Dr. Hemant Shah
Dr. Median Ali
Dr. Aamir Malik

Name: _____
DOB: _____

Referring Physician: _____Tel #_____
Family Physician: _____ Tel # _____
Age: _____ Height: _____ Weight: _____

Main reasons you are coming for this visit:

_____

USUAL SLEEPING HABITS:

How many hours of sleep do you get _____ Night _____ Day _____
Usual time you go to bed_____
Usual time you fall asleep_____
Number of times you wake up_____ To do what? _____
Time you get out of bed_____ with/without an alarm clock
When you wake up do you still feel tired/groggy? _____
Do you wake up frequently with a headache? _____
Any unusual dreams? If so, describe_____
Do you snore? _____ (Y/N) Heavy/Light _____
Does it wake your partner? _____ (Y/N)
Does your partner sleep in separate rooms due to your snoring? _____
On weekends/days off do you sleep longer? (Y/N) _____ (How many hours?) _____
Do you take naps during the day: (describe) _____
Are they Restful _____(Y/N)?
As you are going *to* bed, do your legs have a creepy, crawly feeling? _____
Describe it further: _____
If so, does the discomfort get (circle one) BETTER/WORSE when you do fall asleep?
Does the feeling get (circle one) BETTER/WORSE with moving the legs?
Is it worse during the (circle one) evening/night OR during the daytime?
Do you have *uncontrollable* urges to fall asleep in the daytime? _____
Do you fall to the ground or pass out if you laugh/cry/get emotional? _____
Do your muscles feel weak when you are laughing or excited? _____
At night: any unusual activities? _____
While asleep do you Talk_____ Walk _____ Eat_____
Do you ever injure yourself? _____ Others? _____
Grind your teeth_____ Wet your Bed_____
Wake up coughing_____ Wheezing _____ Chest Pain_____

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DAYTIME SLEEPINESS: In the daytime, do you feel sleepy? _____ Do you fall asleep while (circle all that apply):

- Driving _____
- Doing my job_____
- Eating _____

Have you ever had any accidents or near accidents related to sleep issues? _____
If so, describe what happened. _____

PAST HISTORY:

Currently I have been diagnosed with the following

____ Hypertension
____ Heart attack
____ Stroke
____ Emphysema / Asthma / COPD
____ Depression/Anxiety
____ Diabetes
____ Thyroid disorder

_____ Hiatal Hernia
_____ Gastroesophageal reflux (GERD)
_____ Peptic Ulcer Disease
_____ Irritable Bowel Syndrome
_____ Other (describe)
_____Irregular heart beat

SURGERIES (with dates):

_____ _____
_____ _____

ALLERGIES (and describe what happens)

_____ _____
_____ _____
_____ _____

CURRENT MEDICATIONS:

(Please list all medications you are taking, prescription and over-the-counter).
Any medicines in particular for sleeping OR to keep you up?

MEDICATIONS	DOSAGE	# OF TABLETS	HOW MANY TIMES A DAY

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***FAMILY HISTORY of sleep related problems*:**

MOTHER: _____ BROTHER: _____
FATHER: _____ SISTER: _____

Habits:

Did you ever smoke? (Y/N)_____
Number of packs/day_____ For how long? _____
Date of your last cigarette_____
Alcohol: (type) _____ Amount _____
Any other drugs? _____
Coffee: Y/N _____ Number of cups per day _____ caffeinated/decaf
Cola/Pop (name) _____ Number of cans/bottles a day_____

OCCUPATION:

Type of work _____
Usual work hours _____
Approx. driving distance _____ miles per day to and from
Any use of dangerous equipment or machinery? (Describe) _____

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Please circle any of the following that you have recently experienced. If there is anything else please put it in the blank boxes.						
Constitution:	Weight Loss	Fatigue	Weight Gain			
Cardiovascular:	Chest Pain	Palpitations	Swelling (edema)	Murmurs		
Ears, Nose, and Throat	Heartburn or Reflux	Deviated Nasal Septum	Nasal Obstruction	Hoarseness or Sore Throat	Dentures	
Hematology/Lymph:	Easy Bruising	Bleeding Tendency	Enlarged Lymph Nodes	Anemia		
Neurology:	Headaches	Seizures	Head Injury	Dementia/ Forgetfulness	Unsteady Gait / Walking Problems	
Skin:	Rash	Itching	Dry Skin			
Musculoskeletal:	Muscle Wasting	Tremors	Weakness	Back Pain		
Psychiatric:	Feeling Anxious	Feeling Depressed	Feeling Sad			
Gastronintestinal:	Heartburn	Trouble Swallowing				
Endocrine:	Excessive Thirst	Excessive Urination				
Genitourinary:	Frequent Urination	Loss of Bladder control	Difficult Urination	Renal Failure	Dialysis	

DATE: _____

NAME: _____

EPWORTH SLEEPINESS SCALE

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

_____ Sitting and reading

_____ Watching television

_____ Sitting inactive in a public place, for example, a theater or meeting

_____ A passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon

_____ Sitting and talking to someone

_____ Sitting quietly after lunch (when you have had no alcohol)

_____ In a car, while stopped in traffic

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name-_____ **Date of Birth-**_____/_____/_____

Telephone #-(_____)_____-_____ **Last 4 digits of SSN-**_____

I hereby authorize _____ *to release, use, and disclose health information about me as described below to the following individuals or entities:*

Send To:

_____

_____

_____

Send To:

_____

_____

_____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

RELEASE CONTENT

Dates of Service Requested: _____

[ ] COMPLETE MEDICAL RECORD
[ ] PROGRESS NOTES
[ ] HISTORY & PHYSICAL
[ ] LAB/PATHOLOGY REPORTS
[ ] EKG REPORTS
[ ] PFT REPORTS
[ ] DICTATED LETTERS
[ ] ITEMIZED BILL
[ ] RADIOLOGY REPORTS
[ ] OTHER (PLEASE SPECIFY): _____

REASON FOR DISCLOSURE

My health information is being released or disclosed for the following reason(s) (check all that apply)

[ ] PERSONAL
[ ] LEGAL INVESTIGATION OR ACTION
[ ] INSURANCE ELIGIBILITY OR BENEFITS
[ ] CHANGING PHYSICIANS
[ ] OTHER (PLEASE SPECIFY): _____

CONSENT

I understand that I may revoke authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e. parent, guardian, power of attorney for healthcare, executor)*