New Patient Registration

New Patient Registration

1. First Name: | Middle Initials: | Last Name: | Date of Birth:

Gender:
○ Female ○ Male
○ Prefer Not to Answer

Marital Status:
○ Single ○ Married ○ Domestic Partner ○ Separated
○ Divorced ○ Widowed

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Do you have a smart phone or tablet?
☐ Yes ☐ No

Work Phone: | Email - Required for Telehealth

Preferred Contact Method:
○ Mobile Phone ○ Home Phone ○ Email

What Service Are You Requesting:
○ In - Lab Test ○ In - Home Test ○ Clinic Consult

Social Security # - If insurance requires for billing. | Driver's License #:

Referring Physician: | Phone Number:

Emergency Contact | Contact Phone Number | Relationship to Patient

2. Responsible Party – If the Patient is a Minor

First Name: | Middle Initials: | Last Name: | Date of Birth:

Street Address: | Apt./Unit #: | City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Work Phone:

Email: | Social Security # - If required for billing. | Driver's License #:

3. Primary Insurance

Primary Insurance Company: | Member ID / Policy #: | Group Number:

Client Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name:	Insured Phone #:	Insured Date of Birth:	Insured Gender: ○ Female ○ Male

Insured Street Address:	Insured City:	Insured State:	Zip Code:

4. Secondary Insurance

Secondary Insurance Company:	Member ID / Policy #:	Group Number:

Client Relationship to Insured:
○ Self ○ Spouse ○ Child ○ Other

Insured Name:	Insured Phone #:	Insured Date of Birth:	Insured Gender: ○ Female ○ Male

Insured Street Address:	Insured City:	Insured State:	Zip Code:

5. Include Insurance Card (Front and Back) and Driver's License Photo

Health/Sleep History Questionnaire

6. Patient Name:

7. What is the primary reason for your visit (poor sleep, goals, review results, CPAP eval, etc)?:

8. Sleep Schedule

What time do you get into bed (range or average)?

How long does it take you to fall asleep?

How many times do you wake up in the night, even if just briefly?

What time do you wake up in the morning to start your day?

How many total hours of sleep do you get per day (average or range)?

Do you feel refreshed upon awakening?
○ Yes ○ No

Do you find yourself sleepy or fatigued during the day?
○ Yes ○ No

Have you ever had any car accidents due to feeling tired/fell asleep driving?
○ Yes ○ No

Favorite sleep position: Sides, Back, and/or Stomach?

_____

9. Sleep Related Breathing Disorders

	Yes	No
Does anyone sleep next to you or in the same room as you currently?		
Have you ever been told that you snore?		
Do you ever stop breathing or have shallow or irregular breathing while sleeping?		
Do you ever wake up coughing, choking, gasping for air, or feel short of breath?		
Do you wake up with a headache?		

10. Sleep Studies, CPAP, or Oxygen

Have you ever had a Home Sleep Apnea Test, In-Lab Sleep Study, or Overnight Oxygen Test before?
○ Yes ○ No

If yes, what year was it performed, and what type of study, and are these results available?

_____

_____

11. Ever been diagnosed with sleep apnea?
○ Yes ○ No

If yes, fill out the rest of this table:

Are you a current CPAP user?
○ Yes ○ No

How long have you been on CPAP? _____

What pressures or levels do you use? _____

What DME Company do you use? _____

Serial # of CPAP? _____

Mask type (nasal, pillow, full face?)

_____

Do you like your current mask?
○ Yes ○ No

Do you have any DOT or FAA regulations to meet for CPAP compliance?
○ Yes ○ No

Are you a current oxygen user?
○ Yes ○ No

12. Restless Legs

	Yes	No
Do you have an urge to move your legs, or an unpleasant sensation in the legs?		
Do the sensations ever prevent you from falling asleep or wake you from sleep?		

13. Parasomnias

	Yes	No
Do you have any persistent nightmares that wake you from sleep?		
Ever been told you sleep walk?		
Ever been told you sleep talk?		
Do you ever have episodes where you physically act out your dreams?		
Do you ever have visual or auditory hallucinations or lifelike visions as you fall asleep or wake up?		
Do you ever wake from sleep feeling paralyzed or unable to move?		
Do you ever experience sudden loss of muscle tone or sudden weakness during the day?		

14. Insomnia

	Yes	No
Do you often have issues falling or staying asleep, or waking earlier than intended?		

15. Hypersomnias

	Yes	No
Do you wake feeling rested/restored by sleep?		
Do you often find yourself feeling very tired or sleepy during the day?		

16. **Epworth Sleepiness Scale How likely are you to doze or fall asleep in the following situations? 0: would never doze 1: slight chance of dozing 2: moderate chance of dozing 3: high chance of dozing**

Situation	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (eg a theatre or a meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking with someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Medical History

17. **Please check the box if you have any of the following medical conditions (current or have been diagnosed in the past). If you have a disorder that is not listed, please use the blank areas to let us know this diagnosis**

- ☐ High blood pressure/hypertension
- ☐ High cholesterol or lipids (taking a statin)
- ☐ Heart Disease (heart attack/heart failure)
- ☐ Arrhythmias (afib, aflutter, PVCs/SVTs, etc)
- ☐ Lung Issues (asthma, COPD, diaphragm issues)
- ☐ Diabetes/Prediabetes
- ☐ Kidney disease
- ☐ Polycythemia or anemia (blood issues)
- ☐ Stroke/seizure/neurological disease/dementia
- ☐ GERD/Acid Reflux/Heart Burn
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ ADHD
- ☐ Chronic pain
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Hypothyroidism

Not listed:

_____

18. **Do you have any ALLERGIES to any medications?**

- ☐ I have no known allergies to any medications

_____

- ☐ I have allergies to the following medications:

_____

19. Please list any current/active MEDICATIONS you are taking that are prescribed to you (even if only "as needed"):

☐ I am not taking any prescription medications

_____

☐ I am currently taking the following medications and doses (list):

_____

20. Social History

Do you currently use any tobacco products, cigarettes, vaping, chew, nicotine, etc?
○ Yes ○ No

Have you ever used any tobacco products in the past?
○ Yes ○ No

For how long? _____

When did you quit? _____

How many alcoholic beverages do you have per week, on average?

_____

Do you drink any caffeine, such as tea, coffee, soda, or energy drinks/supplements?
○ Yes ○ No

How many per day? _____

Do you use any recreational drugs (such as marijuana, cocaine, etc)?
○ Yes ○ No

Do you have any history of alcohol/narcotic/benzo abuse, current or past?
○ Yes ○ No

21. What is your current height? _____

What do you currently weigh in pounds? _____

What is your neck size? _____

What do you do for work? _____

What is the approximate elevation of where you live?

_____

Modified Berlin Questionnaire

22. Date:

_____

Patient Name: _____

DOB: _____

Height (inches): _____

Weight (lbs): _____

Gender:
○ Male ○ Female

Please choose the correct response to each question.

23. Category 1

1. Do you snore?
○ a. Yes ○ b. No ○ c. Don't know

If you answered 'yes':

2. You snoring is:
○ a. Slightly louder than breathing ○ b. As loud as talking ○ c. Louder than talking

3. How often do you snore?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

4. Has your snoring ever bothered other people?
○ a. Yes ○ b. No ○ c. Don't know

5. Has anyone noticed that you stop breathing during your sleep?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

24. Category 2

6. How often do you feel tired or fatigued after your sleep?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

7. During your waking time, do you feel tired, fatigued or not up to par?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

8. Have you ever nodded off or fallen asleep while driving a vehicle?
○ a. Yes ○ b. No

If you answered 'yes':

9. How often does this occur?
○ a. Almost every day ○ b. 3-4 times per week ○ c. 1-2 times per week ○ d. 1-2 times per month
○ e. Rarely or never

25. Category 3

10. Do you have high blood pressure?
○ Yes ○ No ○ Don't know