

Clinic Patient Registration-Current

Clinic Patient Registration

1. Patient Demographics

First Name:	Middle Initials:	Last Name:	Date of Birth:
_____	_____	_____	_____
Gender: ☐ Female ☐ Male ☐ Prefer Not to Answer	Street Address:	Apt./Unit #:	
_____	_____	_____	
City:	State:	Zip Code:	Phone:
_____	_____	_____	_____
		Referring Provider/Practice	

Do you have a smart phone or tablet? ☐ Yes ☐ No	Email - Required for Consult/Telehealth		
_____	_____		
Emergency Contact	Contact Phone Number	Relationship to Patient	
_____	_____	_____	

2. Responsible Party – If the Patient is a Minor

First Name:	Middle Initial:	Last Name:	Date of Birth:
_____	_____	_____	_____
Phone:	Email:	Relationship to Patient:	
_____	_____	_____	

3. Primary Insurance - Please List n/a or Self if you do not have insurance

Primary Insurance Company:	Member ID / Policy #:	Group Number:
_____	_____	_____
Client Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured Name:	Insured Date of Birth:
_____	_____	_____

4. Secondary Insurance

Secondary Insurance Company:	Member ID / Policy #:	Group Number:
_____	_____	_____
Client Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured Name:	Insured Date of Birth:
_____	_____	_____

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

Health/Sleep History Questionnaire

6. What is the primary reason for your visit with sleep medicine (sleep apnea/snoring, insomnia/poor sleep, excessive sleepiness/fatigue, review sleep study results, check CPAP, etc)?

7. Will you need an interpreter or translation services during your appt?

☐ Yes ☐ No

If yes, which language?

8. Sleep Studies, PAP, and/or Oxygen:

Have you had ever had a Home Sleep Apnea Test, In-Lab Sleep Study or Overnight Oxygen Test before?

☐ Yes ☐ No

If yes, what year, what type of study, and are the results available?

Have you ever been diagnosed with sleep apnea? ☐ Yes ☐ No

Are you currently using a CPAP machine? ☐ Yes ☐ No

If yes, the below information is needed to make your visit more productive, please fill out if known.

How long have you been on CPAP?

What pressures or levels do you use, if known?

Which company provides your CPAP supplies (masks)?

PAP SERIAL Number (located on PAP & starts w/ "SN")

PAP DEVICE Number (located on PAP & starts w/ "DN")

Mask type (nasal, pillow, full face)?

Do you like your current mask?

☐ Yes ☐ No

Do you have any DOT, CDL, or FAA regulations to meet? ☐ Yes ☐ No

Do you use Oxygen (O2), either with or without PAP? ☐ Yes ☐ No

9. 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?

Do you take any naps, if so how long do you nap per day?

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

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

10. Sleep Related Breathing Issues

	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 with sleep?		
Do you wake up with a headache?		

11. Movement Sleep Issues

	Yes	No
Do you have urges to move your legs, or an unpleasant sensation in the legs when you get into bed that can bother or delay your sleep on a regular basis (>3d per week)?		
Has anyone ever told you that move a lot in your sleep?		

12. Parasomnia Issues

	Yes	No
Do you have any persistent nightmares that wake you from sleep or bother you?		
Ever been told you sleep walk, especially as an adult?		
Do you ever physically act out your dreams, such as running or punching in your sleep?		
Do you ever see things that don't exist (shadows/figures) as you wake up (hallucinations)?		
Do you ever wake from sleep feeling paralyzed or unable to move?		

13. Insomnia/Fatigue/Sleepiness Issues

	Yes	No
Do you frequently have issues falling or staying asleep, or waking earlier than intended?		
Do have any persistent/chronic fatigue (low energy, lack of motivation, tired)?		
Have you ever gotten into a car accident because you fell asleep while you were driving?		

14. 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
While 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 able				
Sitting and talking with someone				
Sitting quietly after lunch without alcohol				
While you are driving, stopped for a few minutes in traffic				

Medical History

15. 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 | ☐ Hypothyroidism |
| ☐ Polycythemia or anemia (blood issues) | ☐ GERD/Acid Reflux/Heart Burn |
| ☐ Chronic pain | ☐ Migraines |
| ☐ Anxiety/Depression/Bipolar/PTSD/Mood Disorder | ☐ ADHD |
| ☐ Stroke/seizure/neurological disease | ☐ Autism/Cognitive Impairment/Dementia |

Not listed:

16. Please list all medications you're currently taking, including over-the-counter medications:

17. Do you have any allergies to any medications?

☐ No, I have no known allergies

☐ Yes, I have allergies to these Medications:

If yes, please list the medications...

18. Social History

Do you currently use any nicotine products, cigarettes, vaping, chew, nicotine, etc?

☐ Yes ☐ No

If you have ever used tobacco products in the past but have since quit, when did you quit?

If yes to either of above questions, how long have you (or did you) use nicotine for?

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

How many caffeinated beverages (coffee, tea, soda, energy drinks) do you have per day?

Do you currently use any recreational drugs (marijuana, cocaine, methamphetamine, opiates, etc.)?

☐ Yes ☐ No

Do you have any history of alcohol/narcotic/benzodiazepine abuse, current or past?

☐ Yes ☐ No

What do you do for WORK, if applicable?

Do you do any shift work (night or swing shift)?

☐ Yes ☐ No

What is the approximate elevation of where you live?

19. Vitals/Biometrics

Current Height (Ft & In)

Current Weight (LBS)

What is your neck size, if known?

Modified Berlin Questionnaire

20. Category 1

1. Do you snore?

☐ a. Yes ☐ b. No ☐ c. Don't know

If you answered 'yes':

2. Your 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

21. 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

22. Category 3

10. Do you have high blood pressure?

☐ Yes ☐ No ☐ Don't know