UT Sleep Disorders Center

PATIENT INFORMATION SHEET
Please print clearly and fill out completely

place label here

Accredited by the American Academy of Sleep Medicine

Name of Patient: _____ Birth Date: _____ Age: _____

Mailing Address: _____

_____
City State Zip

- ❑ Child (under 18)
- ❑ Single Adult
- ❑ Married
- ❑ Widowed
- ❑ Divorced
- ❑ Separated

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Sex: ❑ Male ❑ Female

Employer's Name: _____ Occupation: _____

Employer's Address: _____ Phone: _____

Spouse / Parent if patient a minor: _____ DOB: _____

SSN# of Parent if patient a minor: _____

Employer: _____

Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Who referred you to our office? _____

Have you ever been treated for sleep issues before? ❑ Yes ❑ No If yes, please bring copies of your previous sleep records with you.

Are you allergic to any medications? ❑ Yes ❑ No List: _____

Is there a chance you may be pregnant? ❑ Yes ❑ No

I authorize this physician to release any information acquired in the course of my examination or treatment to my insurance carriers(s). I hereby authorize payment directed to my physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services. I recognize that my charges will be divided between the physician and UT Hospital. My insurance will be billed by both parties.
I RECOGNIZE AND ACCEPT RESPONSIBILITY FOR ANY BALANCE OR FEE NOT COVERED AND OR ANY COST OF COLLECTION.

Signed: _____ Date: _____

UT SLEEP Center
Insomnia / Apnea Questionnaire

Date _____ Patient Name _____ Age _____

Name of Doctor that sent you here _____

Send copy of records to doctor(s) _____

MEDICATIONS: Please list all medication you are taking now.

Medication	Reason Taken	Strength	How Often

Are you currently on oxygen at home? Yes ❑ No ❑

ALLERGIES: List all drug allergies.

Medicine	Type of Reaction

SURGERY / HOSPITALIZATIONS:

Year	Reason

ADULT ILLNESSES:

- ❑ Pneumonia
- ❑ Heart Palpitations
- ❑ Bronchitis
- ❑ Asthma Pleurisy
- ❑ Phlebitis/Blood clot in lung
- ❑ Stroke
- ❑ Rheumatic Fever
- ❑ Heart Murmur
- ❑ Heart Failure
- ❑ Angina / Chest Pain
- ❑ High Blood Pressure
- ❑ Gall Stones
- ❑ Diabetes (sugar)
- ❑ Thyroid Disease
- ❑ Cancer
- ❑ Arthritis
- ❑ Anemia
- ❑ Stomach Ulcers
- ❑ Hay Fever / Allergies
- ❑ Emphysema
- ❑ Liver Disease
- ❑ Kidney Stones
- ❑ Epilepsy
- ❑ Depression/Nerve
- ❑ Tuberculosis
- ❑ Gout
- ❑ Colitis

TOBACCO: Have you ever used tobacco? ❑ Yes ❑ No

❑ Cigarettes ❑ Cigars ❑ Pipe ❑ Smokeless tobacco (snuff)
If you smoked, how many years? _____ How many packs a day? _____
Are you still smoking? ❑ Yes ❑ No If not when did you quit? _____

ALCOHOL: ❑ Beer ❑ Liquor ❑ Wine
❑ Socially ❑ To excess on Occasion ❑ Dailey
❑ Previous/current alcohol addiction

OCCUPATION: Please list all occupations beginning with your current job.
1. _____ 3. _____
2. _____ 4. _____

SOCIAL HISTORY: ❑ Single ❑ Married ❑ Widow(er) ❑ Divorced
EDUCATION: ❑ Grade School ❑ High School ❑ College

FAMILY HISTORY: Please fill in all history information living or deceased. If deceased, give cause of death

Father: age _____			Health _____	Cause of Death _____
Mother: age _____			Health _____	Cause of Death _____
Brother/Sister: age: _____	Sex _____		Health _____	Cause of Death _____
Brother/Sister: age: _____	Sex _____		Health _____	Cause of Death _____
Son/Daughter: age: _____	Sex _____		Health _____	Cause of Death _____
Son/Daughter: age: _____	Sex _____		Health _____	Cause of Death _____

Have any BLOOD relatives ever had: (please circle all that apply)

❑ Asthma	❑ Bronchitis	❑ High Blood Pressure	❑ Cancer	❑ Epilepsy
❑ Emphysema	❑ Tuberculosis	❑ Stroke	❑ Diabetes	❑ Other

PERSONAL HISTORY: Please check all health problems you have.

GENERAL:
❑ Weight gain in the past year?
How much? _____
❑ Weight loss in the past year?
How much? _____
❑ Fever
❑ Chills
❑ Poor appetite
❑ Sleep poorly

EYES
❑ Decreased vision
❑ Glasses / contacts
❑ Pain in eyes

EARS,NOSE,MOUTH & THROAT
❑ Earaches
❑ Ringing in ears
❑ Loss of hearing
❑ Sinus problems
❑ Nose congested or runny

HEART/VASCULAR:
❑ Heart Murmur
❑ Fast, irregular or pounding heart beat
(Circle which one)
❑ Swelling in legs/ankles
❑ Waking up at night short of breath
❑ Need to sleep on more than one pillow

RESPIRATORY
❑ Chest Pain
❑ Frequent cough
❑ Wheezing
❑ Coughing up sputum
❑ Coughing up blood
❑ Shortness of breath at rest
❑ Short of breath walking on level ground
❑ Short of breath walking up hill/steps

GASTROINTESTINAL
❑ Frequent heartburn
❑ Frequent indigestion

GENITOURINARY:
❑ Painful urination
❑ Blood in urine
❑ Frequent urination
❑ Discharge (penile/vaginal)
❑ Difficulty starting or
emptying bladder

FOR WOMEN ONLY:
❑ Irregular periods
❑ Bleeding between periods
❑ Date of last period _____

MUSCULOSKELETAL
❑ Painful joints
❑ Swollen /red joints
❑ Back pain
❑ Sore muscles

SKIN & BREASTS
❑ Rash
❑ Growing/changing mole

❑ Postnasal drainage ❑ Nausea

Continued:

EARS, NOSE, MOUTH & THROAT
❑ Frequent sneezing
❑ Recurrent sore throat
❑ Persistent hoarseness
❑ Dental problems

GASTROINTESTINAL
❑ Diarrhea
❑ Constipation
❑ Abdominal pain
❑ Blood in stool
❑ Difficulty swallowing

SKIN & BREASTS
❑ Lump in breast
❑ Nipple discharge

NEUROPSYCHIATRIC:
❑ Frequent or severe headaches
❑ Dizziness
❑ Passing out/fainting
❑ Tingling in hands or feet
❑ Loss of feeling in hands or feet

PSYCHIATRIC:
❑ Depression If checked, have you ever been in deep depression? ❑ Yes ❑ No
❑ Nervousness

ENDOCRINE:
Have you ever been on any steroid (prednisone, decadron, medrol) tablets or injections within the past year?
❑ Yes ❑ No

HEMATOLOGICAL / LYMPHATIC:
❑ Easily bruised
❑ Abnormal bleeding
❑ Swollen lymph glands

ALLERGIC/IMMUNOLOGIC
Have you had allergy testing (skin pricks) done? ❑ Yes ❑ No
If so, did you test positive for allergies? ❑ Yes ❑ No
If yes, what allergies did you test positive for?_____
Are any allergy problems you have worse with certain seasons of the year? ❑ Yes ❑ No
If so, which season's _____
If you have not had allergy testing, please list anything that makes your symptoms worse. (dust, animals etc.

_____
Do you have any pets inside the home? ❑ Yes ❑ No

Please complete these questions on insomnia and apnea. Some questions are either yes or no, and some need written answers. The more information that is given, the more complete your evaluation will be. The physician will go over the answers with you. We look forward to being able to evaluate your problem and to provide you with therapeutic treatment. Thank you.

Briefly describe the reason you are here, or the main problem you are having:

_____
_____
_____
_____
_____

When was the first time this problem began? _____ years ago

List any medicine or tablets that you take to help you sleep. Tell us what time you take them.

MEDICATIONS	DOSE	TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____

Tell us if you do anything below to help you sleep:

Snack	❑ Yes	❑ No	How Often _____
Bath	❑ Yes	❑ No	_____
Reading	❑ Yes	❑ No	_____
Exercise	❑ Yes	❑ No	_____
Relaxation Exercises	❑ Yes	❑ No	_____
Counting	❑ Yes	❑ No	_____
Lying still	❑ Yes	❑ No	_____

Other _____
_____

Do you do any of the follow in bed at night?

Read	❑ Yes	❑ No
Watch TV	❑ Yes	❑ No
Listen to Radio	❑ Yes	❑ No

Other _____

Do you sleep alone? ❑ Yes ❑ No
If no, whom do you sleep with? _____

Do you sleep on your: ❑ Left Side ❑ Right Side ❑ Back

What time do you usually turn out the bedroom light _____ pm/am

Are you bothered by noises at night? ❑ Yes ❑ No
If so, please explain: _____

Do you use anything listed below to help you sleep?

White noise machine	❑ Yes	❑ No
Ear Plugs	❑ Yes	❑ No
Other	❑ Yes	❑ No

How long does it usually take you to get to sleep? _____ hours _____ minutes

When you are in bed awake, what do you think about?

Trying to fall asleep	❑ Yes	❑ No
Family matters	❑ Yes	❑ No
Work	❑ Yes	❑ No
Other (please explain)	❑ Yes	❑ No

Do you get annoyed/angry when you can't sleep? ❑ Yes ❑ No

When you can't sleep, do you get out of bed? ❑ Yes ❑ No

If so, how long after you got into bed? _____ hours _____ minutes

If you get out of bed what do you do? _____

How long are you up for?	_____ hours _____ minutes
When you return to bed how long does it take you to fall asleep again?	_____ hours _____ minutes
If you do not get out of bed, how long does it take you to fall asleep again?	_____ hours _____ minutes
Once you have fallen asleep, how long do you sleep for?	_____ hours _____ minutes
Do you wake up during the night?	❑ Yes ❑ No
If so, on average, how long are you awake?	_____ hours _____ minutes
How often do you wake up during the night?	_____ times
What time do you finally wake up?	_____ am/pm
What time do you get out of bed?	_____ am/pm

How do you feel when you wake up? _____

If you didn't sleep well, how does it affect you the next day? _____

Do you feel sleepy during the day?	❑ Yes	❑ No
Do you nap during the day?	❑ Yes	❑ No
If so, How often and for how long?	_____ hours _____ minutes	
What time during the day do you take a nap?	_____ am/pm	
If you don't take a nap, what time of day do you feel most tired?	_____ am/pm	
What time of the day do you feel the most alert	_____ am/pm	
As your bed time approaches, do you become more alert?	❑ Yes	❑ No
Do you worry during the d about the next night's sleep?	❑ Yes	❑ No

Does a poor nights sleep make you:

Depressed	❑ Yes	❑ No
Nervous	❑ Yes	❑ No
Irritable	❑ Yes	❑ No
Tired	❑ Yes	❑ No

Does a poor nights sleep affect your:

Concentration	❑ Yes	❑ No
Memory	❑ Yes	❑ No
Ability to work	❑ Yes	❑ No

Are you awake during the night because another person or an animal requires assistance? ❑ Yes ❑ No

Do you toss and turn in bed?	❑ Yes	❑ No	
Are you restless in bed?	❑ Yes	❑ No	
Before you fall asleep do your legs feel achy?	❑ Yes	❑ No	
Do you have to move them around in bed?	❑ Yes	❑ No	
Do you have to get out of bed and walk around to ease your aching legs?	❑ Yes	❑ No	
Do you get cramping in your calves	❑ Yes	❑ No	
When you sleep, do your legs jerk?	❑ Yes	❑ No	❑ don't know
Do you have nightmares?	❑ Yes	❑ No	
If so, when did they begin?	_____ years ago		
How often do they occur?	_____ times per month		

Please explain what your nightmares are about _____

_____

_____

Do you have night terrors? ❑ Yes ❑ No ❑ Don't know
If so, how often? _____ times per month
Do you sleep walk? ❑ Yes ❑ No

Have you ever "come to" and found out you have done something complicated (like driving a care) without remembering it? ❑ Yes ❑ No

Do you sometimes have illusions that something is happing that really isn't? ❑ Yes ❑ No

Do you have hallucinations or feel like you are dreaming during the day? ❑ Yes ❑ No

Do you suddenly feel weak or paralyzed during the day when you laugh, get angry or have other emotional situations? ❑ Yes ❑ No

Do you snore? ❑ Yes ❑ No
If so, how loud? ❑ Loud ❑ Kind of Loud ❑ Very Loud
Do you have problems breathing at night? ❑ Yes ❑ No
If so, please explain: _____

_____

_____

Does your heart beat fast at night? ❑ Yes ❑ No
If so please explain: _____

_____

Do you drink caffeinated drinks? ❑ Yes ❑ No
If so, what type? _____ How much? _____ How often? _____

Do you have regular meal times? ❑ Yes ❑ No
If not, please explain _____

_____

Do you eat a balanced diet? ❑ Yes ❑ No
If not, please explain _____

_____

When was the last time you were able to sleep without any problems? _____ years/months ago

What time would you like to fall asleep at now? _____ am/pm
What time would you like to wake up in the morning? _____ am/pm
How long do you think normal people of your age sleep? _____ am/pm
Do you think your sleep problem is: ❑ Mild ❑ Moderate ❑ Severe

Please tell us any other comments about your sleep problem that you think we need to know about?

_____

_____

_____

_____

_____

Please list all of the people you have seen about your sleep problem, and tell us what they did.

Date	**Name**	**Treatment**

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situation, in contrast to feeling "just tired"? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Situation	Never Doze (0)	Slight Chance (1)	Moderate Chance (2)	High Chance (3)
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. theater, meeting)				
As a passenger in a car for a hour without a break				
Lying down to rest in the afternoon when able				
Sitting and talking with someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				

Epworth Sleepiness Scale 199 14(6):540-S

If you are currently using a CPAP / BiPAP machine, please fill out the following.
If not using a machine, please go to next page.

How long have you been on CPAP? _____ Do you like using it? ❑ No ❑ Yes

Do you use your CPAP/BiPAP nightly? ❑ No ❑ Yes How many hours do you wear it? _____

How many hours per night are you in bed? _____ How many hours are you asleep? _____

Are you feeling better than before you started treatment? ❑ No ❑ Yes

Do you exercise? ❑ No ❑ Yes How many days per week? _____

Which homecare company provided you with your equipment? _____

Has the company provided efficient / courteous service? ❑ No ❑ Yes

Has the company been available to help you with problems? ❑ No ❑ Yes

Any further comments? _____

_____

_____

BED PARTNER QUESTIONAIRE

Date: _____

Patient: _____

Informant: _____

Does he/she snore? ❑ Yes ❑ No
If snores ❑ Softly ❑ Loudly ❑ Frequently ❑ Rarely ❑ Only while on back
❑ All positions

Does he/she gasp? ❑ Yes ❑ No

Does he/she stop breathing ❑ Yes ❑ No
If yes ❑ Rarely ❑ Frequently

Does he/she move much during sleep?	❑ Yes		❑ No
Arms	❑ Sometimes	❑ Much of night	❑ All night
Legs	❑ Sometimes	❑ Much of night	❑ All night
Entire Body	❑ Sometimes	❑ Much of night	❑ All night

What position does he/she sleep in? ❑ Back ❑ Side ❑ Stomach

Does he/she have nightmares?	❑ Yes	❑ No
Does he/she act out dreams	❑ Yes	❑ No
Does he/she sleepwalk?	❑ Yes	❑ No
Does he/she sleep talk?	❑ Yes	❑ No

Please describe any of the above in more detail if you want.

_____
_____
_____
_____
_____

Please describe anything else that is unusual about his/her sleep.

_____
_____
_____
_____
_____

Revised: 02/17/11

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Records Release to Sleep Disorders Clinic

To: UT Sleep Disorders Clinic
1928 Alcoa Highway, Suite 119
Knoxville, TN 37920
865-305-8761 Fax: 865-305-9869

Date: _____

I authorize you to receive records from:

_____

_____

_____

_____

Please send any information, including the diagnosis and records of any treatment or examination rendered to me (Complete Records) unless indicated.

Patient Name: _____

Address: _____

_____

_____

Date of Birth: _____

SSN#: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Revised: 06/25/09

Medical Building B, Suite 119
1928 Alcoa Highway
Knoxville, TN 37920
865.305.8761
FAX: 865.305.9869

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Patient Privacy Questionnaire

Patient's Name: _____

1. May we leave confidential messages with anyone answering the telephone at your home? ❑ No ❑ Yes

2. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home answering machine or voicemail? ❑ No ❑ Yes

3. May we leave confidential messages with anyone answering the telephone regarding appointments, lab results or other healthcare information at numbers other than your home number? ❑ No ❑ Yes
   If yes, please list numbers: (____) _____-_____; (_____) _____-_____

4. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment? ❑ No ❑ Yes

If we are unable to reach you by any other means, we will send information through the U.S. Postal Services to your home address.

A copy of the University Health System Inc. (UHS) Notice of Information Practices has been made available to me. I understand that this Notice describes how my health information may be used or disclosed by UHS and physicians and other providers practicing at UHS and that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (865) 305-9118 or on the website at www.utmck.edu, or by requesting one at the UHS office.

_____ _____

Signature of Patient (or guardian if under age 18) Date