

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: _____

RESPONSIBLE PARTY

[] Same as Patient
Name: _____
Address: _____
Address2: _____
City,State, Zip: _____

EMERGENCY CONTACTS

<i>Name</i>	<i>Relationship</i>	<i>Phone</i>
_____	_____	_____
_____	_____	_____
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
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Evanston, Illinois 60203
Tel: 847.674.3600 Cell: 773-914-4961
Fax: 847.674.3639

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

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

Patient Signature

Date

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

Patient Signature

Date

**Northshore
Sleep
Medicine**

BED PARTNER QUESTIONNAIRE

Name of Patient: _____ Date: _____

Check any of the following behaviors you have observed the patient doing while asleep:

- | | |
|--|--|
| <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"/> Twitching 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?

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.

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.

Name: _____

Date: _____

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EPWORTH SLEEPINESS SCALE

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	_____

Reference: Johns, MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991; 14:540-5.

**Northshore Sleep Medicine
History and Physical**

Patient Name: _____ Date: _____ Phone #: _____

Sex: ___ Age: _____ DOB: _____ Insurance: _____

Email: _____

Referring Physician: _____ Location/Phone #: _____

Family Physician: _____ Location/Phone #: _____

Please complete the following form by filling in the blanks and circling appropriate responses

My main sleep complaint(s) are:

- Trouble sleeping at night For how many months/years? _____
- Feeling tired/sleepy all day For how many months/years? _____
- Snoring For how many months/years? _____
- Restless Legs Syndrome For how many months/years? _____
- Unwanted behaviors during sleep (explain) _____
- Other, please explain _____

<p>To be completed by physician: <u>Chief Complaint</u></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

Sleep Pattern

	<u>Work Days/Weekdays</u>	<u>Off Days/Weekends</u>
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 <u>Work Days/Weekdays</u>	_____ am/pm <u>Off Days/Weekends</u>
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.

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 > 5-10 lbs		

Medical History

Past Sleep Evaluation and Treatment

- 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

Please circle any of the following conditions that you have or have been treated for in the past:

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
Severe anxiety	Alcoholism	Chemical dependency or 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.

Allergies

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

Social History

Do you drink caffeine?

Yes No

If yes:

What

Amount

Coffee _____ cups per day/week

Tea _____ cups per day/week

Soda/Pop _____ cans/bottles per day/week

Energy drinks _____ per day/week

Do you smoke? Yes No
If yes: What Amount per day Number of years

Cigarettes _____
 Cigars _____
 Pipe _____

Do you drink? Yes No
If yes: What Amount Frequency

Beer _____ daily/weekly/
 monthly

Wine _____ daily/weekly/
 monthly

Liquor _____ daily/weekly/
 monthly

Do you use illegal drugs? Yes No
If yes: What type? Amount Frequency

Cocaine _____
 Marijuana _____
 Heroin _____
 Ecstasy _____
 Other _____

Do you use herbal/health food store remedies? Yes No
If yes: Name Amount Frequency

Marital status Single Married Divorced Widowed

Sleep status Sleep alone Share a bed with someone
 Share a bedroom, but have separate beds

Share a dwelling, but have separate 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

Family History

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

<u>Yes/No</u>	<u>Relation</u>
<u>Sleep Problems</u>	
Sleep apnea _____	_____
Narcolepsy _____	_____
Insomnia _____	_____
Restless legs _____	_____
Acting out dreams _____	_____
Sleep talking/ walking _____	_____
<u>General</u>	
Cancer _____	_____
Diabetes _____	_____

Abdomen

- Soft Firm Non-tender Tender Distended
- Non-distended NL bowel sounds Hypoactive bowel sounds
- Hyperactive bowel sounds

Extremities

- Warm Cool Well perfused Cyanosis
- Clubbing Edema

Neuro Exam

- Alert Oriented x ____ Verbal Non-verbal
- Ambulatory Non-ambulatory Focal Strength ____/5
- Bradykinesia Gait _____

Assessment and Plan

- OSA explained Insomnia explained RLS/PLMD explained
- Narcolepsy explained RBD explained Cautioned against drowsy driving
- Cautioned against heavy sedation CPAP therapy explained
- PSG ordered PSG followed by MSLT

Completing physician _____

Date _____