REGISTRATION FORM

SSMHealth | Sleep Services

DEMOGRAPHICS				
Name:			**SSN**:	
Address:				
Street/PO Box	*City*			
Phone: ( )	( )		( )	
Home	*Work*		*Other*	
Email:				
DOB: / /	**Age**:	**Sex**: M ☐ F ☐	**Marital Status**: S M D W	
Height: ft. in.		**Weight**: lbs.		
Emergency Contact(s):				
Name:	Phone : ( )		Relationship:	
Name:	Phone : ( )		Relationship:	
Employer/Occupation:				

INSURANCE INFORMATION	
Medicare # if applicable**:**	**Medicaid #** if applicable**:**
Primary Insurance:	**Secondary Insurance:**
Insured's Name:	Insured's Name:
Insured's SSN:	Insured's SSN:
Insured's DOB:	Insured's DOB:
Relationship to Insured:	Relationship to Insured:
Insurance Company:	Insurance Company:
Address:	Address:
Phone:	Phone:
Policy #: Group#:	Policy #: Group#:

I authorize release of any medical or other information necessary to process insurance claims/related treatment to the health care financing administration and its agents. I am responsible for payment of services rendered.

Signature:____ Date:_____/_____/_________

The sleep studies and follow-up treatments are covered by most major insurances and by Medicare. Should your specific policy not cover sleep studies, you WILL be notified PRIOR to your study.

Review of Sleep Health

How likely are you to doze off or fall asleep in the situations described in the box below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0= NEVER doze ***1=SLIGHT chance of dozing*** ***2=MODERATE chance of dozing,*** ***3=HIGH chance of dozing***

SITUATION	SCORE			
Sitting and Reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive in a public place (e.g. theater or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without a break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes	☐ 0	☐ 1	☐ 2	☐ 3
TOTAL				

Main Sleep Complaint

☐Snoring
☐Pauses in breathing during sleep
☐Daytime fatigue
☐Trouble falling/staying asleep

Other:

How long has this been a problem? ☐ 1-2 years ☐ 2-5 years ☐ 6-10 years ☐ 11-20 ☐ >20 Years

Have you been in a car accident due to falling asleep at the wheel? ☐YES ☐ NO
Have you ever had a near miss accident or event due to falling asleep at the wheel? ☐YES ☐ NO
Have you had any other types of accidents due to sleepiness? ☐YES ☐ NO

Sleep Schedule

What time do you go to bed? Choose an item. ☐ AM ☐ PM
What time do you wake up? Choose an item. ☐ AM ☐ PM
Does your routine change on weekends? ☐ YES ☐ NO

How long does it take for you to fall asleep? minutes

How many times do you wake up in the night?

How long does it take you to fall back asleep? minutes

In the morning upon awakening, do you feel? ☐ Completely Rested ☐ Partially Rested ☐Not Rested at All

Do you take naps during the day? ☐YES ☐ NO If so how often? Choose an item.
Are they refreshing? ☐YES ☐ NO

Sleep History

Have you ever had a sleep study? ☐YES ☐ NO
Have you ever had a home screening sleep study? ☐YES ☐ NO

If so, please fill out as much information as possible

Date of previous study _____/_____/________ Location:

Date of PAP study _____/_____/________ Location:

Have you ever been on CPAP/BiPAP? ☐YES ☐ NO
Do you still use it? ☐YES ☐ NO

What is your pressure setting? Cm/H20
Are you currently using Oxygen? ☐YES ☐ NO
If so, how many liters per minute? Choose an item.

MEDICAL HISTORY

Previous Medical History

EAR, NOSE, THROAT
- ☐ Sinusitis
- ☐ Nasal Polyps
- ☐ Deviated Septum

HEART
- ☐ Hypertension
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Arrhythmias
- ☐ Blood Clots
- ☐ Pacemaker

LUNG
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Pulmonary Fibrosis
- ☐ Pulmonary Hypertension
- ☐ Recurrent Pneumonia

ENDOCRINE
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Menopause (female)
- ☐ Low testosterone (male)

GI
- ☐ Reflux disease
- ☐ Esophagitis
- ☐ Hiatal Hernia

NEUROLOGICAL
- ☐ Stroke
- ☐ Head Injury
- ☐ Seizures
- ☐ Anxiety
- ☐ Neuropathy

MISC
- ☐ Chronic pain
- ☐ Degenerative joint disease
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Migraines
- ☐ Muscle weakness
- ☐ Arthritis
- ☐ Anemia

Medication Listing

Please list all current medications. Include oral contraceptives and vitamins or supplements

Family Medical History

CONDITION	Mother	Father	Siblings
Heart Disease			
Stroke			
High Blood Pressure			
Diabetes			
Cancer			
Sleep Apnea			
Thyroid Disease			
Narcolepsy			
Insomnia			

Review of Symptoms

EAR, NOSE, THROAT
- ☐ Frequent sinus infection
- ☐ Frequent ear infection
- ☐ Post-nasal Drip
- ☐ Wake with dry mouth

HEART
- ☐ Palpitations
- ☐ Chest pain

LUNG
- ☐ Shortness of breath
- ☐ Frequent coughing/wheezing
- ☐ Waking up gasping

GI
- ☐ Difficulty swallowing
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Blood in stool
- ☐ Waking with sour stomach /acid reflux

ENDOCRINE
- ☐ Increased thirst
- ☐ Frequent urination
- ☐ Weight gain
- ☐ Loss of sex drive

NEUROLOGICAL
- ☐ Memory Loss
- ☐ Difficulty concentrating
- ☐ Irritability
- ☐ Depression
- ☐ Visual Loss
- ☐ Dizziness

MISC
- ☐ Night sweats
- ☐ Morning headaches
- ☐ Night leg cramps/pain
- ☐ Crawling sensation in legs at night
- ☐ Leg jerks/kicks during sleep
- ☐ Vivid dreams
- ☐ Sleep attacks
- ☐ Wake feeling paralyzed
- ☐ Racing thoughts/worry at bedtime

Surgical History

NASAL surgeries ☐YES ☐ NO Explain:

THROAT surgeries ☐YES ☐ NO Explain:

Other Surgeries ☐YES ☐ NO Explain:

Social History

If employed, what are your working hours? Start: Choose an item. ☐ AM ☐ PM Stop: Choose an item. ☐ AM ☐ PM

How long have you been on this work schedule?

Are you currently pregnant? ☐YES ☐ NO

Do you Smoke? ☐YES ☐ NO For how long? Amount per day?

Do you drink Alcohol? ☐YES ☐ NO Average number you have per day: Choose an item.

Do you consume Caffeine? ☐YES ☐ NO Average number you have per day: Choose an item.

Physician Listing

Primary Care Physician or practice

List other Physicians or health care practitioners you are currently seeing for treatment: