

SLEEP MEDICINE ASSOCIATES OF NEW YORK CITY, PLLC

11 East 26th Street, 13th Floor
New York, NY 10010

Telephone: 212 481-1818
Facsimile: 212 523-0498

PATIENT REGISTRATION

Dr. Mr. Ms. Mrs. Patient name: _____ Sex: M F

Social Security # _____ - _____ - _____ Date of Birth: ____ / ____ / ____

Street: _____ City: _____ State: ____ Zip: _____

Home phone (____) _____ Cell Phone (____) _____

E-Mail _____ Pager (____) _____

Marital status: Married Single Divorced

EMPLOYER or WORK INFORMATION

Employer: _____ Retired Date: _____

Street: _____ Business Phone:(____) _____ ext. _____

City: _____ State: ____ Zip: _____ Occupation: _____

INSURANCE INFORMATION

Card available yes no Copay paid: cash check credit card bill

Primary Insurance Carrier: _____

ID# _____ Group # _____

Primary Card Holder: _____ DOB: _____

Secondary Insurance Carrier:

ID# _____ Group # _____

EMERGENCY CONTACT

Name: _____ Phone: _____

I hereby authorize Sleep Medicine Associates of NYC, and it's physicians to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to Sleep Medicine Associates of NYC and it's physicians. I understand that I am responsible for any or part of the charges that are not covered by medical coverage.

Signed: _____ Date: _____

SLEEP MEDICINE ASSOCIATES OF NEW YORK CITY, PLLC

11 East 26th Street, 13th Floor
New York, NY 10010

Telephone: 212 481-1818
Facsimile: 212 523-0498

REFERRING PHYSICIAN

Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

Is this physician your primary doctor? Yes No

Name of primary doctor if not the same as above:

Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

Please name other physicians whom you would like to have your sleep report sent to:

Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

Name: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip: _____

UPIN # _____ Phone # _____ Fax: _____

SLEEP HISTORY QUESTIONNAIRE

Patient Name: _____

Date: _____

Please check the appropriate box or give short answers for the following:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Do you feel sleepy or have "sleep attacks" during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you nap during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have trouble concentrating during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have trouble falling asleep when you first go to bed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you awaken during the night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you awaken more than once? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you awaken too early in the morning? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you snore? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. How long have you had trouble sleeping? What do you think precipitated the problem? | | |
| | _____ | |
| | _____ | |
| 10. How would you describe your usual night's sleep (hours of sleep, quality of sleep, etc.) | | |
| | _____ | |
| 11. Do others live at home who interrupt your sleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Are you regularly awakened at night by pain or the need to use the bathroom? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does your job require shift changes or travel? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you drink caffeinated beverages?
(Coffee, tea, or soft drinks) | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever suffered from depression, anxiety, or similar problems? | <input type="checkbox"/> | <input type="checkbox"/> |

SLEEP MEDICINE ASSOCIATES OF NEW YORK CITY, PLLC

11 East 26th Street, 13th Floor
New York, NY 10010

Telephone: 212 481-1818
Facsimile: 212 523-0498

16. Apart from difficulty sleeping, what, if any other medical problems do you have?

17. What sleep medications, prescription or nonprescription, do you take? (Please include the dose, how often you take it, and for how many months/years you have taken it.)

All other medications:

18. What other prescription and over-the-counter medications do you regularly use? (Again, please include the dose, frequency and duration.)

QUESTIONS FOR THE SLEEP PARTNER

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Does your sleep partner snore? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does your sleep partner seem to stop breathing repeatedly during the night? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does your sleep partner jerk his or her legs or kick you while he or she is sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever experienced trouble sleeping? Please explain: | <input type="checkbox"/> | <input type="checkbox"/> |

EPWORTH SLEEPINESS SCALE

Name: _____

Your Sex: M F

Today's date: _____

Your age (years): _____

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

Please CHECK the most appropriate number for each situation:

	Never	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
A. Sitting and Reading	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
B. Watching TV	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
C. Sitting inactive in a public place; e.g. a theatre or a meeting	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
D. As a passenger in a car for an hour without a break	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
E. Lying Down to rest in the afternoon when circumstances permit	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
F. Sitting and talking to someone	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
G. Sitting quietly after a lunch without alcohol	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
H. In a car while stopped for a few minutes in traffic	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>