INITIAL HISTORY AND PHYSICAL

Name: _____ SSN: _____ Marital Status_____
Date of Birth: _____/_____/_____ Drivers License Number _____
Address: _____
City: _____ State: _____ Zip code: _____
Home Number: _____ Work Number _____Cell Number _____
Spouse's Name: _____ Spouse's date of Birth: _____/_____/_____
Parent or guardian if under 18 years old: _____
Emergency contact: _____ Phone: _____
Address: _____ Relation: _____
Who referred you to our facility? _____

Describe your sleep complaints in your own words:

_____

_____

Medical History (Have you ever been diagnosed with any of the following? Check all that apply)

- ☐ Asthma
- ☐ Anxiety Disorder (anxiety attacks)
- ☐ Chronic Fatigue Syndrome
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hypothyroidism
- ☐ Kidney Failure
- ☐ Peptic Ulcer
- ☐ Menopause
- ☐ Allergies
- ☐ Arthritis
- ☐ COPD
- ☐ Deviated Septum
- ☐ Emphysema
- ☐ GERD – Gastro Esophageal Reflux
- ☐ Hyperthyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease
- ☐ Seizures
- ☐ Prostate Disease
- ☐ Cancer - Please describe type and treatment received: _____

_____

Please list any other Medical Conditions that you have or have had: _____

_____

Cardiovascular History (Have you ever been diagnosed with any of the following? Check all that apply)

- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Cardiac Surgery for Coronary Bypass
- ☐ Congestive Heart Failure
- ☐ Diastolic Dysfunction
- ☐ Heart Attack – Myocardial Infarction
- ☐ Chest Pain
- ☐ Arrhythmia
- ☐ Balloon Angioplasty or Stents
- ☐ Cortication of the Aorta
- ☐ Coronary Artery Disease
- ☐ Enlarged Heart
- ☐ High Cholesterol
- ☐ Hyperlipidemia

- ☐ Hypertension (High blood pressure treated or untreated)
- ☐ Internal Defibrillator
- ☐ Microalbuminuri
- ☐ Pacemaker
- ☐ Stroke or TIA
- ☐ Cardiac Surgery for valve replacement
- ☐ LVH – Left Ventricular Hypertrophy
- ☐ Nocturnal Ischemia
- ☐ Peripheral Arterial Disease
- ☐ Ventricular Arrhythmia

List any other Cardiovascular Conditions that you have or have had in the past: _____

_____

_____

Family History (Have any of your blood relatives ever been diagnosed with any of the following? Check all that apply.)

- ☐ Premature Cardiovascular Death (died from heart disease when they were younger than 70 years of age)
- ☐ Stroke or TIA
- ☐ Sudden Cardiac Death
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ Arrhythmia
- ☐ Congestive Heart Failure
- ☐ Obstructive Sleep Apnea
- ☐ Died in their sleep

Surgical History (Have you ever had any of the following surgical procedures? Check all that apply.)

- ☐ Deviated Septum
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Tonsillectomy
- ☐ UPPP
- ☐ Defibrillator
- ☐ Kidney Transplant
- ☐ Coronary Bypass Surgery (CABG)
- ☐ Gastric ByPass
- ☐ Herniated Disk Repair
- ☐ Spinal Fusion
- ☐ Repair of broken bone
- ☐ Pacemaker
- ☐ Lung transplant
- ☐ Heart Valve Replacement

Please list any other surgical procedures that you have had. _____

Past Sleep Diagnosis - In the past have you been diagnosed with any of the following? Please check all that apply.

- ☐ Sleep Apnea
- ☐ Periodic Limb Movement Disorder
- ☐ Narcolepsy
- ☐ Insomnia
- ☐ Restless Legs Syndrome
- ☐ Seizures

Please List all prescription medications that you currently take: _____

_____

_____

_____

_____

Please list any non-prescription medications that you take. Also list any medications that you may use to help you sleep at night: _____

_____

TB Screening

□ Chronic cough, > 3 weeks
□ Bloody sputum
□ Unexplained weight loss
□ Night Sweats
□ Recent travel out of the US or live in concentrated housing with or without another tuberculosis patient.

Current Sleep History

During the Week

What time do you normally go to bed on weeknights? _____
What time do you normally get out of bed on weekdays? _____
Do you nap on weekdays? _____ What time do you nap? _____
How long are your naps? _____

On Weekends

What time do you normally go to bed on weekends? _____
What time do you get out of bed on weekends?_____
Do you nap on weekends? _____ What time do you nap?_____
How long are your naps? _____

Sleep Hygiene

Do you watch television in bed prior to going to sleep? _____
How long is the television left on? _____ hrs. _____ all night
Do you read in bed prior to sleeping? _____
How long do you read in bed prior to turning the lights off? _____

Generally speaking, your challenges with going to sleep at night are related to. (Check all that apply)

- ☐ Temperature of the bedroom.
- ☐ Assisting others
- ☐ Pets
- ☐ Pain or discomfort
- ☐ Noise
- ☐ Telephone
- ☐ Uncomfortable Bed

- ☐ Restless Legs (creepy crawly feelings in your legs)
- ☐ Thoughts running through your mind
- ☐ Inability to settle down
- ☐ Going to bed prior to being sleepy
- ☐ Anxiety
- ☐ Fear of not being able to go to sleep or not being able to get enough sleep
- ☐ Bed Partner activities (snoring, reading, lights on, TV on, restless sleep, etc.)

<u>During the night</u> your sleep is disturbed by? (Check all that apply)

- ☐ Noise
- ☐ Others requiring your assistance (pets or people)
- ☐ Difficulty breathing or shortness of breath especially when lying flat
- ☐ Chest pain
- ☐ Leg cramps
- ☐ Other leg discomfort
- ☐ Pain or discomfort
- ☐ Need to go to the bathroom
- ☐ Hunger
- ☐ Thirst
- ☐ Unusual movements (such as sleep walking or sleep eating)
- ☐ Abdominal pain or gas
- ☐ Back or joint or muscle pain
- ☐ Difficulty breathing through your nose

Please list any other disturbances that you experience._____

Have you ever been told that you do or do you know that you do any of the following? (Check all that apply)

- ☐ Talk in you sleep
- ☐ Walk in your sleep
- ☐ Physically act out your dreams in your sleep?
- ☐ Have you ever awakened to find that you had eaten after going to sleep with no memory of having gotten up to eat.?
- ☐ Wake while sleeping and find that you are in a different location other than where you went to sleep at.
- ☐ Snore
- ☐ Stop Breathing
- ☐ Move your legs or arms repeatedly in sleep
- ☐ Sweat excessively
- ☐ Kick or move frequently
- ☐ Have tingling in your arms or legs.
- ☐ Grind your teeth when sleeping?
- ☐ Nightmares or scary dreams

When going to sleep or waking from sleep do you experience a feeling of paralysis? ____

Have you ever experienced a loss of muscle tone or muscle weakness when experiencing strong emotions such as surprise, happiness, fear or sadness? _____

Do you experience vivid dream like sequences that happen when you are awake? _____

Do you experience uncontrollable urges to take brief naps? _____

Work History

Do you work? _____ What type of work do you do? _____

What time do you go to work? _____ What time do you leave work? _____

Do you experience difficulty doing your normal daily activities because of sleepiness?___

Do you experience difficulty doing your job because of sleepiness? _____

Do you experience difficulty driving because of sleepiness? _____

On a scale of 0 – 10 (with 10 being the worst) how much does fatigue not sleepiness interfere with your ability to function during your normal waking hours? _____

Social Activities

Do you smoke cigarettes or cigars? _____ Did you in the past? _____

Have you quit smoking? _____ How long ago? _____

Do you drink alcoholic beverages? _____ How many a day? _____

Do you use any recreational drugs? If so, please explain _____
_____

How much caffeine do you consume in an average day? _____ How much caffeine do you consume after 2 pm? _____ (caffeine includes chocolate, coffee, tea, soda, some diet/stimulant products)

Do you exercise daily? _____ If so please describe type, frequency and at what times of the day. _____

_____

General Questions

Do you wear dentures? _____ If so are they partials or completes? _____

Do you sleep in a bed or a recliner? _____

Do you require assistance to get in and out of bed at night? _____

Do you use oxygen when sleeping? _____ How much oxygen do you use?_____

When is your sleep most disturbed?

☐ In the first part of the night ☐ In the middle of the night ☐ Early in the morning

Do you wake-up too early? _____ Do you feel that you get enough sleep?_____

Epworth Sleepiness Score

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	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score:	____

FOSQ

1. Do you generally have difficulty concentrating on the things you do because you are sleepy or tired? _____

2. Do you generally have difficulty remembering things because you are sleepy or tired? _____

3. Do you have difficulty finishing a meal because you become sleepy or tired? _____

4. Do you have difficulty working on a hobby (for example: sewing, collecting. gardening) because you are sleepy or tired? _____

5. Do you have difficulty doing work around the house (for example: cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired? _____

6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired? _____

7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired? _____

8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation? _____

PATIENT CANCELLATION AND NO SHOW AGREEMENT

Welcome to THE SLEEP CENTER OF NEVADA. We are glad you have made an appointment with us.

Effective January 1, 2018 THE SLEEP CENTER OF NEVADA will enforce a new Cancellation and No Show Policy.

In order to provide you with high quality health care it is important for you to keep your scheduled appointment with our facility. Valuable time has been reserved for you. A missed appointment or late cancellation of an appointment results in lost time which could have been given to another person waiting to receive care. *Every day we get many calls for appointments from both old and new patients. By cancelling your appointment as soon as possible we can help other patients who are waiting to be seen.*

Our office will call one day ahead and remind you of your appointment; however, it is your responsibility to keep record of your appointment and to arrive on time. If you need to cancel or reschedule your appointment please call 48 hours in advance between the hours of 9:00 am and 6:00 pm.

Patients who cancel appointments with less than **48 hours' notice will be considered a No Show.** Every No Show visit will be recorded in your chart. Multiple No Show appointments within a ***six month period*** can end your ability to make appointments and/or receive medical care at THE SLEEP CENTER OF NEVADA.

We realize that an emergency may occur, and you may not be able to notify us. We will discuss that situation with you when it happens.

After One (1) No Show: You will receive a letter and a phone call informing you of the No Show with a copy of this policy/agreement. You will be able to re schedule your appointment with THE SLEEP CENTER OF NEVADA with no charge at that time. However, if you miss the second appointment without appropriate notification as stated above, there will be a **$100.00 fee.** That will be billed directly to you, not your insurance company.

Thank you for working with us to ensure that services are provided to all of our patients in the best possible way.

Patient name: _____

_____ _____

Signature Patient or Responsible Party Date

_____ _____

Signature of Witness Date

COLLECTION POLICY

Patient name: _____

I hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event that my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection / legal fees that may be added to my account.

Returned checks: a $45.00 NSF fee will be charged for checks initially returned to the bank. If the check is returned unpaid a second time, it may be returned to a collection for recovery.

_____ _____

Signature Patient or Responsible Party Date

_____ _____

Signature of Witness Date

PATIENT BILL OF RIGHT AND RESPONSIBILITIES

You, the patient, have the right to have all of your questions answered prior to the test being done.

You, the patient have the right to assistance in completing the forms provided by the sleep program. This may include having a technologist sit with you and discuss the forms, read them to you, or write your responses for you.

You, the patient, have the right to have a family member accompany you to the sleep study and stay with you until time for the study to begin.

You, the patient, have the right to feel safe when sleeping in the lab.

You, the patient, have the right to voice any concerns that you have regarding the services, the facility or the staff.

You, the patient, have the right to participate in decisions made regarding your care.

You, the patient, have the right to personal privacy while in the facility and to know that any information gathered in the process will be kept private.

You, the patient, have a responsibility to provide accurate and complete information regarding your present medical/sleep history, past history, hospitalizations, medications and other matters related to your health.

You, the patient, have a responsibility to voice any concerns that you have about the care provided to you.

You, the patient, have a responsibility to ask any and all questions that you might have about the sleep study and follow-up process.

You, the patient, have a responsibility to follow the treatment plan prescribed and if you are unable or unwilling you must notify us or your physician.

You, the patient, have a responsibility to accept consequences when you do not complete the sleep study or follow prescribed treatment.

You, the patient, have a responsibility to be respectful of the staff and your surroundings while in the facility.

You, the patient, have a responsibility to meet financial obligations that result from this service.

INFORMED CONSENT STATEMENT

I _____ do consent to a nocturnal polysomnogram with/without positive pressure titration. The purpose of this procedure is to determine if I have a sleep disorder. I am aware that the procedure requires me to sleep overnight for completion of the study.

The recording process includes placing 9 electrodes on my head, 6 electrodes on my face, 2 belts around my chest and abdomen, 4 electrodes on my legs, 1-2 nasal/oral sensor under/in my nose, and a mask if a treatment study is done.

I am aware that a skin cleansing process will be used prior to electrode placement and that this process may leave reddened areas or abrasions on my skin.

I am aware that the electrodes/sensors and or wires may cause discomfort and that it is my responsibility to inform the technologist so that adjustments may be made.

I am aware that paste and/or tape will be used to maintain these electrodes and that I will need to remove residual paste after leaving the lab. I will need to shower or bathe in order to remove any residual paste.

I am aware that sleeping in the lab for this study may result in awakenings caused by the technologist making corrections to the electrodes or sensors.

I am aware that I will be video taped as a part of the recording process and I am consenting to this video taping for the purpose of diagnosing any sleep disorder that I might have. I have been informed that the video will not be used for any other purpose.

I am aware that it is my responsibility to inform the technologist of any special needs that I might have, including: personal time for sleep preparation, need for temperature adjustments, need for adjustment to sensors/electrodes that might cause me discomfort, other issues that might interfere with my personal comfort and of my feelings of security during the study and to notify the technologist of any discomfort or pain that I have while in the lab.

I am aware that the facility staff cannot provide medications of any type to me. I have brought all prescribed medication that I normally take prior to bed, during the sleeping hours and upon awakening and I will take them as prescribed.

I am aware that I will need to obtain results of this study from my doctor not the sleep lab and that it may take up to 10 days to process the study results.

I am aware that if I do not have this procedure and that if I have sleep apnea that continues untreated, that my health condition may worsen.

I am aware that the results of my sleep study may be included in research efforts, however my name and video images will not be revealed.

By signing this, I am giving my consent to have the sleep study performed and to have the study interpreted by the medical staff or Medical Director as ordered by my physician.

Signature of Patient: _____Date: _____ Time: _____AM/PM

Signature of Parent/Guardian: _____Indicate Relationship: _____

Witness: _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This is a summary of a notice that describes how medical information about you that is maintained by the Sleep Facility may be used and disclosed. This notice applies to all services provided by the Sleep Facility.

The Sleep Facility staff consists of physicians, technologist and support staff.

Our Privacy Obligation: We must, by law, maintain the privacy of your protected health information. When we disclose any information regarding you, your health, or the services provided to you, we will provide the minimum required to meet your needs or the legitimate request.

There are times when we may disclose your personal information without your written authorization. This may include treatment, payment or other healthcare functions which may involve administrative, quality and cost studies or other activities to the quality of healthcare to our patients.

Other examples include: relatives, friends or other care givers, as identified by you, public health agencies, reporting of abuse or neglect or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement officials, medical examiners, coroner or funeral director, organ and tissue procurement, workers compensation, national security, and intelligence activities, protective services for the president and others, specialized government functions, correctional institutions, or law enforcement when you are an inmate, and as otherwise required by law.

We may include your health information in research efforts however, we will not use your personal identifying factors such as your name or video images.

For any purposes other than those listed above, your personal and health information will only be used with your written consent. For example we will need your written consent to send your records to a life insurance company, a consulting physician or a friend or relative who may request information. This includes, but is not limited to test results, appointment information and your plan of care.

If for any reason we should need to change this notification we will post these changes in our office for your review.

If you want more information or you believe that your rights have been violated or if you disagree with a finding that we have made about your access to your personal information you may contact our office. You may also file a complaint in writing with Director, Office of Civil Rights of the US Department of Health and Human Services.

We will not retaliate against you if you file a complaint with us or with the Office of Civil Rights.

We need written authorization to discuss your test results or scheduled appointments with anyone other than you. We need written authorization to send your test results to any physician other than the ordering physician.

Please make all requests in writing, when you need your results sent to a physician other than the ordering physician.

Privacy and Communication Release

I am aware that I have the right to privacy regarding my medical information.

I am aware that the results of this study will be provided to my referring physician.

I am aware that I may waive my right to privacy and allow *The Sleep Center of Nevada* to *discuss* information regarding the services provided to the following persons:

Personal Physician:

_____

Name Address Phone Fax

Family Member:

_____

Name Address Phone Fax

Friend:

_____

Name Address Phone Fax

_____ Do not provide any information to anyone other than my referring physician.

I have reviewed this information and am consenting to the above release of my personal information.

Patient Print Name: _____ Signature: _____

Date: _____

Witness Print Name: _____ Signature: _____

Date: _____

SLEEP STUDY INSTRUCTIONS

1. Please be here at your scheduled appointment time. Please note that we are not able to accommodate patients early. Please arrive at your scheduled testing time.
2. Keep a regular sleep routine the night before your test. It is important to stay awake at least 12 hours before your test is scheduled to start. Do not nap.
3. **Bring a current list of all your medications. IF YOU TAKE ANY MEDICATIONS AT NIGHT OR IN THE MORNING, PLEASE BRING THEM WITH YOU. NO MEDICATIONS WILL BE PROVIDED BY THE CENTER.**
4. **Do not use any alcohol or caffeine after 12:00 p.m**. on the day of your test, unless instructed to do so by your physician.
5. **Refrain from using any hair gels or spray**. We recommend bringing a scarf or hat to wear when leaving.
6. **Please, No creams or lotions on your legs or face.**
7. You may want to **bring a pillow** or a familiar item from home. Some patients are more comfortable with their own items.
8. Please eat your last meal at least 3 hour prior to your arrival.
9. Most patients are ready to leave between 5:30 a.m. and 7:00 a.m., please **arrange for pick-up** at this time if you did not drive yourself.
10. Bring pajamas or something comfortable to sleep in. **Sleeping nude or in underwear is not acceptable.**
11. Males are asked to be **clean-shaven** (where you normally shave) upon arrival for testing.
12. This is not an invasive procedure: you may drive yourself-if you normally would, no medications will be provided to you at the lab.

Bring a snack or beverage if you normally require one prior to going to bed.

PATIENT CHECKLIST

- Please bring the following with you to the Sleep Lab:
  - ❑ Comfortable sleepwear: preferably not silk or rayon; 2-piece with buttons down the front, if possible
  - ❑ Favorite pillow and/or blanket, if you choose
  - ❑ Toiletries; toothbrush/paste, comb, shampoo
  - ❑ Clothes to go home in
  - ❑ Medications (no medications will be given by Sleep Lab Technicians)
  - ❑ Reading material, if you choose
  - ❑ Completed sleep questionnaire
- The Sleep Lab provides sheets, blankets, pillows, towels.

If you have any question, please call us at 702-818-2444

Hours of Operation: Monday - Friday, 9:30 AM to 7:00 PM