COMPREHENSIVE
SLEEP & BREATHING

Comprehensive Sleep and Breathing, LLC
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: ☐ CPAP ☐ BIPAP *(Please select one)*

Do you use the machine nightly? ☐ YES ☐ NO

Are you having any problems with your machine?_____

_____

_____

_____

_____

Do you need any supplies ☐ YES ☐ 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

Do you feel rested when you wake up in the mornings? ☐ YES ☐ NO

Do you wake up throughout the night? If so, how many times and why? _____

_____

_____

_____

_____

How many hours do you sleep each night?_____

Luna Sleep CENTERS, LLC

Luna Sleep Centers, LLC
521 Cahaba Park Circle Birmingham, AL 35242
Phone: 205-917-5862

SLEEP DISORDERS CENTER OF ALABAMA

Sleep Disorders Center of Alabama
790 Montclair Road, Suite 200, Birmingham, AL 35213
Phone: 205-599-1020

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Do you ever have RLS (Restless Leg Syndrome)? ☐ YES ☐ NO ☐ SOMETIMES

Sleep Maintenance: ☐ POOR ☐ FAIR ☐ GOOD

Sleep Onset: ☐ POOR ☐ GOOD

Sleep Quality: ☐ POOR ☐ FAIR ☐ GOOD

What time do you go to bed at night? _____:_____ ☐ AM ☐ PM

What time do you get out of bed in the mornings? _____:_____ ☐ AM ☐ PM

Epworth Sleepiness Scale: How likely are you to doze off or feel sleepy in the following situations?

0 Would never doze

1 Slight chance of dozing

2 Moderate chance of dozing

3 High chance of dozing

Plese select one

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

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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:

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	Yes	OPHTHALAMOGIC	Yes	ENT	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	Yes	RESPIRATORY	Yes	CARDIOVASCULAR	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	Yes	HEMATOLOGY	Yes	GENITOURINARY	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	Yes	SKIN	Yes	NEUROLOGICAL	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	☐