Maumelle sleepsolutions

## PATIENT INFORMATION

NAME _____ DOB_____/_____/_____

ADDRESS _____

CITY _____STATE _____ZIP _____

HOME #_____WORK _____CELL _____

EMAIL_____AGE _____

SOC. SECURITY #_____SEX _____

SPOUSE OR PARENT _____WORK # _____

PRIMARY CARE PHYSICIAN_____

PHARMACY _____

WHO REFERRED YOU / HOW DID YOU HEAR ABOUT US? _____

## INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____

ADDRESS _____PHONE_____

ID #_____GROUP #_____

INSURED_____ RELATIONSHIP_____

* If your spouse is the Sponsor/Primary Member, you MUST provide the following information:

SPOUSE/Primary Member's: ID#_____ DOB: _____

SOC. SECURITY# _____

SECONDARY INSURANCE CARRIER_____

ADDRESS_____PHONE_____

ID #_____GROUP #_____

INSURED_____RELATIONSHIP_____

### RELEASE AND ASSIGNMENT

I hereby authorize Maumelle Sleep Solutions, LLC to release my insurance company any information including the diagnosis and records of any treatment or examination rendered to me during the period of such medical or surgical care. I also request my insurance company to pay directly to Maumelle Sleep Solutions, LLC the amount due me in my pending claim for insurance benefits. I agree to be responsible for payment of my account, and agree to pay collection agency fees up to 50% of my balance, should my account be placed with an agency.

SIGNATURE_____DATE_____

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby give my permission and consent to release copies of my medical records from Maumelle Sleep Solutions, LLC to the individuals and/or entities listed below.

_____
_____
_____
_____
_____

_____ _____
Witness Signature of Patient

_____
Date

To Whom It May Concern:
I hereby authorize the release of my medical records, including physician notes, laboratory, sleep study results, and any other information contained in my file to:

Maumelle Sleep Solutions, LLC
501 Millwood Circle, Suite F
Maumelle, AR 72113
Ph: (501) 235-8242
Fax: (866) 562-1199

_____ _____
Witness Signature of Patient

_____
Date

Maumelle sleepsolutions
SLEEP DISORDERS CENTER

Sleep Clinic of ARKANSAS
11600 Kanis Road, Suite 700
Little Rock, AR 72211
Phone: (501) 312-0070 Fax: (501) 312-0072
GozaSleep.com
2201 Wildwood Ave, Suite 100
Sherwood, AR 72120

## QUESTIONNAIRE FOR NEW PATIENTS

**Name:** _____ **D. O. B.:** _____ **Date:** _____

**Check one:** ◯ Single ◯ Married ◯ Divorced ◯ Widowed

**Occupation?** _____

**Who referred you to Sleep Clinic of Arkansas?** _____

**Primary Care Physician?** _____

**Describe your sleep problem(s)**

**Height:__'__" Weight:____lbs**

**Please call the sleep clinic (Phone #: (501) 312-0070 and speak with one of our medical assistants to provide us with the following information if any of the questions in this section apply to you. Prior to your initial visit we may want to obtain records / reports relative to your previous sleep evaluation, sleep study, or other work up related to sleep.**

**Have you ever seen Dr. Goza or any other sleep specialist prior to this time?** ◯ yes ◯ no

**Explain:** _____

**Have you had a sleep study or other test / evaluation related to sleep problems?** ◯ yes ◯ no

**Explain:** _____

| Work days | Days off | (Use averages or "approximates" when answers are nonspecific or variable) |
|---|---|---|
| _____ | _____ | Typical Bedtime |
| _____ | _____ | How long does it take for you to fall asleep? |
| _____ | _____ | How many times do you awaken during the night? |
| _____ | _____ | Estimate the total amount of time you are asleep during a typical night. |
| _____ | _____ | Typical rise time – what time do you get up on a typical day? |
| _____ | _____ | Naps per day - average |
| _____ | _____ | Total amount of sleep time (naps, etc.) during 24 hour "day" |
| _____ | _____ | Estimated total sleep time per 24 hour period |
| _____ | _____ | When you awaken in the mornings, do you usually feel rested? |

**How likely are you to actually doze off or fall asleep in these or similar situations? Do not leave blanks.**

**0 = would never fall asleep 1 = slight chance 2 = moderate chance 3 = very likely to fall asleep / doze**

____ Sitting and reading?
____ Watching TV?
____ Sitting, inactive in a public place (e.g. a theater or 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 to someone?
____ Sitting quietly after a lunch without alcohol?
____ In a car, while stopped for a few minutes in traffic?
0___ TOTAL: (add points from above questions)

**Please check any of these problems which apply to you – Do you have problems with:**

☐ problems getting to sleep ☐ frequent awakenings ☐ awakening too early

☐ not getting enough sleep ☐ excessive sleepiness ☐ unusual behavior during sleep

| Never | Rarely | Sometimes | Frequently | |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | **Do you snore?** |
| ○ | ○ | ○ | ○ | **Do you have morning headaches?** |
| ○ | ○ | ○ | ○ | **Do you sweat a great deal during the night?** |
| ○ | ○ | ○ | ○ | **Have you been told that your breathing pauses of stops during sleep?** |
| ○ | ○ | ○ | ○ | **Do you have problems breathing through your nose?** |
| ○ | ○ | ○ | ○ | **Do you sleep on your back?** |
| ○ | ○ | ○ | ○ | **Do you have pain or discomfort which keeps you awake?** |
| ○ | ○ | ○ | ○ | **Do you have jerking in your legs (or arms, etc. ) during the night?** |
| ○ | ○ | ○ | ○ | **Do your legs ache or feel uncomfortable before sleep/during awakenings?** |
| ○ | ○ | ○ | ○ | **Do you need to move your legs to relieve discomfort/tension when in bed?** |
| ○ | ○ | ○ | ○ | **Do strong emotions, i.e. anger, fear, surprise, laughter, exhilaration, seem to trigger sudden feelings of muscle weakness (**with no loss of awareness)? |
| ○ | ○ | ○ | ○ | **Do you ever feel unable to move as you are falling asleep or awakening?** |
| ○ | ○ | ○ | ○ | **As you fall asleep or are awakening, do you sometimes have visual, auditory, or sensory experiences?**(may be hard to tell dreaming from reality) |
| ○ | ○ | ○ | ○ | **Do you become sleepy when driving?** |

**Has drowsy driving / falling asleep while driving resulted in a motor vehicle accident?** YES ○ NO ○
**If so, please explain:** _____

**Do you have or have you ever had the following conditions? If so, explain**

☐ **Heart disease** _____

☐ **Stroke / mini-stroke** _____

☐ **Lung disease** _____

☐ **High blood pressure** ☐ **Thyroid problems** ☐ **Seizures** ☐ **Reflux**

☐ **Arthritis** ☐ **Cancer** ☐ **Depression** ☐ **Diabetes**

**Other** _____

**Most Recent Blood Tests – when? Which doctor / hospital?** _____

_____

**Previous surgeries (include tonsillectomy / nasal surgery) and hospitalizations – begin with most recent -**

_____

_____

_____

_____

_____

_____

_____

_____

**Please list allergies:** _____

**Check any of these conditions which are present in one of your close family members**

☐ **heart disease** ☐ **loud snoring** ☐ **sleep apnea**

☐ **stroke** ☐ **high blood pressure** ☐ **other sleep disorders**

☐ **Other** _____

| **List current Medications** | **Dose / strength? mg. (other)** | **How often and at what time?** | **Reason medication was prescribed?** | **Who prescribed this Medication for you?** |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

**List any nose sprays that you use, including over the counter sprays: _____**

**YES ◯ NO ◯ Do you drink alcohol? How much? _____**

**YES ◯ NO ◯ Do you drink caffeinated beverages, such as coffee, tea, or soft drinks?**
**_____ Ounces – (How many ounces per day? (4 ounces = 1 cup)**
**_____ Hours before bedtime – last caffeine for the day**

**YES ◯ NO ◯ Do you smoke – or have you ever smoked on a regular basis? ____ Packs per day?**
**_____ years you have smoked**
**_____ years ago–How long ago did you stop smoking (if you have stopped smoking)**

**"Check" spaces to indicate that you have any of the following symptoms**

| | | |
|---|---|---|
| ☐ **Loss of appetite** | ☐ **Cough** | ☐ **Numbness** |
| ☐ **Loss of energy** | ☐ **Shortness of breath** | ☐ **Nervousness** |
| ☐ **Weight loss ( _ lbs in _ yrs)** | ☐ **Legs swelling** | ☐ **Trouble concentrating** |
| ☐ **Weight gain ( _ lbs in _ yrs)** | ☐ **Abdominal pain** | ☐ **Depression** |
| ☐ **Throat pain** | ☐ **Indigestion** | ☐ **Irritability** |
| ☐ **Nose bleeds** | ☐ **Back pain** | ☐ **Sad mood** |
| ☐ **Chest pain** | ☐ **Joint pain** | ☐ **Change in vision** |
| ☐ **Irregular heartbeat** | ☐ **Neck Pain** | ☐ **Hearing loss** |
| ☐ **Dizziness** | ☐ **Problems with urination** | ☐ **Headaches** |

**Additional comments? _____**

**INSOMNIA QUESTIONNAIRE: If you have difficulty falling asleep or staying asleep on a regular basis, please answer the following questions:**

**How long have you been having trouble with insomnia? ____ weeks _____ months_____ years**

**How many nights in a typical month do you have problems sleeping? _____ nights**

***Before going to bed*, which of the following have you done in order to help you get sleepy?**

**Yes ○ No ○ use medication _____**

**Yes ○ No ○ eat a snack (how often?) _____**

**Yes ○ No ○ take a bath (how often?) _____**

**Yes ○ No ○ read _____**

**Yes ○ No ○ exercise – how close to bedtime? _____**

**Yes ○ No ○ use relaxation exercises _____**

**Yes ○ No ○ sleep with a fan blowing (or other noise) _____**

***When in bed and having trouble getting to sleep or returning to sleep* do you -**

**Yes ○ No ○ read**

**Yes ○ No ○ watch TV**

**Yes ○ No ○ listen to music or the radio**

**Yes ○ No ○ check the time on your clock during the night**

**Yes ○ No ○ feel anxious, have muscle tension, or feel like your body cannot relax?**

**Yes ○ No ○ have racing thoughts going through your mind which keep you from sleeping?**

**Yes ○ No ○ Do you sleep with another person or a pet? Who? _____**

**Yes ○ No ○ Are your sleep problems made worse by your bed partner? _____**

**Yes ○ No ○ Are your sleep problems related to environmental issues? If so, are problems due to**

**☐ an uncomfortable mattress ☐ the light in your room (too much or too little)**

**☐ traffic or outside noises Other _____**

**What size is your bed? ○ King ○ Queen ○ Full (double) ○ Twin**

**__ Hours /___ Minutes: Shortest time it took to fall asleep after going to bed – in the past 2 weeks**

**__ Hours /___ Minutes: Longest time it took to fall asleep after going to bed – in the past 2 weeks**

**When you are in bed and awake, do you think about -**

**Yes ◯ No ◯ Trying to fall asleep**

**Yes ◯ No ◯ Family matters**

**Yes ◯ No ◯ Work**

**Yes ◯ No ◯ Do you become annoyed or angry when you cannot get to sleep?**

**Yes ◯ No ◯ Do you get out of bed if you cannot get to sleep? How long do you lie awake before getting out of bed? _____ How long do you stay up? _____**

**Yes ◯ No ◯ As your bedtime approaches, do you become more alert?**

**Yes ◯ No ◯ During the day, do you worry about getting to sleep the next night?**

**_____ How many hours per night would you like to sleep?**
**_____ How many hours per night do you think most people your age sleep?**

**When sleeping away from home, is your sleep ◯ better? ◯ worse? ◯ the same?**

**<u>Please check any of the following medications you have taken for sleep.</u>**

| | No Help | Some help | Very Helpful | Caused side effects explain) |
|---|---|---|---|---|
| **<u>OVER THE COUNTER MEDS:</u>** | | | | |
| ☐ **Benadryl (Diphenhydramine)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Tylenol PM** | ◯ | ◯ | ◯ | _____ |
| ☐ **Excedrin PM** | ◯ | ◯ | ◯ | _____ |
| ☐ **Sominex** | ◯ | ◯ | ◯ | _____ |
| ☐ **Nytol** | ◯ | ◯ | ◯ | _____ |
| ☐ **Unisom** | ◯ | ◯ | ◯ | _____ |
| ☐ **Melatonin** | ◯ | ◯ | ◯ | _____ |
| ☐ **Valerian** | ◯ | ◯ | ◯ | _____ |
| ☐ **Alcohol** | ◯ | ◯ | ◯ | _____ |
| ☐ **Other _____** | ◯ | ◯ | ◯ | _____ |
| **<u>Imidazopyridine – sleep medication</u>** | | | | |
| ☐ **Ambien (Zolpidem)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Ambien CR** | ◯ | ◯ | ◯ | _____ |

| | | | | |
|---|---|---|---|---|
| ☐ **Sonata (Zaleplon)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Lunesta** | ◯ | ◯ | ◯ | _____ |
| ☐ **Rozerem *** | ◯ | ◯ | ◯ | _____ |

***prescription hypnotic medication***

**Antidepressants-taken for sleep**

| | | | | |
|---|---|---|---|---|
| ☐ **Amitriptyline (Elavil)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Imipramine (Tofranil)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Doxepin (Sinequan)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Trazodone (Desyrel)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Mirtazapine (Remeron)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Nefazodone (Serzone)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Trimipramine (Surmontil)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Nortriptyline (Pamelor)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Desipramine (Norpramin)** | ◯ | ◯ | ◯ | _____ |

**Tranquilizers – taken for sleep**

| | | | | |
|---|---|---|---|---|
| ☐ **Lorazepam (Ativan)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Alprazolam (Xanax)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Diazepam (Valium)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Clonazepam (Klonopin)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Quetiapine (Seroquel)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Olanzapine (Zyprexa)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Risperidone (Risperidal)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Aripiprazole (Abilify)** | ◯ | ◯ | ◯ | _____ |

**Benzodiazepines - sleep medication**

| | | | | |
|---|---|---|---|---|
| ☐ **Flurazepam (Dalmane)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Triazolam (Halcion)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Temazepam (Restoril)** | ◯ | ◯ | ◯ | _____ |
| ☐ **Estazolam (ProSom)** | ◯ | ◯ | ◯ | _____ |