

Northshore Sleep Medicine  
Lisa Shives M.D.

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ [ ] Home [ ] Work [X] Mobile  
Phone: \_\_\_\_\_ [ ] Home [ ] Work [X] Mobile

Patient ID #: \_\_\_\_\_ Sex: [ ] M [ ] F  
Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed  
E-Mail Address: \_\_\_\_\_

**EMERGENCY CONTACTS**

Name Relationship Phone

**RESPONSIBLE PARTY**

[ ] Same as Patient

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_

Referring Physician: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

**PATIENT EMPLOYMENT**

[ ] Employed [ ] Retired [X] Other

Employer: \_\_\_\_\_

**INSURED PARTY EMPLOYMENT**

Employer: \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE:**

[ ] Patient [ ] Spouse [ ] Insured Party

Ins Company: \_\_\_\_\_

Co-Pay Amt: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

**SECONDARY INSURANCE:**

[ ] Patient [ ] Spouse [ ] Insured Party

Ins Company: \_\_\_\_\_

Co-Pay Amt: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group: \_\_\_\_\_

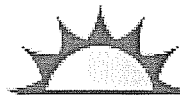
Date of Birth: \_\_\_\_\_

Insured Party: \_\_\_\_\_

Insured Phone: \_\_\_\_\_

I hereby authorize Northshore Sleep Medicine to release any medical records related to my care in order to obtain payment for medical services rendered on my behalf. I also authorize Northshore Sleep Medicine to submit all charges for services rendered to me and assign any benefits payable to Northshore Sleep Medicine. I understand that I am responsible for any portion of my bill not covered by insurance companies, governmental agencies or their intermediaries, or third party payors. I understand that co-pays and balances are due at the time of the visit. This information is valid for (1) one year and will be updated annually. I have read and understand the Patient Responsibilities provided to me. **HIPAA** I hereby acknowledge receipt of the physician's Joint Privacy Notice. I understand that Northshore Sleep Medicine has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**NORTHSHORE  
SLEEP MEDICINE**

**Financial Policy**

**Help Us Help You**

We welcome you to our practice. So that we may provide you with the quality care you deserve, we appreciate your cooperation with the following payment policy.

1. Please come to your appointment with your health insurance card and picture ID.
2. Co-payments are required at the time of service.
3. If you do not have a current insurance card you will be required to pay in full at the time of service.
4. We accept Visa, Master Card and Discover credit cards, as well as cash and checks.
5. Whether we have a contract with your insurance or not, we will bill your insurance as a courtesy and you will be responsible for the balance unless you request otherwise. If you make that request you will be responsible for full payment at the time of service. We make every effort to help you understand your insurance plan, but please understand that this is your responsibility as is the payment of co-pays, co-insurance and deductible.
6. **There is a \$30 no-show fee if you do not give us at least 24 hours notice of your inability to keep an office appointment. If you fail to give us 24 hours notice of cancellation for a sleep study or a nap study (MSLT), the fee is \$100.**
7. Please be advised that due to co-pays, co-insurance and deductibles, “a covered item or service” does not mean that it will be covered at a 100%.
8. Please be aware that as we are in network with most providers, we accept your insurance company’s contracted rate. We have not set the final prices for the services.
9. Our billing service, Health PCP, is available to address your payment concerns and insurance issues. Call Christine Fischer at 866.844.7749.

We at Northshore Sleep Medicine are committed to meeting your healthcare needs and thank you for following our payment policy. We appreciate the opportunity to care for you and your family.

I acknowledge that I have been advised of the above policy.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**NORTHSHORE  
SLEEP MEDICINE**

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• WWW.NSSLEEP.COM •

I, \_\_\_\_\_, authorize Northshore Sleep Medicine to use my data for research purposes with the guarantee that all identifying markers will be removed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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I, \_\_\_\_\_, authorize Northshore Sleep Medicine to release my health information to other health providers as is necessary for my optimal healthcare.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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I, \_\_\_\_\_, authorize Northshore Sleep Medicine to obtain my health information from other providers as necessary for my optimal healthcare.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date



## Sleep Pattern

	Work Days/Weekdays	Off Days/Weekends
Typical Bedtime:	_____	_____
Typical amount of time it takes to fall asleep:	_____	_____
Typical number of awakenings per night:	_____	_____
List any activities that you normally do during nighttime awakenings i.e., restroom, eat, watch TV, etc:	_____	_____
Typical amount of time to fall back asleep after awakening:	_____	_____
Typical wake up time:	_____ am/pm	_____ am/pm
	Work Days/Weekdays	Off Days/Weekends
Desired wake up time:	_____ am/pm	_____ am/pm
How do you usually wake up? (i.e. alarm clock)	_____	_____
Typical time you get out of bed?	_____ am/pm	_____ am/pm
Total hours of sleep per night?	_____	_____
Number of naps per day?	_____	_____

## Review of Sleep Habits/Sleep Environment

- My bedroom is not dark enough
- My bedroom is not quiet enough
- I have temperature problems in my bedroom
- I usually watch TV or read in bed prior to sleep
- I use the computer in bed
- I play video games in bed

- I listen to music
- I listen to relaxation tapes
- I use “white noise” or soothing sounds/music
- I regularly drink alcohol within 2-3 hours of bedtime
- I drink alcohol before bedtime to help me fall asleep
- I smoke prior to bedtime or when I awaken during the night
- I eat a snack at bedtime
- I often travel across 2 or more time zones

### **Sleep-Review of Systems**

- I have trouble falling asleep
- I often wake up during the night
- I am unable to return to sleep easily if I wake up during the night
- I have thoughts that start racing through my mind when I try to fall asleep
- I wake up early in the morning, and I am still tired but unable to return to sleep
- I experience nightmares as an adult
- I have tingling sensations in my legs when I try to fall asleep
- I sweat a great deal during sleep
- I cannot sleep on my back
- I have been told that I stop breathing while I sleep
- I wake up at night choking, smothering, or gasping for air
- I have been told that I snore
- I have been told that I snore only when sleeping on my back
- I have been awakened by my own snoring
- I often wake up with headaches
- I have uncomfortable feelings in my legs and/or arms when I lie down or sit quietly at night

- I have to move my legs or walk around to relieve the uncomfortable feelings
- I am a restless sleeper
- I have been told that I kick or jerk my legs and/or arms during sleep
- I have a hard time falling asleep because of my leg movements
- I have talked in my sleep as an adult
- I have walked in my sleep as an adult
- I grind my teeth in my sleep
- I have acted out my dreams while asleep
- I have hurt myself or others while acting out my dreams
- I have a tendency to fall asleep during the day
- I am tired a lot
- I am often sleepy when I should be alert
- I have had “blackouts” or periods when I am unable to remember what just happened
- I have fallen asleep while driving, at a stoplight, or stopped in traffic
- I have had an auto accident as a result of falling asleep while driving
- I fall asleep while watching TV
- I fall asleep during conversations
- I fall asleep in sedentary situations
- I perform(ed) poorly in school because of sleepiness
- I have had injuries as a result of sleepiness
- I feel sleepiness has impaired me either professionally or socially
- I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- I have had an inability to move while falling asleep or when waking up
- I have had hallucinations or dreamlike images or sounds falling asleep or waking up
- I have to urinate in the middle of the night 2 times or more
- I sometimes/often wet the bed

## General-Review of Systems

Please circle any of the conditions/symptoms you have had in the past month to a significant degree:

Frequent headaches	Fainting/passing out	Sudden loss of vision
Sudden loss of strength	Inability to speak	Hearing loss/ringing in ear(s)
Nosebleeds	Nasal Congestion	Post nasal drip
Seasonal Allergies	Hoarseness for more than 2-4 weeks	Cough for more than 2-4 weeks
Coughing up blood	Shortness of breath or wheezing	Swelling of feet/ankles
Chest pain, tightness, or pressure	Irregular, sudden, or fast heartbeat	Difficulty swallowing food or "sticking" sensation
Frequent heartburn	Abdominal Pain	Frequent constipation
Frequent Diarrhea	Rectal bleeding/black stools	Difficulty urinating/incontinence
Blood in urine	Urinating > 2 times/night	Pain in joints/bones
Unusual bruising/bleeding	Epilepsy/Seizures	Change in wart, mole, skin growth
Unwanted weight loss of 5-10lbs		

## Medical History

- I have had a previous sleep disorder evaluation
- I have had a previous overnight sleep study
- I have had a daytime nap study
- I have been prescribed a CPAP or Bi-Level PAP machine for home use
- I have had surgical treatment for a sleep disorder
- I have previously been prescribed medication for a sleep disorder
- I have previously been treated for a sleep disorder

## Past Medical History

Stroke	TIA (mini stroke)	Blackouts/Fainting
Seizures	Nasal Polyps	Deviated Septum
Hearing Impairment	Hypo/Hyper Thyroid	Reflux/Heartburn
High Blood Pressure	Congestive Heart Failure	Heart Disease
Heart Valve Disease	Cardiac Arrhythmia	Atrial Fibrillation
Cardiac Arrest	Heart Attack/MI	Pulmonary Hypertension
Blood Clots	COPD	Asthma
Emphysema	Bronchitis	Liver Disease
Hepatitis	Jaundice	Anemia
Stomach Problems	Diabetes	High Cholesterol
Colon/Bowel Problems	Kidney Disease	Back Pain
Cancer	Arthritis	Chronic Pain
Fibromyalgia	Chronic Fatigue Syndrome	Depression
Sever Anxiety	Alcoholism	Chemical Dependency of abuse

**Females:** LMP: \_\_\_\_\_ Menopausal: Age \_\_\_\_\_ How Long \_\_\_\_\_  Premenstrual Syndrome

**Males:**  Prostate Problems  Erectile Dysfunction  Impotence

## Past Surgical History

- Tonsillectomy/ Adenoidectomy  UPPP  
 Other head or neck  Cardiovascular  
 Pulmonary  Brain/Spine

List any other surgeries and their dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## Medications

Please list all medications that you take and the doses. If you have a list, please attach it.

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## Allergies

Please list ANY allergies you may have (food, medications, etc.).

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## Social History

Do you drink caffeine?  Yes  No

If Yes:	What	Amount
	Coffee	_____ cups per day/week
	Tea	_____ cups per day/week
	Soda/Pop	_____ cups per day/week
	Energy Drinks	_____ cups per day/week

Do you Smoke?  Yes  No

If Yes:	What	Amount per day	Number of Years
	Cigarettes	_____	_____
	Cigars	_____	_____
	Pipe	_____	_____

Do you use herbal/health food store remedies? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes: Name

Amount

Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____

### Exercise

1.) How many times a week do you engage in exercise activities? \_\_\_\_\_

2.) How many minutes per session? \_\_\_\_\_

3.) What are your exercise activities? \_\_\_\_\_

Please circle any conditions that limit your ability to exercise:

Shortness of Breath

Chest Pain

Balance Problems

Dizziness

Joint/Muscle Pain

Other: \_\_\_\_\_

### Nutrition

How many servings do you eat:

Per Day

Per Week

Fruits

\_\_\_\_\_

\_\_\_\_\_

Vegetables

\_\_\_\_\_

\_\_\_\_\_

Red Meat

\_\_\_\_\_

\_\_\_\_\_

Other Meat

\_\_\_\_\_

\_\_\_\_\_

Fish (any kind)

\_\_\_\_\_

\_\_\_\_\_

Salmon, Mackerel, Anchovies, Sardines, Herring

\_\_\_\_\_

\_\_\_\_\_

Carbohydrates (any kind)

\_\_\_\_\_

\_\_\_\_\_

Sweets

\_\_\_\_\_

\_\_\_\_\_

List the kinds of beverages you consume and how many ounces per day (i.e. water, soda, diet soda, etc.)

Beverage

Per Day

Amount

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any allergies to food: \_\_\_\_\_

\_\_\_\_\_

List any food you dislike: \_\_\_\_\_

\_\_\_\_\_

List any dietary supplements you use (i.e., Protein Powder, etc): \_\_\_\_\_

**Marital Status:**            Single                      Married                      Divorced                      Widowed

**Sleep Status:**            Sleep Alone                      Share a bed with someone  
                                    Share a bedroom, but have            Share a dwelling, but have separate  
                                    separate beds                      bedrooms

**Employment Status:**    Employed                      Unemployed                      Retired

**If Employed:**            Occupation: \_\_\_\_\_

Usual Work Days: \_\_\_\_\_

Usual Work Hours: \_\_\_\_\_

- My job requires I drive a vehicle
- I work with dangerous equipment or substances
- I am a shift worker on rotating shifts
- I am a permanent or long term 2nd or 3rd shift worker
- I am currently a student

Please list any "Alternative Practitioners" whom you see (i.e., Chiropractor, Acupuncturist, Alternative Medicine Doctor, etc.)

Name

Location

_____	_____
_____	_____
_____	_____

### Family History

Has any immediate family member (parents, siblings, children) had any of the following?

Yes/No

Relation

#### Sleep Problems

Sleep Apnea                      \_\_\_\_\_                      \_\_\_\_\_

Narcolepsy                      \_\_\_\_\_                      \_\_\_\_\_

Insomnia                      \_\_\_\_\_                      \_\_\_\_\_

Restless Leg                      \_\_\_\_\_                      \_\_\_\_\_

Yes/No

Relation

**Sleep Problems cont.**

Acting Out Dreams	_____	_____
Sleep talking/walking	_____	_____
Hypertension	_____	_____
Heart Disease	_____	_____
Thyroid	_____	_____
Stroke	_____	_____
Anxiety	_____	_____
Depression	_____	_____
Other:	_____	

**To be completed by NSSM Physician / PA: (Physical Exam)**

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_

Neck Circumference: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_ O2 Sat: \_\_\_\_\_

**Head/OP**

Anicteric Sclera       Icteric Sclera

Septal Deviation:       Yes     No      Nares Abnormal:       Yes     No

OP Clear               OP Exudate

Tongue:     Moist    Dry              Macroglossia:     Yes     No

Mallampati Scale: \_\_\_\_\_      Tonsils: \_\_\_\_\_/4

Dentition:     Good    Fair    Poor      Dentures:     Yes     No      Retrognathia:     Yes     No

**Neck:**

NL Size:     Large     Short

w/ Carotid Bruit       w/o Carotid Bruit     w/LAD     w/o LAD

w/ Thyromegaly     w/o Thyromegaly

**Lungs:**

CTAB                   w/Crackles               w/Wheeze     w/ Consolidation

**CV:**

Regular Rate               Tachy     Brady     Regular Rhythm     Irregular Rhythm

w/Rubs                   w/Murmurs               w/Gallops



# Northshore Sleep Medicine

## BED PARTNER QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Loud Snoring             | <input type="checkbox"/> Bedwetting                            |
| <input type="checkbox"/> Light Snoring            | <input type="checkbox"/> Sitting up in bed while still asleep  |
| <input type="checkbox"/> Twitches of legs or feet | <input type="checkbox"/> Head rocking or banging               |
| <input type="checkbox"/> Pauses in breathing      | <input type="checkbox"/> Kicking with legs                     |
| <input type="checkbox"/> Grinding teeth           | <input type="checkbox"/> Getting out of bed while still asleep |
| <input type="checkbox"/> Sleep Talking            | <input type="checkbox"/> Biting Tongue                         |
| <input type="checkbox"/> Sleepwalking             | <input type="checkbox"/> Becoming very rigid and/or shaking    |

How long have you been aware of the sleep behavior (s) that you checked above?

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Describe the behavior (s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night?

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If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud “snorts” that you may have noticed?

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# Northshore Sleep Medicine

## EPWORTH SLEEPINESS SCALE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best number for each situation:

- 0= Would never doze
- 1= Slight chance of dozing
- 2=Moderate chance of dozing
- 3=High chance of dozing

### Situation

### Chance of Dozing

Sitting and reading

\_\_\_\_\_

Watching TV

\_\_\_\_\_

Sitting inactive in a public place (e.g. a theater or meeting)

\_\_\_\_\_

Sitting as a passenger in a car, for an hour without a break

\_\_\_\_\_

Lying down to rest in the afternoon when your schedule permits it

\_\_\_\_\_

Sitting and talking to someone

\_\_\_\_\_

Sitting quietly after a lunch without alcohol

\_\_\_\_\_

Sitting in a car, while stopped for a few minutes in traffic

\_\_\_\_\_