



Account # \_\_\_\_\_

# PATIENT REGISTRATION

**Please answer all questions completely.**

**PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

Date \_\_\_\_\_

New

Update

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  
Last First Middle  Female

Home Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Cell (\_\_\_\_) \_\_\_\_\_

Patient's Soc. Sec. # \_\_\_\_\_

Driver License No/State \_\_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_ Referring Physician? \_\_\_\_\_

PATIENT'S E-MAIL ADDRESS \_\_\_\_\_

<b>Race</b>	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian
	<input type="checkbox"/> American Indian	<input type="checkbox"/> Native Hawaiian or Other Pacific	
	<input type="checkbox"/> Decline to State		

<b>Ethnicity</b>	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
	<input type="checkbox"/> Decline to State	

<b>Primary Language Spoken</b>	_____
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## Financially Responsible Party (subscriber info)

**If other than self** \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Number Street City

**Patient's Primary Insurance** \_\_\_\_\_ **Subscriber's Social Security #** \_\_\_\_\_

**Subscriber ID #** \_\_\_\_\_ **Subscriber's Group ID#** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Patient's Secondary Insurance** \_\_\_\_\_ **Subscriber's Social Security #** \_\_\_\_\_

**Subscriber ID #** \_\_\_\_\_ **Subscriber's Group ID#** \_\_\_\_\_ **DOB** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Subscriber to Secondary Insurance** \_\_\_\_\_ **Relationship to Patient** \_\_\_\_\_

**Emergency contact** \_\_\_\_\_ Relationship \_\_\_\_\_  
Last Name First Middle

Please check box if authorized to release appointment/medical information.

Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Number Street City

I have read and understand all of the above and hereby give my consent for medical treatment.

I understand that I am responsible for my bill.

I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

**Patient's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011  
31515 Rancho Pueblo Road Ste.104, Temecula, CA 92592  
1955 Citracado Pkwy, Suite 102, Escondido, CA 92029  
9850 Genesee Avenue, Suite 530, La Jolla, CA 92037  
15611 Pomerado Road, Suite 505, Poway, CA 92064  
(P) 760-631-3000 (F) 760-631-3016  
www.neurocenter.com

## Welcome to The Neurology Center

### STATEMENT OF FINANCIAL POLICY

**This facility** will bill your insurance and receive payment directly from them. Any services that your insurance will not cover are your responsibility. If for any reason you are not able to pay your co-payment at the time of service an additional \$15.00 will be added to your statement.

**If you have HMO insurance, it requires authorization** for any treatment in our office. If this authorization has not been obtained before your visit, you will be required to sign a financial waiver. You will be expected to pay for all charges incurred, and if your insurance subsequently authorizes the services, your payment will be refunded upon receipt of insurance payment.

**If we are not a participating provider** for your insurance plan, we will bill your insurance as a courtesy, if you have provided us with complete information to do so.

**If you do not have insurance**, payment is expected at the time of service. We accept Visa, MasterCard and American Express for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

**If you need our doctor to complete forms such as disability or Department of Motor Vehicles, there will be a \$35 fee per form to be completed. *\*\* Form fee may vary \*\****

**Statements are mailed monthly** to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 631-3020 to make payment arrangements.

**New patients: A 24-hour advanced notice is required if you must cancel or change your appointment.** If you miss your initial appointment without notifying our office, we will notify your referring provider and make an attempt to schedule another appointment. If a second appointment is missed with no notification, we will ask that you be referred to another provider.

**For established patients** who miss an appointment without giving a 24-hour advanced notice, there is a \$75.00 charge for general office visits, and a \$200.00 charge for all missed diagnostic testing or study appointments. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen may be accommodated. Please help us better serve you by notifying us as soon as possible if you must change or cancel your appointment.**

### LAB TEST, CAT SCANS, MRI'S, ETC:

When referred to an outside facility, please contact your insurance to ensure it is a contracted facility, in orders to keep your costs down. ***Ultimately, it is your responsibility to know your insurance plan benefits.***

**\*\*\*Please note that our office does not call patients with normal test results. All normal test results will be reviewed during follow up office visit. If you wish to get your results prior to your next appointment please call our office at 760-631-3000 option 4. \*\*\***

### Prescription Refills:

6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011  
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(P) 760-631-3000 (F) 760-631-3016  
[www.neurocenter.com](http://www.neurocenter.com)

Please call your pharmacy for prescription refills, at least 4 to 5 days before you run out of medication. Our doctors cannot authorize refills after office hours or on weekends, as they cannot access your medical records. Refills requested after hours will be reviewed for refill, on the next business day, and may take up to 48 hours to fill. Refills can take up to 4 days if we have to request authorization from your insurance as we have to wait for the approval before we can call pharmacy.

**We provide medical records to other medical providers.**

**The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) with your Primary Care Physician and/or the Provider or entity that referred you to The Neurology Center.**

**HIPAA Notice of Privacy Practices – Acknowledgement of Receipt and Consent to Disclosure  
14712**

The Neurology Center of Southern California participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants with the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. UCSD also has its own Notice of Privacy Practices that can be access at <http://health.ucsd.edu/hipaa/Pages/hipaa.aspx>.

The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals.”

**I have read and understand The Neurology Center’s financial and claims filing policies.  
I have read and understand all of the above and hereby give my consent for medical treatment.**

**I understand that I am responsible for my bill and consent to having my insurance payor billed.**

**I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.**

**Patient’s  
Signature** \_\_\_\_\_

**Responsible Parties Signature (if other than patient)**  
\_\_\_\_\_

**Thank you for choosing The Neurology Center!**



Account # \_\_\_\_\_

## PERMISSION TO FURNISH MY MEDICAL INFORMATION

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

### 1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

I hereby give my consent to The Neurology Center to furnish medical information about me (e.g., blood test results, other test results, doctor’s instructions, etc.) in the event I am not immediately available.

Approved Person(s)

Relationship to Patient

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

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

- I hereby authorize The Neurology Center to disclose medical information in the purpose to contact me with routine results and to remind me of my future appointments. You may email, send text messages and or leave this information on my answering machine.
- I hereby instruct The Neurology Center to furnish information **only** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- Other special instructions regarding furnishing my medical information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Designated Power of Attorney

### 2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

I understand that The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) about me with my Primary Care Physician and/or the Provider or entity that referred me to The Neurology Center.

**In addition, I hereby give my consent to The Neurology Center to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)**

Providers Name

Phone Number

City

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

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

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Designated Power of Attorney

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**NEW PATIENT HISTORY**

**Name** \_\_\_\_\_ **Birthdate** \_\_\_\_\_ **Date** \_\_\_\_\_

Age: \_\_\_\_\_ I am:  Right-Handed  Left-Handed  Ambidextrous

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

What is your primary language spoken? \_\_\_\_\_

How do you prefer to receive information about your diagnosis? \_\_\_ Verbal \_\_\_ Written \_\_\_ Pictures

**Chief Complaint**

Please list the main problems, which bring you to the doctor

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Please describe the problems:

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

**Review of Symptoms**

Check boxes if you are having any of these symptoms; write in details:

**Constitutional**

- Chills
- Fatigue
- Changes in Weight

**Eyes**

- Double vision
- Eye Pain
- Blurred vision

**Ears, Nose, and throat**

- Hearing loss
- Ringing
- Dizziness
- Sore throat

**Cardiovascular**

- Ankle swelling
- Night sweats
- Chest Pain or Pressure
- Skipped beats
- Blackouts

**Respiratory**

- Cough
- Shortness of breath
- Hyperventilation

**Gastrointestinal**

- Abdominal Pain
- Appetite loss
- Blood in stool
- Constipation
- Diarrhea
- Nausea
- Vomiting

**Hematologic/Lymphatic**

- Easy bruising or bleeding
- Anemia

**Musculoskeletal**

- Joint stiffness
- Joint swelling
- Joint Limitation
- Joint pain
- Neck pain
- Back pain

**Genitourinary**

- Blood in urine
- Burning with urination
- Hesitancy
- Nighttime frequency
- Difficulty with urination

**Skin/Breast**

- Rashes
- Nipple discharge

**Endocrine**

- Intolerant of heat or cold
- Excessive urination
- Excessive hunger
- Increased thirst

**Allergic/Immunologic**

- Allergies to medication, Iodine, shellfish,

**Neurological**

- Difficulty with speech
- Impaired memory
- Confusion
- Headaches
- Seizures
- Blackouts
- Fainting
- Trouble swallowing
- Arm pain
- Leg pain
- Weakness or paralysis
- Tremors
- Incoordination
- Uncontrolled movements
- Stroke
- Imbalance
- Numbness
- Tingling

**Psychiatric**

- Mood swings
- Depression
- Anxiety
- Memory
- Hallucinations

Current height \_\_\_\_\_

Current weight \_\_\_\_\_

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

**Past Medical History**

Check if you have had any of these problems. Give details.

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Heart Disease                  |
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> High Blood Pressure            |
| <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> High Cholesterol               |
| <input type="checkbox"/> Blindness, part or full    | <input type="checkbox"/> Headache                       |
| <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Multiple Sclerosis             |
| <input type="checkbox"/> Concussion                 | <input type="checkbox"/> Myopathy or Muscular Dystrophy |
| <input type="checkbox"/> COPD                       | <input type="checkbox"/> Neuropathy                     |
| <input type="checkbox"/> Double vision              | <input type="checkbox"/> Parkinson's Disease            |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Seizure (Epilepsy)             |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Stroke                         |
| <input type="checkbox"/> Diabetes                   |   |
| <input type="checkbox"/> Dementia                   | <input type="checkbox"/> Substance Abuse Disorder       |
| <input type="checkbox"/> Fibromyalgia               | <input type="checkbox"/> _____                          |
|   | <input type="checkbox"/> _____                          |

**Allergies:**

Please list any allergies to medications \_\_\_\_\_

Are you allergic to X-ray dye? \_\_\_\_\_

Are you allergic to shellfish? \_\_\_\_\_

**Medications** – Please list all the medications you are currently taking. Include aspirin, birth control pills, hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	Dosage	How often taken?	For how long have you taken it?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

**Surgical Procedures** – List chronologically

Operations	Hospital & City	Date
1.		
2.		
3.		

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

**Other Hospitalizations or Other Medical Problems**

1.	
2.	
3.	
4.	

**Have you had any of these tests? Give details.**

- Angiogram of the brain
- EEG (brain wave test)
- EMG (nerve-muscle test)
- CAT scan
- Magnetic Resonance Imaging (MRI)

**Social History**

Your place of birth: \_\_\_\_\_

Marital Status:       Married       Single       Divorced       Widowed

Education Completed: (YEARS)       9       10       11       12       13       14       15       16       16+

Occupation: \_\_\_\_\_

Do you exercise regularly?     Yes     No, if so, what do you do? \_\_\_\_\_

**Habits**

Check any of the following that you have used and state amount:

- Caffeine    How much per day? \_\_\_\_\_
- Alcohol    How much per day? \_\_\_\_\_
- Tobacco    How much per day? \_\_\_\_\_

**Family History**

Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father):

- |   |                     |
|---|---------------------|
| Check if positive                       | <b>Relationship</b> |
| <input type="checkbox"/> Alcoholism     | _____               |
| <input type="checkbox"/> Cancer         | _____               |
| <input type="checkbox"/> Diabetes       | _____               |
| <input type="checkbox"/> Heart Disease  | _____               |
| <input type="checkbox"/> Mental Illness | _____               |
| <input type="checkbox"/> Migraine       | _____               |
| <input type="checkbox"/> Seizures       | _____               |
| <input type="checkbox"/> Stroke         | _____               |
| <input type="checkbox"/> Tuberculosis   | _____               |

Are there any other diseases that run in the family? \_\_\_\_\_

Did you need any assistance filling out this form?         Y         N

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



# Sleep Survey

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you snore? Yes \_\_\_\_ No \_\_\_\_

Do you feel tired, fatigued, or sleepy during the day? Yes \_\_\_\_ No \_\_\_\_

Has anyone observed you stop breathing while you sleep? Yes \_\_\_\_ No \_\_\_\_

Do you nap during the day? Yes \_\_\_\_ No \_\_\_\_

---

## Do you have any of the following?

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| <b>Heart Disease</b>                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>History of Stroke</b>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>High Blood Pressure</b>                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Depression</b>                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Morning Headaches</b>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Trouble with Memory Or Concentration</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

<b>Sleep Orders For Office Use Only</b>	
<input type="checkbox"/>	<b>Sleep Consult</b>
<input type="checkbox"/>	<b>PSG</b>
<input type="checkbox"/>	<b>CPAP Titration Study</b>

---

**Physician Signature**

# Pain Survey

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

If you suffer from chronic pain, are you interested in seeing our interventional spine and pain specialist to learn about non-opioid medication treatments?    Yes \_\_\_\_\_ No \_\_\_\_\_

If so, where is the location of your pain? \_\_\_\_\_



Was a pain consult ordered?    Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

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

**FOR HEADACHE/MIGRAINE PATIENTS ONLY**  
**PLEASE STOP HERE IF YOU ARE NOT BEING SEEN FOR HEADACHES/MIGRAINES**

**HEADACHE HISTORY AND PROFILE QUESTIONNAIRE**

1. When did you first start having any kind of headache? \_\_\_\_\_
2. How frequent were your headaches initially? \_\_\_\_\_
3. When did you first start having any kind of severe headache? \_\_\_\_\_
4. How many headaches of any kind do you experience on average per month in the last year? \_\_\_\_\_
5. How long have they been this frequent? \_\_\_\_\_
6. On average how many days a month are you completely headache **FREE (no pain)**? \_\_\_\_\_
7. On average how many moderate to severe headaches do you experience per month? \_\_\_\_\_
8. How long do your moderate to severe headaches typically last? (Circle)  
No more than: Minutes   3 hours   4 hours   24 hours   2days   1 week or longer
8. How painful are your headaches? (1 is mild and 10 is severe and disabling) (Circle)  
1      2      3      4      5      6      7      8      9      10
9. Where are your headache typically located? (Check all that apply)  

Behind the eye	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Temple	<input type="checkbox"/> Right	<input type="checkbox"/> Left
Forehead	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Side of the head	<input type="checkbox"/> Right	<input type="checkbox"/> Left
Back of head	<input type="checkbox"/> Right	<input type="checkbox"/> Left	Neck	<input type="checkbox"/> Right	<input type="checkbox"/> Left
Whole head	_____				
10. How would you describe your headache character?  
Throbbing   Stabbing   Pressure   Burning   Tightness   Dull   Sharp   Other
11. Do any of the following symptoms occur before or during your headaches? (Circle all that apply)  
Nausea   Vomiting   Sensitive to light   Sensitive to noise   Sensitive to smell  
Blurred or Double vision   Loss of vision   Flashing, sparkling, colored lights in eyes  
Eye lid droop   Eye tearing   Dizziness   Difficulty concentrating  
Speech difficulty   Numbness/tingling   Weakness of face, arm or leg  
Other \_\_\_\_\_
12. Do any of the following trigger your headache or make them worse? (Circle all that apply)  
Exercise   Increased stress   Lack of sleep   Weather change/Storm   Bright light   Loud noise  
Fatigue   Missing a meal   Strenuous activity   Certain smells or perfume   Coughing/sneezing  
Bending over   Sexual activity   Dehydration   Eye strain   Caffeine/Lack of Caffeine   Alcohol:  
wine, beer, or liquor  
Foods: chocolate, cheese, MSG, gluten or other \_\_\_\_\_

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

**HEADACHE HISTORY AND PROFILE QUESTIONNAIRE**

13. If you are female, did or do your headaches change with the following? (Circle all that apply)  
Menstrual cycle      Birth control      Pregnancy      Menopause      Other hormonal medications

14. Do your headaches ever awaken you in the middle of the night or present upon awakening in the morning?  
(Circle)  
Night:              Occasionally              Often  
Morning:            Occasionally              Often

15. Do any of your family members have headaches? No Yes If yes, who? \_\_\_\_\_

16. Do you have a history of:  
Anxiety    Depression    Trouble sleeping    Irritable Bowel Syndrome    Fibromyalgia    Chronic  
Fatigue    Seizure Disorder    Bipolar Disorder    Restless Leg Syndrome

17. List the testing you have had for your headaches (MRI, CT, spinal puncture): If yes, please provide the facility name:

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

18. How many days a week do you use medication for acute treatment of headache (prescription or over the counter)? \_\_\_\_\_

19. Which medication(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. How long have you been using that amount of medication for acute treatment? \_\_\_\_\_

21. How many times in the **last year** did you go to the ER because of headaches?  
0    1-2    3-4    5+

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

## HEADACHE HISTORY AND PROFILE QUESTIONNAIRE

### Medications you have tried

ABORTIVE AGENTS	PROPHYLACTIC AGENTS
<b>Over the counter</b>	<b>Anti-Depressants</b>
Ibuprofen                                      Aleve – naproxen	Elavil- amitriptyline
Excedrin    Tylenol	Pamelor- nortriptyline
BC Powder	Vivactil- protriptyline
	Prozac- fluoxetine
<b>Triptans</b>	Paxil- paroxetine
Imitrex- sumatriptan (pill, nasal spray, or injection)	Effexor- Venlafaxine
Treximet – Imitrex/naproxen	Cymbalta - Duloxetine
Maxalt- rizatriptan	<b>Seizure Medications</b>
Relpax- eletriptan	Topamax- topiramate
Zomig- zolmitriptan (pill or nasal spray)	Zonegran- zonisamide
Axert- almotriptan	Depakote- divalproex or valproic acid
Amerge- naratriptan	Neurontin- gabapentin
Frova- frovatriptan	Lamictal- lamotrigine
	Lyrica- pregablin
<b>Other Pain Relievers</b>	
Fioricet- butalibital/acetaminophen/caffeine	<b>Blood pressure medication</b>
Fiorial- butalibital/aspirin/caffeine	Inderal- propranolol
DHE- dihydroergotoamine	Verapamil
Midrin	Atacand-candesartan
	Atenolol, metoprolol, nadolol, timolol
<b>Narcotics</b>	
Norco, Lortab, Percocet	<b>Botox Injections</b>
Oxycodone, Hydrocodone, Dilaudid, Morphine	
Tylenol with Codeine	<b>Natural Supplements</b>
	Riboflavin                                      Butterbur
<b>Other NSAID's (Non-Steroidal Anti-inflammatory)</b>	Magnesium
	Co Q 10
Ketoprofen    Relafen	
Diclofenac (Cambia or Zipsor)              Meloxicam	<b>Procedures:</b>
	Accupuncture                                      Chiropractor
<b>Muscle Relaxants</b>	Cefaly band                                      Massage
Norflex    Zanaflex	Occipital Nerve Block                      SphenoCath
Flexeril-cyclobenzaprine                      Baclofen	Transcranial Magnetic Stimulation Device

**FOR SLEEP PATIENTS ONLY**  
**PLEASE STOP HERE IF YOU ARE NOT BEING SEEN FOR SLEEP.**

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www.neurocenter.com

## SLEEP MEDICINE HISTORY AND PROFILE QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Care Provider \_\_\_\_\_

**Reason for your visit today?**

\_\_\_\_\_

<b>Do you snore?</b>	<b>Yes / No / Don't know</b>		<b>If yes, circle one of the following:</b>	
Snoring is:	Rare	1-2 x/week	3-4 x/week	every night
Snoring is:	Soft	Moderately loud	Loud enough to be heard outside bedroom	
Snoring is:	Only when lying on your back Present in any position			
Does snoring disrupt the bed-partner's sleep?	Yes	or	No	
Has anyone told you that you stop breathing during sleep?	Yes	or	No	
Any episodes of gasping or choking during sleep?	Yes	or	No	
Have you gained weight in the past year?	Yes	or	No	If yes, How many lbs? ____
Have you gained weight over the past 5 years?	Yes	or	No	If yes, How many lbs? ____

**Please circle any symptoms that you experience with your sleep:**

Discomfort in legs	Kicking during sleep	Restless sleep
Frequent awakenings	Grinding/Clenching teeth	Frequent (>1) urination at night
Shortness of breath	Excessive perspiration	Racing heartbeat
Morning headaches	Frequent heartburn	Nasal congestion
Dry mouth		

**Sleep Medicine Questionnaire (continued...)**

**Please answer the following questions if you have previously had a sleep study or have been diagnosed with a sleep disorder. Otherwise, skip to the next section:**

Have you ever had a sleep study either at home or in a sleep laboratory facility? Yes or No

If yes, When and Where? \_\_\_\_\_

Was sleep apnea diagnosed? Yes or No

If yes, please describe: \_\_\_\_\_

Are you on CPAP? Yes or No If yes, what is your pressure setting? \_\_\_\_\_

**Sleep Schedule:**

Bedtime on **weekdays or work days**: \_\_\_\_\_ Wake up time: \_\_\_\_\_

Bedtime on **weekends or days off**: \_\_\_\_\_ Wake up time: \_\_\_\_\_

Number of naps per week: \_\_\_\_\_ At what time? \_\_\_\_\_ How long are the naps? \_\_\_\_\_

Work hours: \_\_\_\_\_ Type of work: \_\_\_\_\_

Any trouble getting to sleep? Yes or No How many times per week? \_\_\_\_\_

Any trouble staying asleep? Yes or No How many times per week? \_\_\_\_\_

Do you use sleep aides (prescription or over-the-counter)? Yes or No

Names of the sleep aides and # of times used per week: \_\_\_\_\_

Caffeinated beverages? Yes or No How many per day? \_\_\_\_\_ How many total ounces? \_\_\_\_\_

Do you smoke cigarettes or use nicotine/tobacco products? Yes or No

Do you drink alcohol? Yes or No # of drinks per day? \_\_\_\_\_ # per week? \_\_\_\_\_

Circle: wine/beer/other liquor

Do you exercise? Yes or No Type of exercise: \_\_\_\_\_ Days per week: \_\_\_\_\_

**Sleep Medicine Questionnaire (continued...)**

**Epworth Sleepiness Scale**

How likely are you to doze off in the following situations? Answer with a number 0 – 3 as indicated below:

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

<b>Situation:</b>	<b>Chance of Dozing:</b>
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
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 lunch without alcohol	_____
In a car, while stopped for a few minutes at a stoplight or in traffic	_____
<b>Total Score:</b>	_____