

DEMOGRAPHIC DATA

Name of Patient: Lamis Ismail

Gender: female **Date Of Birth (mm/dd/yyyy):** 09/21/1980 **Age:**33 **Marital Status:** Married **Height:**49 **Weight:** 181

Insurance: Caresource

Social Security Number: 111-11-4569

Nearest Relative: Lina Alaama **Relationship:** Mother

Primary Care Physician

Primary Care Physician: Pascaline Mahango

Phone: 778-707-7831

Patient Address

Home address: 2976 Cliffrose crest **City:** Coquitlam **State:** BC **ZIP:** 12345

Home Phone Number: 604-440-0150

Cell Phone Number:

Employment Information

Employment Name: Digitalize Media

Business Phone: 604-210-0606

Address of Employer: #205 - 115 School House Street

City: Coquitlam **State:** BC **ZIP:** 78965

Spouse Information

Name of Spouse: Ammar AlJaghlit

Date of Birth: 04-24-1969

Social Security 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:

Address of Parent:

Phone of Parent:

Guardian Information (If Patient is a Minor)

Name of Guardian:

Gender of Guardian:

Home Address of Guardian:

City: **State:** **ZIP:**

Marital Status of Guardian:

Home Phone Number of Guardian:

Cell Phone Number of Guardian:
Social Security Number of Guardian:
Date Of Birth (guardian): Age:

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

0 When reading

0 When watching TV

0 When inactive in a public place (theater, at a meeting or lecture)

0 While waiting (at a stop light, at a doctor office)

0 While lying down to rest or take a break during the day

0 While sitting and talking to someone in person or on the phone

0 While sitting quietly during the day after eating

0 When riding as a passenger in a car, train, or plane for an hour or more

0 While driving a vehicle

0 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?

Has anyone told you snore: yes For how long?

Do you snore sleeping in all positions? yes For how long?

Has your family told you that you quit breathing at night? yes For how long?

Have you ever awakened gasping for breath? yes For how long?

Do you awaken with dry mouth? yes For how long?

Do you have morning headaches? yes For how long?

Do you have (tingly) legs and feel as if you have to move them? yes For how long?

Do you kick your legs at night? yes For how long?

Do you sleep better away from your own bed? (Vacation) yes For how long?

Do you have pain that bothers you at night? yes For how long?

Do you grind your teeth at night? yes For how long?

Do you sleep walk? yes For how long?

Do you talk in your sleep? yes For how long?

Have you ever experienced periods in which you feel paralyzed while you are going to sleep or waking up? yes For how long?

Have you ever experienced sudden physical weakness during strong emotions? (i.e Legs going limp while laughing or when angry) yes For how long?

Have you ever had a visual hallucination or dream like mental images when falling asleep? yes For how long?

do you have difficulty staying awake to drive? yes For how long?

your weight changed in the last 5yrs? yes Gained: Pounds | Lost: Pounds

Have you ever had an automobile accident due to sleepiness? yes if so, Date of accident:

Details about the accident:

SLEEP SCHEDULE

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

FSS Questionnaire

During the past week, I have found that:
3 My motivation is lower when I am fatigued
3 Exercise brings on my fatigue
3 I am easily fatigued
3 Fatigue interferes with my physical functioning
3 Fatigue causes frequent problems for me
3 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
27 TOTAL SCORE

PAST MEDICAL HISTORY

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

MEDICATIONS

NAME	DOSE
Oxalate	10mg
Tylano2	Tylano2

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

SOCIAL HISTORY

Caffeine:

How much caffeine do you consume on a daily basis?

How many cups per day?

Tobacco:

Do you smoke? never How many packs a day How many years?

Alcohol:

Do you drink? never

Illicit Drugs

Do you take any illicit drugs ? never What are you using?

Home: married Have Children? no If yes, how many?

Work:

Current work status: Retired Work days: Work nights:

Shift work

Occupation

FAMILY HISTORY

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

SYMPTOMS REVIEW

Constitutional Review

Fever yes

Night Sweats yes

Unexplained weight loss/gain yes

Ear, Nose and Throat Review

Hearing Loss yes

Hoarseness yes

Sore Throat yes

Nasal Congestion yes

Pulmonary Review:

Coughing yes

Shortness of breath yes

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

☒ 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.

☒ 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.

☒ 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

☒ 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

☒ 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.

☒ 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.

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

Past Due Accounts

☒ 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 hereby 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

☒ 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

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.

☒ 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

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

Lamis Ismail

Date : January 8, 2013, 1:22 pm

Online User Information

User Remote Address : 50.98.231.42

User IP Address:50.98.231.42