COMPREHENSIVE SLEEP & BREATHING

Comprehensive Sleep and Breathing, LLC
1406 McFarland Blvd, Ste C
Tuscaloosa, AL 35406
Phone: 205.343.0004

Comprehensive Sleep and Breathing - New Sleep Questionnaire

Name:	Date of birth:
Date:	

History of Present Illness

Have you been diagnosed with Sleep Apnea in the past?........ ☐ Yes ☐ No

Have you ever had a Sleep Study? (Date/ Physician) .... ☐ Yes ☐ No

Do you currently use a CPAP or BIPAP? .... ☐ Yes ☐ No

Snoring

Have you ever been told that you snore? .... ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No If yes, is it ☐ Occasionally ☐ Frequently ☐ Nightly

How long have you been snoring? ☐ Months ☐ Years

How is your snoring described? ☐ Soft ☐ Medium ☐ Loud

Is your snoring worse is any of these situations: ☐ Lying on your back ☐ Drinking alcohol

Does your snoring wake up others?........ ☐ Yes ☐ No

Associated Symptoms

Have you ever been awakened by your own gasping/choking for air?........ ☐ Yes ☐ No

Have you ever been told that you stop breathing in your sleep?........ ☐ Yes ☐ No

Do you ever have any of the following symptoms:

Heartburn while sleeping?........ ☐ Yes ☐ No

Wake up to Urinate? How many times?........ ☐ Yes ☐ No

Dry mouth upon awakening?........ ☐ Yes ☐ No

Morning headache?........ ☐ Yes ☐ No

Recent unexplained weight gain?........ ☐ Yes ☐ No

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Night sweats?.. ☐ Yes ☐ No

Memory loss? .... ☐ Yes ☐ No

Decreased concentration?.. ☐ Yes ☐ No

Irritable in the mornings?.. ☐ Yes ☐ No

Sexual Dysfunction?.. ☐ Yes ☐ No

Have you ever experienced loss of muscle tone while you were awake, such as buckling of your knees, dropped head, or dropped jaw? .... ☐ Yes ☐ No

Have you ever experienced a brief loss of muscle control just after falling asleep (Sleep Paralysis)? ☐ Yes ☐ No

Have you ever experienced brief hallucinations that take place as you're falling sleep (hypnagogic hallucinations)?.. ☐ Yes ☐ No

Have you ever been told that you were physically acting out your dreams while sleeping? .... ☐ Yes ☐ No

Insomnia

Do you have a hard time falling asleep and/or staying asleep? .... ☐ Yes ☐ No

Is it better if you move to another place, on vacation, or on the weekends?.. ☐ Yes ☐ No

Do you take Over the Counter medications to help you sleep?.. ☐ Yes ☐ No

Do you have a clock and/or TV in your bedroom?.. ☐ Yes ☐ No

Around the Clock History

What time do you typically go to bed? ____

Do you work shift work?.. ☐ Yes ☐ No

Is your bedtime regular? .... ☐ Yes ☐ No

Are your Sleep times different on weekends? .... ☐ Yes ☐ No

What do you do before bed? ☐ Read ☐ TV ☐ Phone ☐ Computer

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

How many hours of sleep do you estimate that you get each night? ____________________

Do you wake up throughout the night? ☐ Yes ☐ No How many times?________

How long do you stay awake? _______________

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Do you watch the clock or television when you wake up throughout the night? ☐ Yes ☐ No

What time do you wake up and get out of the bed?____

How do you feel when you wake up? ☐ Sleepy ☐ Unrefreshed ☐ Tired ☐ Grumpy

Do you take naps during the day? ☐ Yes ☐ No how long are your naps?____________

What time of the day do you nap? ____

Are your naps refreshing? ☐ Yes ☐ No

Do you have the urge to move your legs at night? ☐ Yes ☐ No

Have you ever been diagnosed with restless leg syndrome (RLS) ☐ Yes ☐ No

Parasomnias

Have you ever experienced any of the following:

Sleep Talking? ☐ Yes ☐ No

Sleep Walking? ☐ Yes ☐ No

Teeth grinding? ☐ Yes ☐ No

Eating while sleeping? ☐ Yes ☐ No

Excessive Daytime Sleepiness

Do you feel extremely sleepy during the day? ☐ Yes ☐ No

Any safety concerns while working or driving? ☐ Yes ☐ No

Have you ever had a vehicle collision because you feel asleep while driving? ☐ Yes ☐ No

Do you use caffeine or other aids to stay awake? ☐ Yes ☐ No

Primary Care Provider _____________________________ Pharmacy & Address____

Drug Allergies:____

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Name:	Date of birth:
Date:	

Please list any medications you are currently taking: ☐ No changes in last 6 months

Drug Name:	Dose:	Frequency:

Do you have any drug allergies? ☐ Yes ☐ No *if yes, then list them below*

List any medical diagnosis you have: ☐ No changes in last 6 months

List any surgeries you have had: ☐ No changes in last 6 months

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REVIEW OF SYSTEMS: Have you experienced any of the following problems in the last 30 days? **Please Check "Yes"**

GENERA/CONSTITUTIONAL		**OPHTHALAMOGIC**		**ENT**	
	Yes		Yes		Yes
Recent weight change	☐	Changes in vision	☐	Difficulty hearing	☐
Fever	☐	Blindness	☐	Dizziness/Vertigo	☐
Fatigue	☐	Wear Glasses/Contacts	☐	Sinus infection	☐
Appetite changes	☐	Other eye problems	☐	Sinus drainage	☐
Please list: ______________________		Please list: ______________________		Please list: ______________________	
ENDOCRINE		**RESPIRATORY**		**CARDIOVASCULAR**	
	Yes		Yes		Yes
Significant hair loss	☐	Shortness of breath	☐	Heart racing	☐
Thyroid problems	☐	Coughing up blood	☐	Chest pain	☐
Heat intolerance	☐	Wheezing	☐	Heart skipping	☐
Cold intolerance	☐	Coughing Sputum production	☐	Swelling of extremities	☐
Excessive thirst	☐			Shortness of breath lying down	☐
Please list: ______________________		Please list: ______________________		Please list: ______________________	
GASTROINTESTINAL		**HEMATOLOGY**		**GENITOURINARY**	
	Yes		Yes		Yes
Difficulty swallowing	☐	Swollen glands	☐	Blood in urine	☐
Constipation	☐	Blood transfusion	☐	Painful urination	☐
Diarrhea	☐	Prolong bleeding	☐	Overnight urination	☐
Blood in stool	☐	Easy to bruise	☐	Frequent urination	☐
Difficulty swallowing	☐				
Please list: ______________________		Please list: ______________________		Please list: ______________________	
MUSCULOSKELETAL		**SKIN**		**NEUROLOGICAL**	
	Yes		Yes		Yes
Joint pain	☐	Lumps	☐	Unusual weakness	☐
Joint swelling	☐	Itching	☐	Unusual headaches	☐
Weakness of extremities	☐	Rash	☐	Seizures	☐
Trauma to joints	☐	Changes in moles	☐	Fainting	☐

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PSYCHIATRIC		COVID/FLU VACCINES	
	Yes		Yes
Depression	☐	Flu(2022-2023)	☐
Anxiety	☐	COVID	☐
Difficulty sleeping	☐	BOOSTER	☐

Family History: (has mom, dad, siblings or children been diagnosed with any of the following) select one , if so

Heart Disease: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Cancer: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Stroke: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Hypertension: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Diabetes: ☐ Mom ☐ Dad ☐ Sibling ☐ Children

Other:(Please list) ____

Mom: ☐ Alive ☐ Deceased Age________________

If deceased, what medical complications?____

Dad: ☐ Alive ☐ Deceased Age________________

If deceased, what medical complications?____

Social History:

Do you smoke? ☐ Yes ☐ No If so, how many years? ____________________

Do you drink alcohol? ☐ Yes ☐ No How many per week? ____________________

Do you use recreational drugs? ☐ Yes ☐ No What kind? ☐ Tea ☐ Coffee ☐ Soda

Do you drink caffeine? ☐ Yes ☐ No How many per day?____________________

Do you have any pets? ☐ Yes ☐ No

Have you traveled outside of the country in the last 5 years? ☐ Yes ☐ No

Yes, where? ____

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Financial Policy

AUTHORIZATION TO RELEASE INFORMATION

You agree that all records concerning your care with Comprehensive Sleep Centre LLC shall remain the property of Comprehensive Sleep Centre LLC. Comprehensive Sleep Center, LLC (dba Sleep Disorders Center of Alabama, LLC and Luna Sleep Centers, LLC) understand and agree that such information is used AND authorize release of medical record information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal. state and local laws. I further authorize any other individual or entity that has provided health care to me to release to Comprehensive Sleep and Breathing Disorders Center any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. Release of records may be needed for accreditation, certification, licensing or credentialing activities of Comprehensive Sleep Center LLC. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

ASSIGNMENT OF BENEFITS

I hereby request that payment of authorized Medicare, Medicaid and all other insurance benefits be made on my behalf to Comprehensive Sleep and Breathing Disorders Center for any services provided to me and/or my dependents. I authorize any holder of medical information about me and/or my dependents to release to the appropriate entity and its agents any information needed to determine these benefits payable for related services.

GUARANTEE OF PAYMENT

If my insurance has a contract with Comprehensive Sleep and Breathing Disorders Center, I am not responsible for amounts that are agreed to be written off. If my insurance does not have a contract with Comprehensive Sleep and Breathing Disorders Center, I agree to be responsible for any amounts not paid by my insurance plan. Your credit card on file will be used for these types of payments. In the event that I default on payment of my account, I understand that I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fees. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

ADDITIONAL CHARGES

- Three "No Show" appointments will result in our office not rescheduling you until a $100 multiple no show fee is collected. This is charged directly to you, it does not go to your insurance company. If appointments are canceled 24 hours prior to their scheduled time, this will not affect you.

By signing below, I understand that I am financially responsible for any costs incurred during my visit that my insurance policy does not cover. I understand that it is my responsibility to ensure that services provided by Comprehensive Sleep Center LLC are covered under my insurance plan. I understand that it is my responsibility to obtain a referral for any services to be covered by my insurance company, if my plan requires it's and that I will be responsible for the full cost of the visit if a referral is not obtained prior to my visit.

______________________________	________________
Patient Name (Print)	Date of Birth
______________________________	________________
Patient Signature	Today's Date

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Epworth Sleepiness Scale

Name:	Date of birth:
Date:	

This questionnaire was developed to determine the level of daytime sleepiness in individuals. It has become one of the most frequently used methods for determining a person's average level of daytime sleepiness. Remember to review your response with your doctor. Please rate how likely you are to doze or fall asleep in the following situations by selecting the response that best applies. If you have not done some of these activities recently, select what would most likely happen if you were in that situation.

0 Would never doze

1 Slight chance of dozing

2 Moderate chance of dozing

3 High chance of dozing

Chance of Dozing

0	1	2	3	
☐	☐	☐	☐	**Sitting and Reading**
☐	☐	☐	☐	**Watching Television**
☐	☐	☐	☐	**As a passenger in a car over an hour without a break**
☐	☐	☐	☐	**Sitting Inactive in a public place (ex. Theater or meeting)**
☐	☐	☐	☐	**Lying down to rest in the afternoon when circumstances permit**
☐	☐	☐	☐	**Sitting and talking to someone**
☐	☐	☐	☐	**Sitting quietly after lunch without alcohol**
☐	☐	☐	☐	**In a car, while stopped in traffic for a few minutes**

Your score will range from 0 to 24. A score above 10 indicates excessive daytime sleepiness. A score above 16 is associated with a high level of excessive daytime sleepiness.

This questionnaire is not intended to take the place of talking with a doctor. Regardless of the questionnaire results. If you have concerns about your symptoms, you are encouraged to discuss them with your doctor.

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Patient Demographics

Patient Name : ____
First *Middle* *Last*

Date of Birth: ____________________ SSN:____________________

Address: ____
Street Name and Number *City* *State* *Zip*

Phone: (Home) ____________________ (Cell):____________________

Sex: ☐ MALE ☐ FEMALE Email:____________________

Primary Insurance Company: ______________________________

Contract#:____________________ Group#:____________________

Policy Holder Name:____________________ Date of Birth: ____________________

Relationship to patient: ____________________ Phone#: ____________________

Secondary Insurance Company: ______________________________

Contract#:____________________ Group#:____________________

Policy Holder Name: ____________________ Date of Birth: ____________________

Relationship to patient: ____________________ Phone#:.____________________

Emergency Contact: ______________________________

Relationship: ____________________ Phone#: ____________________

CONSENT FOR TREATMENT: I consent to necessary treatment, including drugs, medicine, procedures, x-rays, lab tests and/or other studies that may be used by the physician, nurse, or staff. I understand that this office practice is available for outpatient care from 8am to 5pm on Monday -Thursday and 8am to 12pm on Friday.

____________________ ____________________
Patient Signature Date

____________________ ____________________
PCP Referring MD

PHARMACY : ______________________________

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Authorization to Discuss Medical Information

I hereby authorize you to use or disclose medical information regarding my care to the following individuals as listed below. Information that may be transmitted may include: appointment dates/time, lab tests/results, medications, diagnoses, or care plan.

Name:	Date of birth:
Date:	

Information to be given to:

Name: ______________________________ Relationship: ______________________________

Phone: ______________________________

Name: ______________________________ Relationship: ______________________________

Phone: ______________________________

Name: ______________________________ Relationship: ______________________________

Phone: ______________________________

______________________________ ______________________________
Patient Signature Date

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