David Anderson, MD, PLLC
SLEEP MEDICINE
2525 College Ave • Conway, AR 72034 Phone: (501) 712-1998 • Fax: (501) 712-1999

PATIENT INFORMATION 8.14

NAME _____ DOB_____ SEX

ADDRESS _____

CITY_____ STATE _____ Zip_____

HOME #_____WORK _____CELL_____

EMAIL_____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____

ID #_____ GROUP_____

INSURED _____RELATIONSHIP _____

* If your spouse is the Sponsor/Primary Member, you MUST provide the following information:

SPOUSE/Primary Member's: ID#_____ DOB: _____

SOC. SECURITY# _____

SECONDARY INSURANCE CARRIER_____

ID #_____GROUP# _____

INSURED_____RELATIONSHIP_____

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QUESTIONNAIRE FOR NEW PATIENTS 4.14

Please fill out before your appointment with the help of your spouse or bed partner.

Name: _____ Date of Birth: _____

Bed Partner? | Yes __ No

Job/Employer: _____

Hours worked per week?_____ Current work schedule? Days Nights Rotating shifts

How many hours before bedtime do you usually have your last drink containing caffeine?_____
How much and how often do you drink alcohol?_____
Have you ever smoked? ◯ No ◯ Yes: Packs/day: _____ Years smoked:_____ Year Quit: _____

What concern brought you here today? _____
_____

Have you completed a Sleep Study within the last 12 months? If so, where? _____

Do you currently take any sleep aids? No ☐ Yes: _____

Are you currently on a CPAP or BIPAP machine? (circle one) YES NO

(Use averages or "approximates" when answers are nonspecific or variable)

_____ pm Usual time you get into bed?
_____ min About how long does it take for you to fall asleep?
_____ How many times do you wake up during the night? Short?____ Long?____

_____ am Usual time you get out of bed for the day?
_____ Estimated total time spent sleeping on a typical night?
_____ How many naps do you usually take during the day?

Do you currently have difficulty: falling asleep or staying asleep? If yes, how many nights per week does this happen (ON AVERAGE)? ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7

What is the chance that you would actually doze off or fall asleep during these situations during the day? **0 = never 1 = slight chance 2 = medium chance 3 = high chance**

____ Sitting and reading?
____ Watching TV?
____ Sitting, inactive in a public place (restaurant or meeting)?
____ As a passenger in a car for an hour without a break?
____ Lying down in the afternoon?
____ Sitting and talking to someone?
____ Sitting quietly after a lunch without alcohol?
____ In a car, while stopped for a few minutes in traffic?
__0__ **TOTAL: Add points from the questions above**.

Have you ever had an accident because you were sleepy or fell asleep? ○No ○Yes: Please explain:
_____

In what positions do you sleep: Back Side Stomach Sitting Up

During sleep do you have: (If possible, please have your bed partner fill out this section)

	Snoring		Pain that disrupts your sleep
	Pauses in breathing		Leg or arm movements/jerking
	Restlessness		Sleep Talking
	Sweating		Leave the bed while asleep
	Mouth breathing		Fall out of the bed while asleep
	Trouble breathing through your nose		Acting out dreams while asleep

While awake do you:

	Wake up with headaches - Days a week:
	Are you unrefreshed when you wake up?
	Do strong emotions (surprise, fear, excitement, etc) trigger muscle weakness while fully alert?
	As you are falling to sleep or waking up do you ever feel unable to move (paralyzed)?
	As you are falling to sleep or waking up do you ever see, hear, or feel things which are not there?
	As you are falling to sleep do you have a strong urge to move your legs that disrupts sleep?

Medical History: Have you **ever** had any of the following conditions?

Acid Reflux Diabetes High blood pressure Heart disease_____

Depression Seizures Stroke/mini-stroke Lung disease_____

Menopause Gout Thyroid problems Seasonal Allergies Cancer_____

Previous Surgeries: Tonsils Adenoids Nasal Surgery Hysterectomy

Other medical problems or surgeries: _____

Family History: Which conditions do parents, children, brothers / sisters, grandparents have?

_Heart Disease Stroke High Blood Pressure Sleep Apnea Restless Leg Syndrome Other Sleep Disorders:_____

Drug Allergies: _____ **Food Allergies**:_____

Recent Symptoms: Check the box next to any symptoms which apply to you recently.

☐ Weight gain ____lbs	☐ Shortness of breath	☐ Memory problems	☐ Dizziness
☐ Weight loss ____lbs	☐ Cough	☐ Trouble concentrating	☐ Irritability
☐ Loss of energy	☐ Nose bleeds	☐ Numbness	☐ Sad mood
☐ Loss of appetite	☐ Throat pain	☐ Indigestion	☐ Nervousness
☐ Palpitations	☐ Hearing loss	☐ Abdominal pain	☐ Joint pain
☐ Leg swelling	☐ Vision problems	☐ Night time urination	☐ Back pain

Medications: Current medications including all nose sprays and over the counter medications.

Medication Name	Dosage (mg)	When taken	Medication is for	Who prescribed
Example: somapril	200 mg	Breakfast & noon	High blood pressure	Dr.Smith-PCP

Pharmacy:

_____

Please list your current physicians:

_____

_____

_____

_____