DEMOGRAPHIC DATA

Name of Patient: Lamis Ismail
Gender: female **Date Of Birth (mm/dd/yyyy):** 09/21/1980 **Age:**33 **Marital Status:** Married **Height:**48 **Weight:** 180
Insurance: Caresource
Social Security Number: 125-55-1548
Nearest Relative: Lina Alaama **Realtionship:** Mother

Primary Care Physician

Primary Care Physician: Pascaline Mahango
Phone: 778-707-7831

Patient Address

Home address: 2976 Cliffrose crest **City** Coqutilam **State:** BC **ZIP:** 123456
Home Phone Number: 604-440-0150
Cell Phone Number: 604-229-2029

Employment Information

Employment Name: Digitalize Media
Business Phone: 604-210-0606
Address of Employer: #205 - 115 School House Street
City: Coqutialm **State:** BC **ZIP:** 78965

Spouse Information

Name of Spouse Ammar AlJaghlit
Date of Birth: 04-24-1969
Social Secutity Number: 789-55-4521

Employment:

Employment Name: CBC Factory INC
Business Phone: 403-272-5506
Address of Employer: 8 Street SE
City: Calgary **State:** AB **ZIP:** 456321

If Single, Information of Parent

Name of Parent: Lina Ismail
Address of Parent: 2816 165 Street SE Lynoowd WA
Phone of Parent: 206-228-6178

Guardian Information (If Patient is a Minor)

Name of Guardian: Myself
Gender of Guardian:
Home Address of Guardian: 318 Marlobt Way NE
City: Calgary **State:** AB **ZIP:** 85214
Martial Status of Guardian: Married
Home Phone Number of Guardian: 604-123-4567

Cell Phone Numberof Guardian: 604-123-4568
Social Secutity Number of Guardian: 789-654-123
Date Of Birth (guardian): 02/05/2001 **Age:** 44

Employment Information of Guardian

Employment Name:
Business Phone:
Address of Employer:
City: State: ZIP:

EXCESSIVE DAYTIME SLEEPINESS

Do you experience excessive daytime sleepiness? yes
Rate your chance of dozing in the situations below using the following scale:
0=has not happened to me this past year and I do not think it would
1=has happened a time or two in the last year or has a slight chance of happening
2=has happened on occasion in the last few months and is likely to happen again
3=happens frequently and will happen again
2 When reading
2 When watching TV
2 When inactive in a public place (theater, at a meeting or lecture)
2 While waiting (at a stop light, at a doctor office)
1 While lying down to rest or take a break during the day
1 While sitting and talking to someone in person or on the phone
3 While sitting quietly during the day after eating
3 When riding as a passenger in a car, train, or plane for an hour or more
3 While driving a vehicle
19 TOTAL

SLEEP HISTORY

Describe the problem you are experiencing with your sleep and when it first began:
I Can not sleep
Are you a restless sleeper? yes **For how long?** 6 years
Has anyone told you snore: yes **For how long?** 6 years
Do you snore sleeping in all positions? yes **For how long?** 6 years
Has your family told you that you quit breathing at night? yes **For how long?** 10 years
Have you ever awakened gasping for breath? yes **For how long?** 10 years
Do you awaken with dry mouth? yes **For how long?** 10 years
Do you have morning headaches? yes **For how long?** 10 years
Do you have (tingly) legs and feel as if you have to move them? yes **For how long?** 10 years
Do you kick your legs at night? yes **For how long?** 10 years
Do you sleep better away from your own bed? (Vacation) yes **For how long?** 10 years
Do you have pain that bothers you at night? yes **For how long?** 10 years
Do you grind your teeth at night? yes **For how long?** 10 years
Do you sleep walk? yes **For how long?** 10 years
Do you talk in your sleep? yes **For how long?** 20 years
Have you ever experienced periods in which you feel paralyzed while you are going to sleep or waking up? yes**For how long?** 20 years
Have you ever experienced sudden physical weakness during strong emotions? ***(i.e Legs going limp while laughing or when angry)*** yes **For how long?** 20 years
Have you ever had a visual hallucination or dream like mental images when falling asleep? yes**For how long?** 20 years
do you have difficulty staying awake to drive? yes **For how long?** 20 years
your weight changed in the last 5yrs? yes **Gained:** 30 **Pounds** | **Lost:** Pounds
Have you ever had an automobile accident due to sleepiness? yes**if so, Date of accident:** 08/12/2001
Details about the accident: No real injury

SLEEP SCHEDULE

Weekdays: Bedtime: 9 pm | Wake time: 5 am
Average amount of sleep per night: 8 hours
Weekends: Bedtime: 9 pm | Wake time: 5 am
Average amount of sleep per night: 16 hours
How long does it take you to go to sleep? 2 hours | 15 mins
Do you wake feeling rested? no
Do you currently use CPAP treatment at night? yes **If so, Pressure:** 15
Are you currently using supplemental oxygen? yes **If yes, 600 LPM**
Do you have rotating or night shift work? yes
How many times do you wake up from sleep? 6 times
Do you fall back to sleep easily? no **Do you nap?** yes **If so, how often?** everyday

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FSS Questionnaire

During the past week, I have found that:
5 My motivation is lower when I am fatigued
5 Exercise brings on my fatigue
5 I am easily fatigued
5 Fatigue interferes with my physical functioning
5 Fatigue causes frequent problems for me
5 My fatigue prevents sustained physical functioning
3 Fatigue interferes with carrying out certain duties and responsibilities
3 Fatigue is among my three most disabling symptoms
3 Fatigue interferes with my work, family, or social life
39 TOTAL SCORE

PAST MEDICAL HISTORY

X Tonsillectomy	**X**Hernia Repair	**X**Appendectomy	**X**Cardiac Bypass
XHysterectomy	**X**Orthopedic Surgery	Cardiac Cath	Nasal Surgery
Diabetes	Heart Disease	Emphysema	**X**Asthma
Lung Disease	Arthritis	Ulcers	Thyroid Disease
Seizure Disorder	**X**High Blood Pressure	**X** High Cholesterol	**X**GERD/Reflux

OTHER:
Depresion

MEDICATIONS

NAME	DOSE
Tylano1	1 mg
Tylano2	2 mg
Tylano3	3 mg
Tylano4	4mg
Tylano5	5mg
Tylano6	6mg
Tylano7	7mg
Tylano8	8mg
Tylano9	9mg
Tylano10	10mg

Over the counter medications: Advil
Do you have any allergies to medications? Allergic to Anti histamine

SOCIAL HISTORY

Caffeine:
How much caffeine do you consume on a daily basis? 2
How many cups per day? 5 cups

Tobacco:
Do you smoke?currentlysmoke **How many packs a day** 1 **How many years?** 20

Alcohol:
Do you drink? quit

Illicit Drugs
Do you take any illicit drugs ? never **What are you using?**

Home: married **Have Children?** yes **If yes, how many?** 3

Work:
Current work status: Currently employed **Work days:** All days **Work nights:** none
Shift work no shift
Occupation Designer

FAMILY HISTORY

Condition	YES/NO	Family Member
Diabetes	yes	Dad
Stroke	yes	Dad
High B/P	yes	Dad
Heart Disease	yes	Dad
Cancer	yes	Dad
Anxiety	yes	Dad
Depression	yes	Dad
Sleep Apnea	yes	Dad
Daytime Sleepiness	yes	Dad
Snoring	yes	Dad
Obesity	yes	Dad
Narcolepsy	yes	Dad
Other	workoholic	Dad

SYMPTOMS REVIEW

Constitutional Review	
Fever	no
Night Sweats	no
Unexplained weight loss/gain	no
Ear, Nose and Throat Review	
Hearing Loss	no
Hoarseness	no
Sore Throat	no
Nasal Congestion	no
Pulmonary Review:	
Coughing	no
Shortness of breath	no
Difficulty breathing lying flat	yes
Difficulty breathing at night	yes
Wheezing	yes
Coughing up blood	yes
History of positive TB skin test	yes
Musculoskeletal Review	
Muscle aching	yes
Joint Pain	yes
Endocrine Review	
Excessive thirst	yes
Skin moistness or dryness	yes
Heat intolerance	yes
Cold intolerance	yes
GYN Review	
Post-menopausal	yes
I am or could now be pregnant	yes
Cardiac Review:	
Chest Pain	yes
Ankle Swelling	yes
Heart Murmur	yes
GI Review:	
Black Stools or bleeding from bowels	yes
Nausea/Vomiting	yes
Trouble swallowing	yes
Abdominal pain	yes
GU Review	
Frequent bladder infections	yes
Painful urination	yes
Frequent urination	yes
Blood in urine	yes
Night time urination	yes
Loss of bladder control	yes
Difficulty starting a stream of urine	yes
Skin Review	
Skin Rash	yes
Easy bruising	yes
Psychosocial/Social Review	
Loss of appetite	yes
Feeling depressed	yes
Anxiety	yes
Agitation	yes
Increased stress/trouble at work	yes
Neurological Review:	
Paralysis	yes
Numbness/Weakness in hands, feet, or legs	yes
Trouble with balance	yes
History of stroke	yes
Difficulty with concentration	yes
Seizures	yes
Headaches	yes

DISCLOSURES AND AUTHORIZATIONS

NAME: Lamis Ismail

L.I I am requesting that Home Sleep Clinic, (HSC) and the doctors who practice there to test me for possible sleep disorders. I understand that as a patient, I am required to authorize HSC for such service and hereby authorizing such tests.

L.I I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand that HSC will retain the ownership rights to these images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law.

L.I I acknowledge that I have consulted my physician and understand that the nature of the test(s) that I am about to undergo with HSC. By signing this document, I consent to the test that will be performed on me by the staff of HSC.

Receipt of Notice of Privacy Practice and Disclosure, Patients Rights and Responsibilities and Provider Performance Standards

L.I I have reviewed the Notice of Privacy Practices of HSC, Patient Rights and Responsibilities and Provider Performance Standards, and understand my rights stated in these documents. I authorize the use and disclosure of my protected health information for the purpose of treatment, determination of benefits, payment and care as described in the Notice of Privacy Practice. This includes any doctors and their staff who provides services to HSC, and any employee or agent of any medical equipment company used to supply medical equipment to me. I authorize HSC to leave messages on my answering machine/voicemail, with whoever may answer my home phone and to call me at work.

Patient Assignment of Benefits Agreement

L.I I authorize direct remittance of payment of all insurance or Medicare benefits to HSC for all covered services. I understand and agree that this Assignment of Benefits will have continuing effect for so long as I am receiving services from HSC. I authorize my insurance company to mail ALL PAYMENTS directly to HSC.

L.I I understand that I ultimately bear the financial responsibility for the payment of all fees associated with services and procedures provided by HSC. I will be responsible for all charges not covered by my insurance and if I receive any payments from my insurance carrier directly for any services provided by HSC, I will immediately forward such payments to HSC.

L.I I understand that the Explanation of Benefits (EOB) from my insurance carrier in NOT a bill from HSC, and that no charges are due from me until I receive a statement directly from HSC.

Past Due Accounts

L.I I understand that a fee may be charged by HSC on all accounts which are 90 days, or more past due at a rate of 50% per month. I understand that the 50% per month may be added to any account that is 90 days or more past due, and herby agree to pay such charges if levied. I also understand that in the event my account is placed with a collection agency, and/or a lawsuit is brought against me for collections of amount due HSC I will be responsible for payment of all costs if collections, including but not limited to court costs and reasonable attorneys fees.

Commercial Drivers

L.I I understand that if I am diagnosed with sleep disorder, the agency that has issued my commercial drivers license may be contacted if I do not follow my doctors instructions and recommendations or if I am not compliant with my treatment plan.

Responsibility of Equipment

L.I I understand that the equipment that I am taking home with me is my responsibility. I understand that the equipment must return the next day or I will be charged $100.00 per day that it is not returned.

X I have read all of the above, and initials and signature represent my unqualified acceptance and acknowledgement of each of the statements written above. I authorize a copy of this form to be used in place of the original

X I have read and understood the Patient Rights and Responsibilities section

Lamis Ismail
Date : January 7, 2013, 9:48 pm

Online User Infomration

User Remote Address : d50-98-231-42.bchsia.telus.net
User IP Address:50.98.231.42