___________ If yes, how long? ___________ How much? _________/ day
5. Do you drink alcohol? ______If yes, how long? ____________ how much? ________/ day/ wk/mo
6. Do you drink caffeinated beverages (coffee, tea, cola)?________ How much? ________/ day/ wk / mo

General History

1. Have you had any recent problems with your memory or concentration?
   If yes, explain:
   ____
2. Have you notice any changes in your mood or irritability lately?
   If yes, explain:
   ____
3. Are you having any other problems (e.g. stress, anxiety, or pressures)?
   If yes, explain:
   ____
4. Have you been depressed lately?
   If yes, explain:
   ____
5. Are you having any sexual problems (impotency, premature ejaculation, lack of desire etc.)?
   If yes, explain:
   ____
6. Do you often travel across time zones, thereby affecting your sleep/wake schedule?
   If yes, explain:
   ____
7. Do you work night shifts and or rotating shifts?
   If yes, explain:
   ____

8.How did you hear about us? Physician referral/ Friend/ Web Page/ Yellow pages or advertisement

____