MEDICAL WEST
SLEEP MEDICINE
an affiliate of the UAB HEALTH SYSTEM

Patient History Questionnaire

Name: ______________________________________ Date of Birth: __________________________

Age: _____ Height: _____ Weight: _____ Occupation: _________________________________

It is important for you to be accurate in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. This information will be held in the STRICTEST CONFIDENCE.

1. In the space provided below, please describe your sleep problem(s) in your own words, including when and how this began and what treatments you have received for this in the past.
   ____
   ____
   ____
   ____
   ____

2. Has it been a continuous or intermittent problem?
   ( ) almost every night
   ( ) for periods of at least one week
   ( ) irregularly
   ( ) other ____

3. How long has this problem bothered you?
   ( ) longer than 2 years
   ( ) 1 to 2 years
   ( ) several months
   ( ) within the last 3 months
   ( ) within the last month

4. On the scale below, please estimate the severity of your problem:
   ( ) mildly upsetting
   ( ) moderately severe
   ( ) extremely severe
   ( ) totally incapacitating

5. How strongly do you want help with your problem?
   ( ) very much
   ( ) much
   ( ) moderately
   ( ) could do without it

6. How do you describe your sleep problem? Check all that apply to you.
   ( ) difficulty falling asleep
   ( ) wake up during the night
   ( ) wake up early in the morning
   ( ) excessive daytime sleepiness
   ( ) difficulty awakening

7. Do any other members of your family have sleep problems? ___YES ___NO If yes, please explain: ________
   ____
   ____
   ____

8. Is your present work situation satisfactory? ___YES ___NO

9. Does your sleep problem disturb your sex life? ___YES ___NO

10. Is your present social life satisfactory? ___YES ___NO

11. Does your sleep problem require you to cut back on social activities? ___YES ___NO

Please list all the medications that you are currently taking:

Medication	Amount	Frequency

General Sleep Habits

1. How many hours of sleep do you usually get per night? ____________________

2. What time do you usually go to bed on WEEKDAYS? __________ WEEKENDS? __________

3. How long does it take you to fall asleep? ____________________

4. How many times do you typically wake up at night? ____________________

5. What time do you usually awaken in the morning on WEEKDAYS? __________ WEEKENDS? __________

6. On average, how long do you stay in bed after waking up in the morning? ____________________

7. Do you usually: (check all that apply to you)
   ( ) sleep with someone else in your bed   ( ) sleep with someone else in your room
   ( ) provide assistance to someone during the night (child, bed partner, animal)

8. Is your sleep often disturbed by:
   ( ) heat   ( ) light   ( ) cold   ( ) bed partner   ( ) noise
   ( ) not being in your usual bed   Other:______________________________

9. Are your sleep habits on weekends different from the rest of the week?
   ( ) no   ( ) yes - please explain______________________________

10. With whom are you now living? (wife, husband, children, parents, etc. and their ages)
    ____

11. Do you work split shifts or rotating (variable) shifts?   ___YES ___NO
    If so, what is your schedule?______________________________

12. Do you usually drink coffee or tea within 2 hours before you go to bed?   ___YES ___NO

13. Do you do physical exercises before you go to bed?   ___YES ___NO

14. Do you read before falling asleep?   ___YES ___NO

15. Do you take naps during the afternoon or evening?
    ( ) never   ( ) seldom   ( ) frequently - if so, for how long______________________________

16. Do you feel refreshed after a short (10-15 minute) nap?   ___YES ___NO

17. How do you feel after a typical night of sleep?
    ( ) usually feel drowsy and/or tired: If so, for how long: ( )1 hour ( )2 hours ( )3+ hours
    ( ) most of the time, I feel good
    ( ) consistently, I feel good

18. Do you feel better during: ( )morning   ( )afternoon   ( )evening

19. List your daily consumption of the following:
    Coffee: ____________________
    Tea: ____________________
    Colas: ____________________
    Chocolate: ____________________
    Nicotine: ____________________
    Alcohol: ____________________
    Drugs: ____________________
    Marijuana/THC: ____________________

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Check any of the following that apply to you:

- ☐ I am currently on CPAP/BIPAP. Settings: ______cm
- ☐ I am on supplemental oxygen. Settings: ______ LPM
- ☐ I have been told that I snore.
- ☐ I often feel sad or depressed.
- ☐ I have been told that I hold my breath while I sleep.
- ☐ I have trouble concentrating at work or school.
- ☐ I have high blood pressure.
- ☐ I have fallen asleep while driving.
- ☐ I have been told by friends and family that I'm often grumpy or irritable.
- ☐ I have experienced vivid dreamlike scenes upon falling asleep or awakening.
- ☐ I sweat excessively during the night.
- ☐ I have fallen asleep during a social setting such as the movies or parties.
- ☐ I have noticed my heart pounding or beating irregularly during the night.
- ☐ I have dreams soon after falling asleep or during naps.
- ☐ I wake up in the mornings with headaches.
- ☐ I have "Sleep Attacks" during the day no matter how hard I try to stay awake.
- ☐ I suddenly wake up gasping for breath.
- ☐ I have episodes of feeling paralyzed during my sleep.
- ☐ I am overweight.
- ☐ I wake up at night with acid/sour taste in my mouth.
- ☐ I seem to be losing my sex drive.
- ☐ I wake up at night coughing or wheezing.
- ☐ I often feel sleepy and struggle to stay alert.
- ☐ I wake up suddenly during the night feeling like I'm choking.
- ☐ I frequently wake with a dry mouth or sore throat.
- ☐ I experience muscle tension in my legs at times other than exercising.
- ☐ I have difficulty falling asleep.
- ☐ I have noticed (or others have commented) that my legs or arms twitch during sleep.
- ☐ I have thoughts racing through my mind preventing me from falling asleep.
- ☐ I have been told that I kick my legs during sleep.
- ☐ I wake up and can't go back to sleep.
- ☐ I experience an aching or crawling sensation in my legs while trying to go to sleep.
- ☐ I worry about things and have trouble relaxing.
- ☐ I experience leg pain or cramps at night.
- ☐ I wake up earlier in the morning than I would like.
- ☐ I occasionally can't keep my legs still: I have to move them to feel comfortable.
- ☐ I lie awake for ½ hour or more before falling asleep.
- ☐ I have a history of stroke or TIA.
- ☐ I have a history of : Check all that apply:
  ( ) Coronary artery disease ( ) heart attack ( ) cardiac surgery ( ) congestive heart failure
- ☐ I have asthma

* R O S *

CLINIC REVIEW OF SYSTEMS

Patient's Name: ____________________

Date of Birth: ____/____/____

Today's Date: ____/____/____

REVIEW OF SYSTEMS

Please mark any symptom(s) you are currently having, or have experienced in the last two (2) weeks. If you are not having any of these symptoms please mark, "No Problems".

No Problems	

Constitutional / General Health	
Appetite change	
Excessive sweating	
Fatigue	
Fever	
Chills	
Night sweats	
Unexpected weight change	
Weight gain ________ lbs.	
Weight loss ________ lbs.	
Eyes	
Blurred vision	
Corrective lenses	
-- Contacts	
-- Glasses	
Decreased vision	
Diplopia (double vision)	
Eye irritation	
Eye pain	
Spots in vision	
Vision loss	
Ears, Nose, Mouth & Throat	
Ear pain	
Hearing loss	
Tinnitus (ringing in ears)	
Vertigo	
Facial pain	
Nasal discharge	
Nasal congestion	
Epistaxis (nose bleed)	
Postnasal drainage	
Bleeding gums	
Dental pain	
Mouth lesions	
Hoarseness	
Sore throat	
Cardiovascular (Heart)	
Chest pain	
-- At rest	
-- Upon exertion	
Decreased exercise tolerance	
Dizziness	
Dyspnea (difficult or labored breathing)	
-- At rest	
-- Upon exertion	
Orthopnea (shortness of breath when lying flat)	
Palpitations	
Pre-syncope (feeling as if you will faint)	

Cardiovascular (Heart) Cont.	
Syncope (fainting)	
Claudication (cramping pain in the leg induced by exercise)	
Leg ulcers	
Edema (swelling)	
Peripheral edema (swelling in the lower limbs)	
Respiratory	
Cough	
- Nocturnal (at night) cough	
- Productive cough	
- Nonproductive cough	
Hemoptysis (coughing up blood or blood-stained mucus)	
Shortness of breath	
Pleuritic (sudden, intense, sharp, stabbing, or burning pain in chest when inhaling or exhaling) pain	
Wheezing	
Snoring	
Apneas	
Gastrointestinal	
Abdominal pain	
Acid brash (regurgitation of saliva with some acid material from the stomach)	
Bloating	
Food intolerance	
Early satiety (feeling full after only a small amount of food)	
Fullness	
Epigastric discomfort (right below your ribs in the area of your upper abdomen)	
Nausea	
Vomiting	
Hematemesis (vomiting blood)	
Dysphagia (difficult swallowing)	
Reflux	
Heartburn	
Altered bowel habits	
Constipation	
Diarrhea	
Hematochezia (fresh blood in or with stools)	
Black stools	
Bloody stools	

Genitourinary (Kidney & Bladder)	
Change in urinary stream	
Dysuria (painful or difficult urination)	
Hematuria (blood in urine)	
Incontinence (lack of voluntary control over urination)	
Nocturia (getting up from sleep to urinate)	
Urinary frequency	
Urinary urgency	
Sexual dysfunction	
Female Patients Only	
Dysmenorrhea (painful period)	
Dyspareunia (painful intercourse)	
Vaginal discharge	
Menopausal	
Postmenopausal	
Last cycle: ______/_____/______	
Male Patients Only	
Urinary dribbling	
Urinary hesitancy	
Penile discharge	
Musculoskeletal / Orthopedic	
Back pain	
Joint pain	
Joint swelling	
Limited range of motion	
Muscle aches	
Muscle weakness	
Stiffness	
Integumentary (Skin & Hair)	
Hair changes	
Lesions	
Changes in moles	
Pigment changes	
Pruritis (severe itching of skin)	
Rash	
Breast masses	
Breast skin changes	
Nipple discharge	
Neurologic (Brain & Nerves)	
Abnormal gait	
Dizziness	
Focal weakness	
Headache	
Incoordination	
Memory problems	
Numbness	
Numbness in feet	

Continued on next column

Neurologic (Brain & Nerves)	
Numbness in hands	
Paresthesia (tingling, pricking, pins & needles) in feet	
Paresthesia (tingling, pricking, pins & needles) in hands	
Seizures	
Slurred speech	
Tremor	
Psychiatric (Mood & Thinking)	
Anxiety	
Decreased concentration	
Depression	
Dizziness	
Irritability	
Panic attacks	
Sleep disturbances	
Sadness/tearfulness	
Endocrinological (Glands)	
High blood sugar	
Low blood sugar	
High cholesterol	
Polydipsia (abnormally great thirst)	
Polyphagia (excessive hunger or increased appetite)	
Polyuria (frequent urination)	
Cold intolerance	
Heat intolerance	
Hematologic (Blood / Lymph)	
Bruising	
Bleeding tendencies	
Lymphadenopathy (enlarged lymph nodes)	
Recurrent infections	
Allergic / Immunologic	
Eczema	
Seasonal allergies	
Urticaria (hives)	
Any Symptoms not listed:	

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Epworth Sleepiness Scale:

Please use the following scale to rate how likely you are to doze off or fall asleep in the situations listed below:

- **0- No** chance of dozing off or falling asleep
- **1- Slight** chance of dozing off or falling asleep
- **2- Moderate** chance of dozing off or falling asleep
- **3- High** chance of dozing off or falling asleep

Situation Even if you haven't done some of these things recently, try to work out how they would have affected you.	**Chance of dozing or falling asleep** Choose one answer for each situation.
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting in an inactive place (like a meeting or theater)	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 with someone	0 1 2 3
Sitting quietly after lunch (without alcohol)	0 1 2 3
In a car while stopped for a few minutes in traffic	0 1 2 3
Total Score	________ out of 24

UAB MEDICAL WEST

CLINIC PATIENT INFORMATION

Patient Information

Today's Date: ____________

Full Name: ____________________ (Last) ____________________ (First) ______ (M.I)

Date of Birth: ____________

Address: ____________________ (Street Address) ______ (Apartment/Unit #)

____________________ (City) ______ (State) ______ (ZIP Code)

Home #: ____________ Cell #: ____________ Email: ____________

SS #: ____________ Race: ____________

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced Gender: ◯ Male ◯ Female

Employment

Employer: ____________ Dept/Title: ____________

Address: ____________________ (Street Address) ______ (Phone #)

Emergency Contact

Spouse/Companion/Guardian:

Full Name: ____________________ Relationship: ____________

Address: ____________________ Phone: ____________

Nearest relative or friend not living with you:

Full Name: ____________________ Relationship: ____________

Address: ____________________ Phone: ____________

Insurance Information

Primary Insurance: ____________ Policy #: ____________ Group#: ____________

Name of Insured: ____________ Relationship: ____________

SS#: ____________ DOB: ____________

Secondary Insurance: ____________ Policy #: ____________ Group#: ____________

Name of Insured: ____________ Relationship: ____________

SS#: ____________ DOB: ____________

Worker's Compensation ◯ YES ◯ NO

Contact Person: ____________ Title: ____________ Phone: ____________

Billing Information

Person Responsible for Payment

Full Name: ____________ Relationship: ____________ SS#: ____________

Address: ____________________ (Street Address) Phone # ____________

Employer: ____________ Dept/Title: ____________

Address: ____________________ (Street Address) Phone # ____________

Referral Information

Referred by: ____________________ Phone: ____________

RECEIPT FOR HIPAA PRIVACY NOTICE AND AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION (MW119)

Patient Name ______________________ Date of Birth ______________________

Social Security Number ______________________ Preferred Phone Number ______________________

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that **I may revoke this authorization at any time by notifying Medical West** in writing, but if I do it will not have an effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise. I hereby authorize Medical West to disclose health information to the following:

Name & Relation ______________________ Phone # ______________________

Name & Relation ______________________ Phone # ______________________

Name & Relation ______________________ Phone # ______________________

Name & Relation ______________________ Phone # ______________________

PLEASE NOTE THAT NOT ANSWERING THE QUESTIONS BELOW MAY RESULT IN THE STAFF OF MEDICAL WEST LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE.

☐ Yes ☐ No The physicians and staff of Medical West may confirm my appointment to my voice mail / answering machine at the number provided on my patient information sheet.

☐ Yes ☐ No The physicians and staff of Medical West may leave lab results or results of other diagnostic studies (e.g., MRI, CT, Bone Scan, etc.) on my voice mail / answering machine.

☐ Yes ☐ No The physicians and staff may release information to my pharmacy without prior authorization in order to allow call in of a prescription.

Special Instructions ______________________

My signature below is acknowledgement that I have received a copy of the Medical West Privacy Notice (MR119) and that I agree to the conditions stated in this notice.

Printed Name of Patient or Authorized Representative ______________________

Relationship ______________________ Patient Signature or Authorized Representative ______________________ Date/Time

CONSENT FOR TREATMENT

Consent for Healthcare Services:
I hereby authorize the provider(s) or clinic staff to provide maintenance, care, tests, diagnostic procedures, x-rays, medical and surgical treatments as may be necessary for the preservation or protection of my/the patient's health, safety and well-being. I understand that no guarantees have been given as to the effectiveness or outcome of any treatment or procedure rendered. I intelligently, voluntarily and freely give my consent or warrant that I am legally authorized to give consent on behalf of the patient.

Authorization to Release Information:
I authorize the provider(s) and/or clinic staff to release medical records, related medical information and charge information for my/the patient's outpatient/clinic visit for further medical treatment and determining insurance coverage and medical payment owed for clinic/hospital charges, including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carriers, or welfare funds. I certify that the information given by me/the patient in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical information given by me/the patient to release to the Social Security Act is correct. I authorize any holder of medical information given by me/the patient to release to the Social Security Administration or its intermediaries or the Medicaid agency or its intermediaries any information needed for Medicare or Medicaid claim. I consent to the release of information including psychiatric, drug, alcohol and substance abuse records, except for psychotherapy notes which require specific written authorization by me/the patient/patient's legal guardian. I consent to the release of information to any specialist in the event of a referral from the provider(s).

Assignment of Benefits (if covered by insurance):
I direct that my/the patient's insurance company pay the benefits for this treatment directly to the clinic. I assign to the clinic/hospital for security, any right I/the patient may have to receive such payment directly from the insurance company, and hereby revoke any prior authorization which I/the patient may have given to the contrary. I agree to cooperate fully with the clinic's efforts to obtain payment under such policy and will execute any additional documents my/the patient's insurance company may require to process the clinic's claim. In the event of overpayment of insurance benefits, (as where two policies are subject to a coordination of benefits). I authorize the clinic to refund to the company making such overpayment.

Estimate of Charges:
As a hospital-based outpatient health center, it is possible that patients' co-payments may vary for certain outpatient services and procedures. Medicare requires we provide patients an estimate of Facility Fee and Health Care Professional Fee co-payment amounts. The average patient out-of-pocket expense ranges from $0-$50.00. We recommend that patients review their insurance benefits to determine what their policy will pay and what out-of-pocket expenses may be incurred.

Financial Responsibility:
I understand that by signing below, I AGREE TO PAY THE CLINIC BILL for services rendered. I agree that I will pay this bill in full whether charges are or should have been covered by insurance. I have been advised that the clinic does not extend credit, and that any copayment or established self-pay rate is due in full at the time of service. I agree that if this account is not paid when due, and if the clinic should refer it to an attorney for collection, I will pay all costs of collection including interest, and a reasonable attorney's fee (even if suit is not filed), and reasonable collection agency fees. Acknowledgement of Notice of Health Information Practices

☐ I/the patient have/has received a copy of the Medical West an affiliate of the UAB HEALTH SYSTEM's **Notice of Health Information Practices.** These practices have been explained to me. All questions concerning this notice have been addressed to my satisfaction.

____
Relationship

____
Printed Name of Patient or Authorized Representative

____
Patient Signature or Authorized Representative   Date/Time

Pulmonary Health Center
985 9th Ave SW, Suite 306
Bessemer, AL 35022
Phone: (205) 481-7058

NO SHOW/CANCELLATION POLICY FOR CLINICS ACKNOWLEDGMENT FORM

I acknowledge the following:

- It is important to my health that I show up on time for my doctor's appointment.
- If I do not show up for a scheduled appointment, it may affect my health and it creates an unused appointment slot that could have been used for another patient.
- It is important that I notify my doctor's office at least 24 hours in advance when I need to cancel an appointment.
- My doctor may choose to terminate me from this practice if I have more than two no-show occurrences at any given time.

______________________________ _______________
Signature Date