ARIZONA PREMIER PULMONARY & SLEEP SPECIALISTS

13606 N. 59th AVENUE, SUITE 1, GLENDALE, AZ 85304

Phone: (602) 978-6100 **Fax :(602)978-6555**

Pulmonary Disease - Sleep Medicine/Polysomnogram Interpretation - Critical Care Medicine Fiber-optic Bronchoscopy - Pulmonary Function Testing – Cardiopulmonary Exercise Testing Pulmonary Disability Evaluation-Valley Fever Clinic

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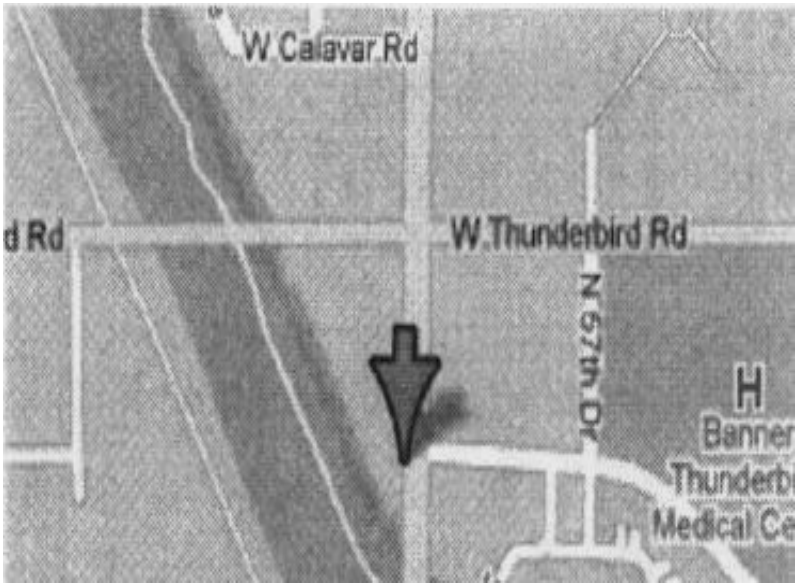
MANJIT S. BHAMRAH, M.D., F.C.C.P.
Diplomat of American Board of Pulmonary & Sleep Medicine

RACHEL JACOB, FNP-C

JOANN CALEY, FNP-C

TAMEKA DAVIS, PRACTICE ADMINISTRATOR

OUR LOCATION:



13606 N. 59TH AVENUE #1, GLENDALE, AZ 85304

LOCATED 1 BLOCK SOUTH OF THUNDERBIRD RD ON THE SOUTHWEST CORNER OF 59th AVENUE & EUGIE.

ARIZONA PREMIER PULMONARY & SLEEP SPECIALISTS PATIENT REGISTRATION

Responsible Person's Information

Last Name:	**First Name:**	**Middle Initial:**	**Name you prefer to be called:**
Mailing Address:	**City:**	**State:**	**Zip Code:**
Street Address:	**City:**	**State:**	**Zip Code:**
Home Phone#:	**Cell Phone#:**	**Work Phone#:**	
Birth Date:	**Social Security#:**	**Sex: M ☐ F ☐**	
Marital Status: ☐ **Single**	☐ **Married**	☐ **Divorced**	☐ **Separated** ☐ **Widowed**
Employment Status: ☐ **Full Time**	☐ **Part Time**	☐ **Retired**	☐ **Unemployed** ☐ **Disabled** ☐ **Student**
Race: ☐ **White**	☐ **Hispanic**	☐ **Black**	☐ **Native American** ☐ **Asian** ☐ **Other:**
Primary Language Spoken:			
Primary Care Physician:	**Referred By:**	**E-Mail Address:**	
WHO IS THE PRIMARY CONTACT PERSON REGARDING CARE? ☐ PATIENT ☐ OTHER Name of contact:			
First Name:	**MI:**	**Last Name:**	**Sex: M ☐ F ☐**
Birth Date:	**Social Security#:**	**Relation to Patient:**	

Insurance Information

Primary Insurance:	**ID#:**		**Group#:**	
Policyholders Name:	**Sex: M ☐ F ☐**	**DOB:**	**Relation to Patient:**	
Secondary Insurance:	**ID#:**		**Group#:**	
Policyholders Name:	**Sex: M ☐ F ☐**	**DOB:**	**Relation to Patient:**	

Emergency Information **(*PLEASE PROVIDE CONTACT INFORMATION*)**

Emergency Contact Name:	**Emergency#:**
Address:	**Relation to Patient:**

ADVANCE DIRECTIVES:

DO YOU HAVE A LIVING WILL? ☐ YES ☐ NO IF NOT, WOULD YOU LIKE INFORMATION ABOUT A LIVING WILL? ☐ YES ☐ NO
IF YOU HAVE A LIVING WILL, MAY WE HAVE A COPY TO FILE IN YOUR CHART? ☐ YES ☐ NO (STAFF INITIALS:_____)
PLEASE CONTACT ME AT: ☐ HOME PHONE ☐ WORK PHONE ☐ OTHER_____
WHEN CONTACTED BY PHONE, MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE/VOICE MAIL? ☐ YES ☐ NO

I hereby assign my insurance benefits to be paid directly to the physician for services rendered. I understand that I am financially responsible for any non-covered services, co-insurances, or deductibles, including any balance of my account until the insurance pays their portion. If my insurance pays me directly for services provided by the physician, I agree to forward such payments to Paseo Medical Specialists, dba Arizona Premier Pulmonary & Sleep Specialists. I understand that it is my responsibility to notify this office of any changes in the above information. I also authorize the physician to release any information required to process this claim. In the event that any unpaid balance should be forwarded to a collection agency, I understand that I will be fully responsible for any and all costs. I also understand that my protected health information (PHI) will not be released in any form without my written consent, as described in this office's privacy and confidentiality policy. I understand that I have a right to a copy of this policy at any time, and that any requests for access to or copies of my PHI must be made in writing. I also understand that it is the policy of this office to give at least 72 hours notice prior to receiving requested PHI information, and that I may be charged a nominal copying fee for any records requested for my personal use. I also understand that any previous account balances must be paid in full prior to the release of any records, to any entity, myself included. Charges for minors will be the responsibility of the signer below.

SIGNATURE:_____ DATE:_____ - _____ - _____

(PATIENT OR LEGAL REPRESENTATIVE)

ARIZONA PREMIER PULMONARY & SLEEP SPECIALISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received a copy of **Paseo Medical Specialists, dba Arizona Premier Pulmonary & Sleep Specialists** Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____ _____

Patient Legal Representative (if applicable) Date

_____ _____

Print Name of Legal Representative Date

FOR CLINIC USE ONLY:

Paseo Medical Specialists, dba Arizona Premier Pulmonary & Sleep Specialists, made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained)

- ❑ Notice of Privacy Practices given at time of appointment
- ❑ Notice of Privacy Practices sent with new patient paperwork prior to appointment
- ❑ Other: _____

REVISED03/2020

Appointment and Cancellation Policy for Medical Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so we have had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

Scheduled Appointments

For a scheduled appointment please call
602-978-6100 Ext 125

Cancellation of an Appointment

In order to be respectful of the medical needs of the community please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment.

If it is necessary to cancel your scheduled appointment we require that you call 24 HOURS in advance. Appointments are in demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments please call 602-978-6100 Ext. 126

Late Cancellations

Late cancellations will be considered as a "no show".

No Show Policy

A "no show" is someone who misses an appointment without canceling it 24 HOURS in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner.

A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". An administrative fee of $40.00 will be billed to the patient's account. The patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment 24 HOURS in advance. A copy of the letter will be placed in the patient file. Three "no shows" will result in the temporary suspension of services. In order to reinstate services the patient will be required to meet with the practice administrator or delegate to evaluate the situation.

Life-threatening Emergencies
Always call 911 immediately in case of a life-threatening emergency.

SIGNED:_____ DATE:____-____-____

Patient/Legal Representative

Name of Patient: _____

AUTHORIZATION TO SPEAK
WITH NEXT OF KIN

ARIZONA PREMIER PULMONARY & SLEEP SPECIALISTS

13606 N 59TH Ave Suite #1, Glendale, AZ 85304
Ph: (602) 978-6100 Fax: (602) 978-6555

MANJIT S. BHAMRAH, M.D., F.C.CP.

PATIENT: **DOB:**

For the purpose of continuity of care, I hereby authorize information about my medical condition (including treatment options, prescriptions, diagnostic tests, etc.) to be discussed with the following individual(s):

Name	**Relationship to Patient**	**Phone Number**
Name	**Relationship to Patient**	**Phone Number**

I understand that this authorization may be changed or revoked at any time by giving written request to Paseo Medical Specialists, dba Arizona Premier Pulmonary & Sleep Specialists, and until such time, shall remain valid indefinitely. I also understand that I may request information to be discussed on a limited basis, such as:

(Describe any limitations that you **do not** wish to be disclosed with the individual(s) listed above):

Patient's Signature:_____ **Date** ---------- _____

Witnessed by:_____ _____ _____ _____
Staff Signature **Date** **Staff Signature** **Date**

"Breathe Better, Sleep Better, Feel Better"

Accredited by AASM
American Academy of Sleep Medicine

Manjit Bhamrah, M.D., F.C.C.P., Board certified Pulmonary Diseases & Sleep Medicine
Rachel Jacob, FNP-C JoAnn Caley, FNP-C
Tameka Davis, Practice Administrator
13606 N. 59th Avenue, Suite 1, Glendale, Arizona 85304
602-978-6100 Fax: 602-978-6555
www.azpremierpass.com

CONSULTATION HEALTH HISTORY QUESTIONNAIRE

We are delighted to schedule and provide the very best care and service at Arizona Premier Pulmonary And Sleep specialists. Please take time to answer the following questions.

Information contained here is a confidential record NOT to release without your authorization.

NAME (Last):_____ (First):_____**DOB**:_____Age____ yrs SEX___

MAIN HEALTH REASON (s) FOR **TODAY'S VISIT**: _____Date:_____

Referring Provider: _____ MD/DO/NP/PA/DDS

Names of Specialists that you see: 1. _____2._____

PHARMACY Name: _____ **CROSS STREETS:** _____

CURRENT ACTIVE MEDICATIONS: (PLEASE LIST EACH) ☐ SEE SEPARATE LIST MADE

PULMONARY MEDICATIONS (LIKE INHALERS-PUT ON TOP)	**DOSE**	**HOW OFTEN PER DAY**	**REASON FOR TAKING**
OTHER MEDICATIONS (LIKE FOR DM, HTN, ARTHRITS)	**DOSE**	**HOW OFTEN PER DAY**	**REASON FOR TAKING**

DRUG ALLERGIES: (PLEASE LIST REACTION TYPE AND SEVERITY)

NAME OF DRUG	REACTION TYPE: (RASH, HIVE, ITCHING, BREATHING DIFFICULTY, ANAPHYLAXIS)	(REACTION SEVERITY: MILD/MODERATE/SEVERE)

Are you allergic to any of the following? _____Contrast dye _____Iodine _____Shellfish

PLEASE DESCRIBE IF APPLICABLE TO YOU:

1. **Cough:** _____No _____Yes
   - How long is cough going on? _____Days _____weeks _____months _____years
   - What time of the day: _____ Morning _____evening/night _____throughout the day
   - Rate severity: _____Mild _____Moderate _____severe to the point of passing out
   - Character: _____Dry _____Productive _____color of expectoration
   - Treatment received so far: _____None _____antibiotics _____steroids _____inhalers
   - Course: _____getting better _____getting worse _____No change
   - Prior diagnosis given: _____
   - Any recent travels: _____No _____Yes Any Sick contact: _____No _____Yes

2. **SHORTNESS OF BREATH**: _____No _____Yes
   - For how long? _____Days _____Weeks _____Months _____Years
   - Rate severity? _____Mild _____Moderate _____Severe
   - What relieves? _____Rest _____Inhalers ____Medication (sub-lingual)
   - Course: _____Getting better _____Getting worse _____Unchanged
   - Worsens during sleep ____Yes ____No
   - How many head pillows do you use during sleep? _____One _____Two _____ Use recliner

Describe your shortness of Breath: ***Mark One Box Only***

- ☐ Grade 0. I only get breathless with **strenuous exercise**.
- ☐ Grade 1. I get short of breath **when hurrying** on the level or **walking up a slight hil**l.
- ☐ Grade 2. I walk **slower than people of the same age do** on the level because of breathlessness, or I have to **stop for breath when walking on my own pace** on the level
- ☐ Grade 3. I stop for breath **after walking about 100 meters** on or after a **few minutes on** the level
- ☐ Grade 4. I am too **breathless to leave the house** or I am breathless when dressing or undressing

3. **HEMOPTYSIS: Are you COUGHING UP BLOOD?** _____No ____Yes

Amount: _____Streaky _____Teaspoon _____ Tablespoon

How long ago: _____First time _____Last time

4. **Do You Wheeze?** _____No _____Yes

5. **CHEST PAIN:** _____No _____Yes
   - Location: ____Left ____Right ____Front ____Back ____Center of chest
   - Quality: _____Sharp ____Dull Worsens with breathing?_ ____No _____Yes
   - Duration: ____Sec ____Minutes ____Hours Severity Scale (1 to 10) _____
   - What relieves it? _____ What worsens it? _____

6. **ASTHMA:** _____No _____Yes

   - What age it started:_____ what age it stopped: _____
   - What are your Main asthma symptoms: _____cough _____shortness in breath _____wheezing?
   - When was the last hospitalization: _____None _____yes, when?_____
   - Any history of intubation for asthma? _____None _____yes, when? _____
   - When was the last Urgent care visit for asthma? _____None _____Yes, When? _____
   - Did you receive allergy shot? ____never _____ yes, when _____
   - What are your triggers for asthma? _____
   - How many Puffs of rescue inhaler taken **during the day** in last **one week**? _____
   - How many puffs of rescue inhaler taken **during the night** in **one month**? _____

7. **COPD:** _____No _____Yes

   - How long ago you told to have COPD _____years ago
   - Any hospitalized for COPD? _____No _____yes, when? _____
   - Any history of intubation for COPD? _____None _____yes, when? _____
   - What brought your COPD? _____smoking _____family history _____air pollution
   - Did you receive Antibiotics and or Steroid taper in the last one year; _____No _____yes, when_____
   - Are you on Oxygen therapy: _____no _____yes, since when_____
   - When last CT chest done? _____None _____yes, when? _____

ROS: (Please circle ***POSITIVE SYMPTOMS BELOW***)

CONSTITUTIONAL: fever chills major weight changes
EYES: **red eyes** **dry eyes**
EARS: ear pain ear discharge
NOSE: nasal congestion runny nose nasal itching sneezing nasal polyps postnasal drip
THROAT: Sore throat feeling of lump in throat hoarseness
CARDIOVASCULAR: Chest pain palpitations swelling of feet
RESPIRATORY: OTHER SYMPTOMS_____
GASTROINTESTINAL: Difficulty swallowing heartburn abdominal pain diarrhea
GENITO URINARY: Blood in urine kidney stone
MUSCULOSKELETAL: Pain/swelling in bone muscle pain joint pain
INTEGUMENTARY/SKIN: Skin rash skin lesion needing biopsy Urticaria
NEUROLOGICAL: Headaches numbness in fingers or feet seizure stroke
HEMATOLOGIC/LYMPHATIC: Anemia easy bruising lumps in necks axilla groin
ENDOCRINE: Excessive thirst heat/cold intolerance
ALLERGIC/IMMUNOLOGIC: Allergies to pollens trees grasses animal dander
PSYCHIATRIC: Anxiety depression panic attacks
TRAUMA: Traumatic brain injury chest trauma
SLEEP HISTORY: Snoring gasping choking daytime sleepiness chronic fatigue insomnia restless legs

PAST PULMONARY HISTORY (Please put check mark (√) all that apply -------NONE

√	PULMONARY CONDITIONS	√	PULMONARY CONDITIONS	√	PULMONARY CONDITIONS
	Asthma		Blood clot-DVT/PE		QuantiFERON assay positive
	Bronchitis, chronic, 3mo/yr x 2 yr		Coccidiomycosis/Valley fever		Pleural effusion
	Bronchiectasis		COPD		Pleurisy
	Chest procedure-bronchoscopy		Diaphragmatic disorder		Pneumonia
	Chest procedure-lung biopsy		Emphysema		Pneumothorax
	Chest procedure for lung cancer		Nasal polyp		Pulmonary hypertension
	Sarcoidosis		Sinusitis		Rib fracture
	Whooping cough		Tuberculosis exposure		Other
	Oxygen therapy-how long		Other		

PAST MEDICAL HISTORY (Please put check mark (√) all that apply ----------NONE

√	MEDICAL CONDITION	√	MEDICAL CONDITION
	ANXIETY		LUPUS
	ATRIAL FIBRILATION		RHEUMATOID ARTHRITID
	CANCER, WHICH ORGAN----------		SJOGREN SYNDROME
	CHRONIC KIDNEY DISEASE		THYROID DISORDER
	CHRONIC PAIN AT----------		MULTIPLE SCLEROSIS
	CORONARY ARTERY DISEASE/CHF		NEUROMUSCULAR DISEASE/MYOPATHY
	DEPRESSION		PARKINSON'S DISEASE
	DEMENTIA/ COGNITIVE DYSFUNCTION		SEIZURE DIORDER
	DIABETES MELLITUS		STROKE
	GERD		TRAUMATIC BRAIN INJURY
	OTHER:		**OTHER:**

PAST SURGICAL HISTORY (Please put check mark (√) all that applies): ----------NO SURGERY

SURGERY AND PROCEDURES	YEAR		YEAR
BRONCHOSCOPY		NASAL POLYP SURGERY	
CABG, CORONARY ARTERY BYPASGRAFT SURGERY		SINUS SURGERY	
LUNG RESECTION SURGERY		THYROID GLAND RESECTION SURGERY	
THORACOTOMY FOR EMPYEMA		UVULO PALATO PHAYNGOPLASTY/UPPP	
TRACHEOSTOMY		OTHER:	

PERSONAL AND SOCIAL HISTORY:

Place of birth: _____ how long living in Arizona? _____

Marital status: _____Married _____Single _____Widowed _____Divorced _____Separated

Last menstrual period (IF APPLICABLE) _____

Do you currently use Tobacco: _____No _____Yes?

Have you ever used Tobacco: _____No _____Yes?

Age began: __ ____ Age Quit _____ Total years smoked _____ Average # Pack/day_____

What products tried to quit: _____Gum _____Patches _____Chantix

Do you Vape? _____No _____Yes **Do you smoke Hookah**? _____No ____Yes

Have you used street drugs: _____No _____Yes?

_____Marijuana _____Cocaine _____Heroin _____Methamphetamine _____ others

OCCUPATIONAL HISTORY: Do you currently work: _____No _____Yes

Name Major Occupation (s) you have/had worked with, **in the past**: _____

_____

Any history of Exposure to: _____Yes _____ No

Asbestos: _____No _____Yes, which years_____

Beryllium: _____No _____Yes, which years_____

Coal work: _____No _____Yes, which years_____

Silica dust: _____No _____Yes, which years_____

Radon/Uranium: _____No _____Yes, which years_____

Fumes/Dust/ Chemicals: _____No _____ Yes, which years _____

Other: _____

ENVIRONMENTAL EXPOSURE HISTORY:

Pets at home: Dogs _____ No _____ Yes Cats _____No _____Yes other, explain _____

Birds Exposure: _____ No _____ Yes, which year's _____

Black Mold exposure: _____ No _____ Yes, which year's _____

Hot Tub Exposure: _____ No _____ Yes, which year's _____

Other: _____

FAMILY HISTORY:

	MOTHER	FATHER	SIBLING
ASTHMA			
COPD			
EMPHYSEMA			
BLOOD CLOTS DVT/PE			
LUNG CANCER			
TUBERCULOSIS			
PULMONARY FIBROSIS			
AUTOIMMUNE DISEASE			
OTHER			

Sleep Questionnaire

SLEEP COMPLAINT(S)

❑ Trouble falling asleep ❑ Trouble remaining asleep ❑ **Excessive Daytime Sleepiness** ❑ Snoring ❑ insufficient quantity of sleep ❑ Unwanted behaviors during sleep ❑ Other, Explain_____ ❑ **how long**? _____

PRIOR SLEEP DISORDER DIAGNOSIS OR STUDIES: ❑ **NONE**

❑ I have a **prior sleep diagnosis** of _____Prior sleep studies (where, when) _____

I am currently prescribed ❑ **CPAP** or ❑ **Bi-level** pressure. Settings _____

❑ Yes ❑ No------- I have **had surgery** for a sleep disorder ❑ UPPP ❑ Tonsillectomy.

❑ Yes ❑ No------ I use a **dental device** for sleep-disordered breathing.

Any weight change during the past year ❑ gained _____ pounds ❑ lost _____ pounds ❑No change

BREATHING DURING SLEEP:

❑ Yes	❑ No -----	I have been told that I **snore** ❑ loudly.
❑ Yes	❑ No -----	I have been told that I **stop breathing** while asleep.
❑ Yes	❑ No------	I have **awakened by** my own **snoring**.
❑ Yes	❑ No------	I awaken at night **choking or gasping** for air.
❑ Yes	❑ No------	I have **morning headaches.**
❑ Yes	❑ No------	I **sweat** a great deal **at night**.

DAYTIME IMPAIRMENT(S):

❑ Yes	❑ No---------	I often **feel drowsy** during the day, more than I expect is normal.
❑ Yes	❑ No---------	I feel **un-refreshed or tired in the morning** despite sleeping at night.
❑ Yes	❑ No--------	I take **daytime naps**. How many? _____
❑ Yes	❑ No--------	I have **uncontrollable urges to fall asleep** during the day.
❑ Yes	❑ No--------	I have **fallen asleep while driving**.
❑ Yes	❑ No--------	I **performed poorly in school or work** because of sleepiness
❑ Yes	❑ No---------	I have an impairment **in Attention**, concentration, memory, or cognition
❑ Yes	❑ No--------	I have **Mood disturbances** or irritability
❑ Yes	❑ No--------	I have **reduction in Motivation, or energy**
❑ Yes	❑ No -------	I have constant **Concerns or worries** about sleep
❑ Yes	❑ No -------	I have **Tension headaches** in response to sleep loss

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the **following situations** in contrast to feeling just tired?
(0 = would never doze, **1 = slight chance of dozing**, **2 = moderate chance**, **3 = high chance of dozing)**

SITUATION	**Chance of dozing**			
1. Sitting and reading	0	1	2	3
2. Watching TV	0	1	2	3
3. Sitting inactive in a public place (ex: movie theatre or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon, if circumstances permit	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch	0	1	2	3
8. In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL SCORE: ------- ---- /24

RLS/PLMD:

❑ Yes ❑ No--------- I **kick or jerk my legs** excessively during sleep. ❑ **bothers my bed partner**.

❑ Yes ❑ No-------- I experience a **creeping-crawling or tingling sensation in my legs in evening** when I **try to fall asleep** that can be **relieved by** walking or movement.

❑ Yes ❑ No------ I have ***Restless leg syndrome that have not responded to treatment.***

OREXIN RELATED:

❑ Yes ❑ No----- I experience **sudden muscle weakness** in response to emotions such as laughter, anger or surprise.

❑ Yes ❑ No------ I experience an **inability to move** while falling asleep or when waking up.

❑ Yes ❑ No------ I have experienced **hallucinations or dreamlike images** when falling asleep or waking up.

❑ Yes ❑ No------ I have frequent **uncontrollable bouts of sleep** during the day.

PARASOMNIAS:

❑ Yes ❑ No----- I **act on my dreams** while asleep ***with injury to self or others***. (Hitting, kicking, fallen out of bed, without memory or recall).

❑ Yes ❑ No----- I have frequent **nightmares**.

❑ Yes ❑ No----- I **talk** in my sleep.

❑ Yes ❑ No----- I have **sleep walked** as an adult

(**If Yes, explain**: when was **first** Episode, _____when was the **last** episode _____, **how often** in one month_____

When does it occur in sleep: _____beginning _____first half of night _____second half of night _____end of sleep)

MISCELLANEOUS (CIRCADIAN, GERD, DEPRESSION, BRUXISM, PAIN)

❑ Yes ❑ No----- I frequently **travel across two or more** time zones.

❑ Yes ❑ No------- I awaken alert in the morning earlier than it is time to get up.

❑ Yes ❑ No------- I regularly **work night shifts.**

❑ Yes ❑ No------- I work **rotating shifts**, including night shift work.

❑ Yes ❑ No------- I frequently have **heartburn or acid reflux at** night.

❑ Yes ❑ No------- I feel **depressed**.

❑ Yes ❑ No --------- **Chronic pain** interferes with my sleep.

❑ Yes ❑ No--------- The need to **urinate frequently** interrupts my sleep.

❑ Yes ❑ No-------- I **grind my teeth** in my sleep.

SLEEP WAKE PATTERN

Typical bedtime: _____ weekday _____ on weekend

Typical awakening time: _____ weekday _____ on weekend

Typical **TOTAL hours** in **bed**: _____ hours. Typical **TOTAL hours** of **sleep**: _____ hours

Typical amount of **time it takes to fall** asleep _____

Typical **number of awakenings** per night_____ **Time it takes to fall back** asleep after awakening ____

❑ Yes ❑ No------ My sleep **pattern is irregular**.

SLEEP ENVIRONMENT HABITS, SLEEP MEDICATIONS, SLEEP FAMILY HISTORY

Typical **sleep position**(s) ❑ back ❑ side ❑ stomach ❑ head elevated ❑ in a chair

❑ I sleep alone ❑ I share a bed with someone.

❑ My **bedroom** is ❑ comfortable ❑ noisy ❑ too warm ❑ too cold

❑ Yes ❑ No---------- I have **pets in the bedroom**.

❑ Yes ❑ No---------- I **watch TV** in bed prior to sleep.

❑ Yes ❑ No---------- I **read in bed** prior to sleep.

❑ Yes ❑ No---------- I **work or study** in bed.

❑ Yes ❑ No---------- I **drink alcohol prior to bedtime**.

❑ Yes ❑ No---------- I **smoke prior** to bedtime or when awaken during the night.

❑ Yes ❑ No---------- I eat a **snack at bedtime**.

❑ Yes ❑ No---------- I **eat if I awaken** during the night.

❑ Yes ❑ No---------- I drink **caffeinated beverages** ____cups/bottles/cans ❑ tea ❑ coffee ❑ soda per day

❑ Yes ❑ No---------- I have interruption in sleep from **unusual sounds** in the home or outside.

❑ Yes ❑ No---------- I get **racing thoughts** prior to sleep.

❑ Yes ❑ No---------- I sleep better when on vacation

❑ Yes ❑ No---------- I **take prescribed medications** for sleep. Name_____

❑ Yes ❑ No---------- I **take herbal or over the counter medications for** sleep. Name_____

❑ Yes ❑ No---------- I have history of **Brain Injury or concussion, meningitis, nocturnal seizures**

❑ Yes ❑ No---------- I have **Family history of _____sleep apnea ____Insomnia _____ narcolepsy**