

## Presbyterian Sleep Disorders Center

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Welcome:

We look forward to having you as a patient. In order to better accommodate you, we ask that you complete the attached information and bring it with you to your first appointment.

In addition to the paperwork, **please ask your referring provider to send us previous sleep studies, recent x-ray films, CT scans, lab results, progress notes and any other test results or information relevant to the condition for which you are being seen. You must also bring all your prescription medications, over the counter medications and any herbal supplements you are taking regularly to your appointment.**

If, for any reason, you are unable to keep your appointment, it is important that you call to cancel your appointment no less than 24 hours prior to your scheduled time. New patient appointments are for forty-five minutes; we have patients in need of these times if you are unavailable to use them.

Please be prepared to pay your co-pays, co-insurance, or deductibles at the time of your visit. Our office also asks that you bring your insurance information with you, as it is needed to submit your charges to the correct insurance company. **If your insurance requires a referral, you must have it with you at the time of your appointment or we will need to reschedule your visit.**

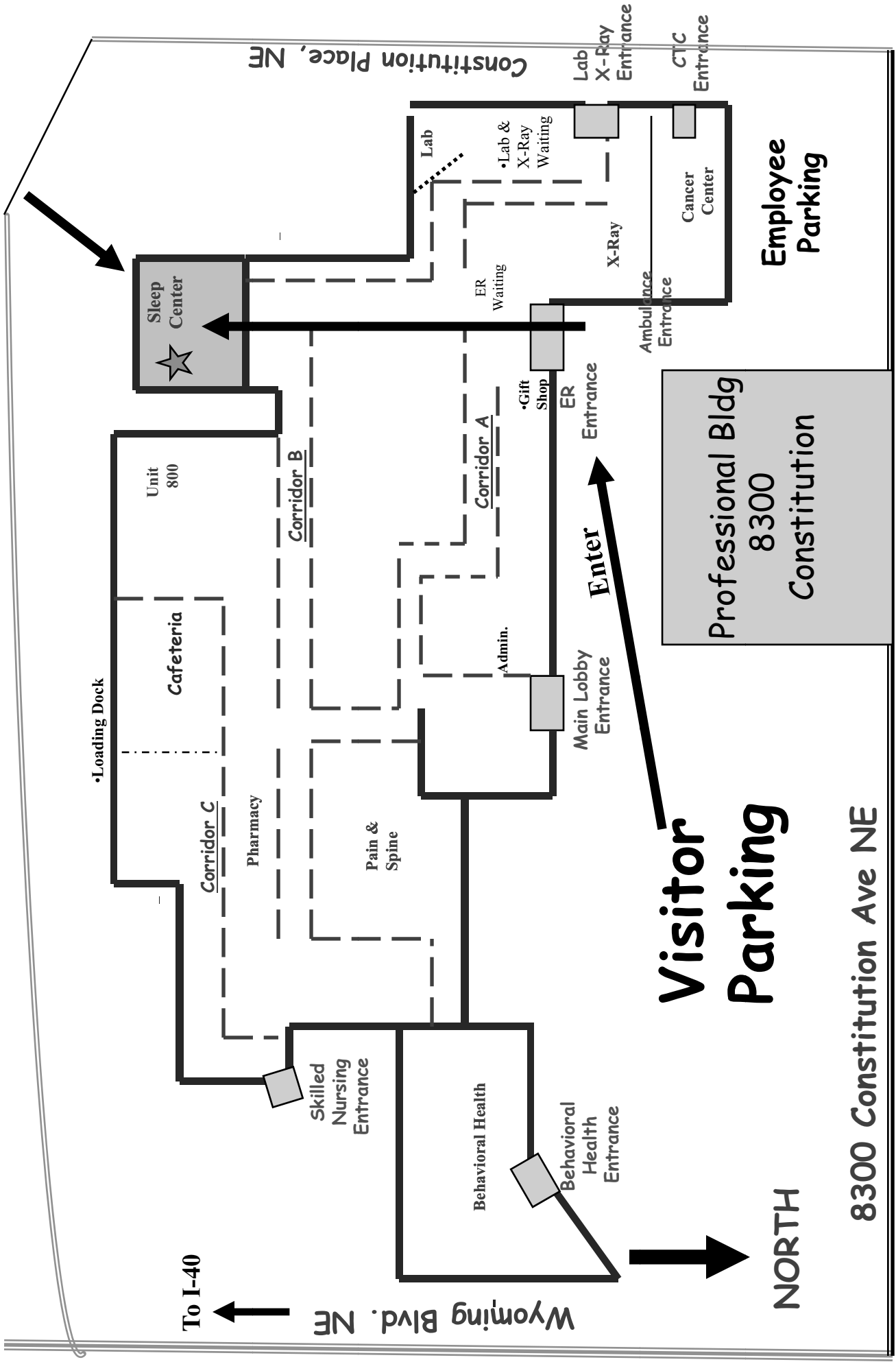
Our office accepts cash, checks, and Visa/ MasterCard/ Discover/ American Express for your co-payments. There is a \$25.00 returned check fee.

If you have any questions, please call our office and select the appointment option for assistance. Thank you for taking the time to complete this information prior to your appointment.

Sincerely,  
Providers & Staff

YOUR APPOINTMENT IS SCHEDULED FOR: \_\_\_\_\_

**PLEASE ARRIVE 30 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT.**



Sleep Center inside Presbyterian Kaseman Hospital (505) 291-2700

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete the front and back of all forms. Thank you!**

**Primary reason for your visit to the Sleep Disorders Center:**

\_\_\_\_\_

**Who is your primary care provider?** \_\_\_\_\_

### NEW PATIENT QUESTIONNAIRE

1. **Have you ever had a sleep study?**  Yes  No If yes, When and Where  
\_\_\_\_\_
2. Are you using Continuous Positive Airway Pressure (CPAP)?  Yes  No
3. Have you ever used CPAP?  Yes  No
4. What time do you go to bed with lights out? \_\_\_\_\_ Are you tired when you go to bed?  Yes  No
5. How long does it take for you to fall sleep? \_\_\_\_\_
6. What time do you get out of bed in the morning? \_\_\_\_\_
7. Do you wake up frequently during the night?  Yes  No If yes, how many times a night do you wake up? \_\_\_\_\_. Do you look at the clock when you wake up in the middle of the night?  Yes  No How long does it take you to fall back to sleep? \_\_\_\_\_
8. Do you feel anxious when you are not able to fall asleep?  Yes  No
9. How many hours are you asleep and how many hours are you in bed?  
\_\_\_\_\_/\_\_\_\_\_
10. Do you sleep better when you are away from home?  Yes  No
11. Are there any environmental factors that disturb your sleep such as a snoring partner or other noises, temperature, or security concerns?  Yes  No If so, please list:
12. Do you feel rested when you wake up?  Yes  No
13. Do you feel tired during the morning or afternoon?  Yes  No If yes, how long has this been a problem? \_\_\_\_\_ months/ years
14. Do you snore?  Yes  No How long have you been snoring? \_\_\_\_\_
15. Do you stop breathing at night?  Yes  No If yes, according to whom?  
\_\_\_\_\_
16. Have you ever awakened with a sense of suffocation, gasping, choking, or with a snort?  
 Yes  No
17. Do you nap during the day?  Yes  No If yes, what time do you nap? \_\_\_\_\_  
How long do you nap? \_\_\_\_\_
18. Do you experience any of these while in bed? Please check all that apply:  chest pain  
 chest palpitations  acid reflux/heartburn  night sweats  hot flashes  morning headaches  frequent urination (\_\_\_\_) times
19. Have you ever awakened in the morning and found you were unable to move (paralyzed)?  Yes  No
20. Do you ever hallucinate, imagine that you see or hear people, animals, objects, or frightening events when you are drowsy or just as you are falling asleep?  Yes  No
21. When you laugh, get angry, get excited, or get startled, do you experience heaviness of your head and buckling or weakness of your legs?  Yes  No

22. Do you grind your teeth at night?  Yes  No
23. When you try to relax in the evening or sleep at night, do you ever have unpleasant, restless feeling in your legs (for example - creepy, crawly sensations under the skin) that can be relieved by walking or movement?  Yes  No
24. Has anyone told you your legs jerk while you are sleeping?  Yes  No
25. Do you have any pain that disrupts your sleep?  Yes  No  
If yes, please describe \_\_\_\_\_
26. Do you have nightmares?  Yes  No If yes, what part of the night? \_\_\_\_\_
27. Do you smoke, drink alcohol, coffee, or any other caffeinated drink **with or after dinner**? Circle those that apply. Indicate the time and amount
28. Are you currently taking a sleeping pill?  Yes  No If yes, please list \_\_\_\_\_  
What other sleeping pills have you tried in the past? \_\_\_\_\_
29. Have you had a motor vehicle accident because of sleepiness or drowsiness?  Yes  No

### EPWORTH SLEEPINESS SCALE

*How likely are you to doze off or fall asleep in the following situations?*

ACTIVITIES	WOULD NEVER DOZE	SLIGHT CHANCE OF DOZING	MODERATE CHANCE OF DOZING	HIGH CHANCE OF DOZING	SCORE
Sitting and reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting, inactive in a public place	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	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after a lunch without alcohol	0	1	2	3	
Sitting in a car while stopped for a few minutes in traffic	0	1	2	3	
<b>TOTAL SCORE</b>					



**V. FAMILY HISTORY Has any blood relative had:**

MEDICAL PROBLEMS	YES	NO	RELATIONSHIP (FATHER, MOTHER, BROTHER, SISTER, CHILDREN)
Allergies/Hay Fever			
Anemia			
Asthma			
Cancer			
Depression			
Diabetes Mellitus			
Emphysema			
Heart Attack or heart disease (indicate age when it first occurred)			
Hypertension			
Insomnia			
Kidney Disease			
Restless Legs Syndrome			
Snoring/Sleep Apnea			
Stroke (indicate age when it first occurred)			

How many children do you have? \_\_\_ Are they healthy?  Yes  No **If not, why?** \_\_\_\_\_

**VI. SOCIAL HISTORY**

Where were you born? \_\_\_\_\_

Where have you lived? \_\_\_\_\_

Last grade completed in school? \_\_\_\_\_

Married How long? \_\_\_\_\_  Single  Divorced  Widowed  living with partner

Do you have pets at home? \_\_\_\_\_ What kind? \_\_\_\_\_ How many? \_\_\_\_\_

What jobs have you held (now and in the past- please circle current job or indicate if retired or on disability)? \_\_\_\_\_

Have you ever served in the military?  Yes \_\_\_\_\_  No

Have you been exposed to asbestos or chemicals? \_\_\_\_\_

Do you smoke  No  Yes Packs per Day \_\_\_\_\_ For how many years? \_\_\_\_\_

If no, did you ever?  No  Yes. Packs per Day \_\_\_\_\_ total years? \_\_\_\_\_ year you quit \_\_\_\_\_

Do you use alcohol?  No  Yes How many drinks per day? \_\_\_\_\_ How many drinks per week? \_\_\_\_\_

Do you use caffeine?  No  Yes Type  Coffee  Tea  Soda

How many drinks per day? \_\_\_\_\_

**VII. IMMUNIZATIONS**

Last flu shot? \_\_\_\_\_

Pneumonia vaccine? \_\_\_\_\_ If yes, when? \_\_\_\_\_

## Review of Systems

### PLEASE PUT A CHECK MARK ONLY IF HAVING PROBLEMS

#### Constitution

- Activity Change
- Appetite Change
- Chills
- Excessive Sweating
- Fatigue
- Fever
- Unexpected Weight Change

#### Choking

- Choking
- Cough
- Shortness of Breath
- Wheezing

#### Pale skin

- Pale skin
- Rash
- Wound/ Infections

#### Cardiovascular

- Chest Pain
- Leg Swelling
- Palpitations

#### Neurological

- Dizziness
- Headaches
- Light-headedness
- Numbness
- Seizures
- Speech Difficulty
- Fainting
- Tremors
- Weakness

#### HENT

- Facial Swelling
- Neck Pain
- Hearing Loss
- Ear Pain
- Ringing in the Ears
- Nosebleeds
- Congestion
- Runny Nose
- Post Nasal Drip
- Sneezing
- Sinus Pressure
- Jaw Problem
- Mouth Sores
- Sore Throat
- Trouble Swallowing
- Voice Change

#### GI

- Heartburn
- Abdominal Pain
- Blood in Stool
- Constipation
- Diarrhea
- Nausea
- Vomiting

#### Hematologic

- Enlarged lymph nodes
- Bruises/Bleeds easily

#### GU

- Difficulty Urinating
- Painful Urination
- Kidney Stones
- Frequency
- Up at night to urinate: # of times \_\_\_ per night
- Blood in Urine
- Urgency
- Urine Decreased

#### Psychiatric

- Agitation
- Behavior Problem
- Confusion
- Decreased Concentration
- Sad Mood all the time
- Hallucinations
- Hyperactive
- Nervous/Anxious
- Feeling like hurting yourself
- Sleep Disturbance
- Suicidal Ideas

#### Eyes

- Eye Itching
- Pain from light
- Visual Disturbance (cataracts, Glaucoma)

#### MS

- Joint Pain
- Back Pain
- Walking discomfort
- Joint Swelling
- Muscle Aches and Pains

#### Respiratory

- Chest Tightness

#### Skin

- Color Change

