

1406 McFarland Blvd, Ste C Tuscaloosa, AL 35406

Phone: 205.343.0004

Established Sleep Patient Form Name: Date of birth: Date: Which machine do you use: BIPAP (Please select one) **CPAP** Do you use the machine nightly? YES NO Are you having any problems with your machine? YES Do you need any supplies NO If yes, please list the company you get your supplies Any changes with your blood pressure? **WORSE** SAME **IMPROVED** Rate your daytime energy and alertness: POOR **FAIR** GOOD **EXCELLENT** NO YES Do you feel rested when you wake up in the mornings? Do you wake up throughout the night? If so, how many times and why?



521 Cahaba Park Circle Birmingham, AL 35242

How many hours do you sleep each night?_____

Phone: 205-917-5862



Sleep Disorders Center of Alabama

790 Montclair Road, Suite 200, Birmingham, AL 35213

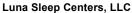


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Do you ever	r have RLS	S (Restless	Leg Syndr	rome)?									
Sleep Maint	tenance:	POOR	R	FAIR GOOD									
Sleep Onse	et:	POOR	R	GOOD									
Sleep Quali	ity:	POOR	R	FAIR GOOD									
What time d	do you go t	to bed at nig	jht?	_:									
What time d	do you get	out of bed i	n the morn	nings?: AM PM									
Environth Classinass Casley Havy likely, one year to down off on feel classy; in the fall suring attending 2													
Epwortn	Sieepin	ess Scale	e: How II	ikely are you to doze off or feel sleepy in the following situations?									
	ld never		_	ght chance									
doze			of d	dozing 🚨 of dozing 😈 of dozing									
Plese	select	one											
Plese 0	select	one 2	3										
			3	Sitting and Reading									
			3	Sitting and Reading Watching Tolovision									
			3	Watching Television									
			3	Watching Television As a passenger in a car over an hour without a break									
			3	Watching Television									
			3	Watching Television As a passenger in a car over an hour without a break									
			3	Watching Television As a passenger in a car over an hour without a break Sitting Inactive in a public place (ex. Theater or meeting)									
			3	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									





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Comprehensive Sleep and Breathing - Med & Surgery Name: Date of birth: Date: Please list any medications you are currently taking: No changes in last 6 months Drug Name: Dose: Frequency: Yes Do you have any drug allergies? 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		Swelling of extremities	
Excessive thirst		production		Shortness of breath lying down	
Please list:		Please list:		Please list:	
GASTROINTESTINAL		HEMATOLOGY		GENITOURINARY	
	Yes	HEMATOLOGY	Yes	GENITOURINARY	Yes
GASTROINTESTINAL Difficulty swallowing	Yes	HEMATOLOGY Swollen glands	Yes	Blood in urine	Yes
	Yes		Yes		Yes
Difficulty swallowing	Yes	Swollen glands	Yes	Blood in urine	Yes
Difficulty swallowing Constipation	Yes	Swollen glands Blood transfusion Prolong bleeding	Yes	Blood in urine Painful urination Overnight urination	Yes
Difficulty swallowing Constipation Diarrhea	Yes	Swollen glands Blood transfusion	Yes	Blood in urine Painful urination	Yes
Difficulty swallowing Constipation Diarrhea Blood in stool	Yes	Swollen glands Blood transfusion Prolong bleeding	Yes	Blood in urine Painful urination Overnight urination	Yes
Difficulty swallowing Constipation Diarrhea Blood in stool Difficulty swallowing	Yes	Swollen glands Blood transfusion Prolong bleeding Easy to bruise	Yes	Blood in urine Painful urination Overnight urination Frequent urination	Yes
Difficulty swallowing Constipation Diarrhea Blood in stool Difficulty swallowing	Yes	Swollen glands Blood transfusion Prolong bleeding Easy to bruise	Yes	Blood in urine Painful urination Overnight urination Frequent urination	Yes
Difficulty swallowing Constipation Diarrhea Blood in stool Difficulty swallowing Please list:	Yes	Swollen glands Blood transfusion Prolong bleeding Easy to bruise Please list:	Yes	Blood in urine Painful urination Overnight urination Frequent urination Please list: NEUROLOGICAL	Yes
Difficulty swallowing Constipation Diarrhea Blood in stool Difficulty swallowing Please list:		Swollen glands Blood transfusion Prolong bleeding Easy to bruise Please list:		Blood in urine Painful urination Overnight urination Frequent urination Please list:	
Difficulty swallowing Constipation Diarrhea Blood in stool Difficulty swallowing Please list: MUSCULOSKELETAL		Swollen glands Blood transfusion Prolong bleeding Easy to bruise Please list: SKIN		Blood in urine Painful urination Overnight urination Frequent urination Please list: NEUROLOGICAL	
Difficulty swallowing Constipation Diarrhea Blood in stool Difficulty swallowing Please list: MUSCULOSKELETAL Joint pain		Swollen glands Blood transfusion Prolong bleeding Easy to bruise Please list: SKIN Lumps		Blood in urine Painful urination Overnight urination Frequent urination Please list: NEUROLOGICAL Unusual weakness	



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



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