OGNOMY

NEW PATIENT VISIT

NAME:_____ **DOB:** _____

Please read instructions carefully and complete the following. It is important that we have complete and accurate information about you and your medical condition(s).

PHYSICIAN INFORMATION

Please complete the following information for all physicians/health care providers you have seen within the past 5 years:

Specialty/Problem	Provider Name	City	Approximate dates seen	May we send a summary of your visits to this person?	
Primary Care Provider					

I authorize Sleep Medicine Centers of WNY, its employees or agents, to forward my medical information (including psychological, psychiatric, alcohol and drug abuse diagnosis and treatment information) to those persons marked "yes" above, and other healthcare providers who may be responsible for my continuing medical care.

Patient or Legal Guardian Signature: _____

MEDICATION(S)

Please list any prescription/non-prescription medications that you are taking.
Please include vitamins, nutritional supplements, oral contraceptives, pain relievers, diuretics, laxatives, and cold medications, etc.

- ☐ I am not taking any medications
- ☐ I have attached a printed medication list on another sheet

MEDICATION	DOSE	HOW OFTEN TAKEN

Are you allergic to, or have you had hives, skin rash, breathing problems or other allergic reaction to medication? ☐ No ☐ Yes If yes, please list: _____

PAST MEDICAL HISTORY

Do you have a pacemaker ☐ No ☐ Yes

Have you EVER had any of the following:

	N	Y	If yes, please describe
Anesthesia complications			
Anxiety, depression, mental illness			
Blood problems (bleeding, anemia, high/low white count)			
Diabetes			
High blood pressure			
High cholesterol or triglycerides			
Stroke or TIA			

NEW PATIENT VISIT

Indicate whether you have <u>EVER</u> had a medical problem and/or surgical problem related to each of the following.

- Describe the problem or type of surgery and approximate dates.
- CIRCLE the appropriate choice when multiple choices are listed in a question

	None	Medical	Surgical	Describe
Eyes (cataracts, glaucoma)				
Ears, nose sinuses, tonsils				
Thyroid, parathyroid glands				
Heart valves, heart rhythm, heart failure				
Coronary (heart), arteries (angina, heart attack)				
Arteries (aorta, arteries to head, arms, legs)				
Veins, blood clots in veins				
Lungs				
Esophagus or stomach (ulcer)				
Bowel (small or large intestine)				
Appendix				
Liver or gall bladder				
Hernia				
Kidneys, bladder				
Bones, joints, muscles				
Back, neck, spine				
Brain				
Skin				
Breasts				
Uterus, tubes, ovaries				
Prostate, penis, testes, vasectomy				
Other – Describe				

<u>PAST SOCIAL HISTORY</u>

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

Please indicate if the following applies:

	No	Yes	Describe
Are you currently employed?			Full time Part time Disability Retired Other
Do you exercise?			
Do you consume caffeinated beverages?			Soda Coffee Tea Energy Drinks # per day _____
Do you consume alcoholic beverages?			# of beverages per week _____
Have you ever used any tobacco products?			Currently use # packs per day _____ Quit approx date _____ Other_____
Have you ever undergone treatment for drug /alcohol abuse			

<u>FAMILY HISTORY</u>

Do any of your immediate family members have sleep disorders including sleep apnea, insomnia, or narcolepsy?

☐ No ☐ Yes, please describe: _____

Indicate if any of your immediate family members have any medical conditions.

	Alive or Deceased	Age(s)	Describe any medical conditions:
Father	☐ Alive ☐ Deceased	_____	_____
Mother	☐ Alive ☐ Deceased	_____	_____
Brother(s)	☐ Alive ☐ Deceased	_____	_____
Sister(s)	☐ Alive ☐ Deceased	_____	_____
Children	☐ Alive ☐ Deceased	_____	_____

NEW PATIENT VISIT

SLEEP MEDICINE HISTORY

Have you ever had a sleep study ☐ No ☐ Yes – please indicate where and approximate date_____

*****Please upload copy of sleep studies under the "documents" section in the app.

Are you currently on CPAP/BiPAP ☐ No ☐ Yes – please list your home care vendor: _____

Have you ever had a NEAR ACCIDENT or ACCIDENT due to excessive drowsiness? ☐ No ☐ Yes _____

How many hours of sleep are you now getting in a typical night? _____ hours

How long does it take you to fall asleep once you are in bed? _____ minutes

Do you …

	N	Y
feel very drowsy or sleepy at any point during the day?		
have strange hallucinations-like dreams while napping?		
have "sleep attacks" during the day (i.e., periods when you cannot prevent yourself from falling asleep)?		
have "cataplectic attacks" (i.e., episodes of weakness in the legs and/or collapse that occur with emotions like laughter or crying)		
have episodes of sleep paralysis (i.e., being awake in bed not able to move or speak)		
wake up with "pins and needles" or restlessness in the legs		

Check off any of the following behaviors occurring during your sleep that you or someone else has noted in the past year:

__Walking in your sleep
__ Talking in your sleep
__ Heart palpitations
__ Grinding your teeth
__ Twitching of the legs or arms
__ Waking up with frequent urge to urinate
__ Rolling or rocking movement
__ Shouting, screaming, or swearing
__ Violent movements
__ Waking up with anxiety or tension
__ Excessive sweating
__ Waking up with chest pain
__ Waking up gasping or choking
__ Waking up with heartburn
__ Waking up with frightening images
__ Waking up with air hunger
__ Waking up with the feeling of weight on chest
__ Apnea (i.e., lapses in breathing, periods of no breathing)
__ Frequent coughing
__ Falling out of bed
__ Bed-wetting
__ Large Body jerks
__ Loud snoring
__ Restless sleep
__ Waking up with terror
__ Asthma

How likely are you to doze off in the situations below:

	High (3)	Moderate (2)	Slight (1)	None (0)
Sitting & reading				
Watching TV				
Sitting inactive in a public place				
Sitting for an hour as a passenger in a car				
Lying down in the afternoon to rest				
Sitting & talking to another person				
Sitting quietly after lunch (no alcohol)				
Sitting in a car stopped in traffic				

REVIEW OF SYSTEMS

Have you experienced the following symptoms DURING RECENT WEEKS ?

- CIRCLE the symptom(s) you have experienced when multiple symptoms are listed in a question.

N	Y	
		Skin rash, sore, excessive bruising
		Excessive thirst or urination
		Significant headaches
		Double or blurred vision, cataracts, glaucoma
		Diminished hearing, dizziness, sinus problem
		Cough, shortness of breath, wheezing, asthma
		Coughing up sputum or blood
		Blackouts or loss of consciousness
		Chest pain, pressure, rapid or irregular heart beats

N	Y	
		Abnormal swelling in legs or feet
		Pain in calves when you walk
		Difficulty swallowing, heartburn, nausea, vomiting
		Significant problems with constipation, diarrhea
		Difficulty starting urinary stream or emptying bladder
		Fever, large lymph nodes
		Weight loss/gain of more than 10 pounds in 6 months
		Experiencing an unusually stressful situation
		Awakening at night short of breath

NEW PATIENT VISIT

Insurance and Billing Information

PATIENT NAME (PLEASE PRINT)	SSN #	SEX M F	BIRTH DATE
STREET ADDRESS (IF STUDENT-PERMANENT ADDRESS)	CITY AND STATE	ZIP CODE	HOME PHONE #
E-MAIL ADDRESS	CELL PHONE#		BUSINESS PHONE # EXT.
I GIVE THE SLEEP MEDICINE CENTER STAFF PERMISSION TO LEAVE MESSAGES REGARDING MY MEDICAL CARE AND/ OR APPOINTMENT CONFIRMATION INFORMATION ON (CHECK ALL THAT APPLY): ☐ E-MAIL ☐ CELL PHONE ☐ HOME PHONE			SPOUSE OR PARENT'S NAME

FINANCIALLY RESPONSIBLE PARTY'S NAME (IF DIFFERENT FROM PATIENT)	FINANCIALLY RESPONSIBLE PARTY'S NAME (IF DIFFERENT FROM PATIENT)
REFERRING PHYSICIAN	ADDRESS/ CITY/ STATE/ ZIP CODE (IF KNOWN)
PRIMARY CARE PHYSICIAN	ADDRESS/ CITY/ STATE/ ZIP CODE (IF KNOWN)
PHARMACY NAME AND PHONE NUMBER	ADDRESS/ CITY/ STATE/ ZIP CODE (IF KNOWN)

RACE	ETHNICITY	LANGUAGE PREFERENCE

NAME OF PRIMARY HEALTH INSURANCE CARRIER	IDENTIFICATION NUMBER	GROUP NUMBER
NAME OF POLICY HOLDER (IF DIFFERENT THAN PATIENT):	DATE OF BIRTH (IF DIFFERENT THAN PT):	EMPLOYER:
NAME OF SECONDARY HEALTH INSURANCE CARRIER	IDENTIFICATION NUMBER	GROUP NUMBER
NAME OF POLICY HOLDER (IF DIFFERENT THAN PATIENT):	DATE OF BIRTH (IF DIFFERENT THAN PT):	EMPLOYER:

IS THIS VISIT RELATED TO AN AUTOMOBILE OR WORK ACCIDENT: ☐ YES ☐ NO	IF YES, PLEASE INDICATE: ☐ AUTOMOBILE ☐ WORK RELATED	DATE OF INJURY/ ACCIDENT

NAME OF INSURANCE CARRIER FOR **WORK INJURY** **OR** NAME OF NO-FAULT CARRIER FOR **AUTOMOBILE ACCIDENT**			STREET ADDRESS	
CITY	STATE	ZIP CODE	TELEPHONE #	CLAIM NUMBER
EMPLOYER'S NAME (AT TIME OF INJURY **IF WORK RELATED**)				

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.
PLEASE INCLUDE ALL NECESSARY INSURANCE FORMS AT THIS TIME.
INSURANCE ASSIGNMENT OF BENEFITS.

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.
I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I request payment of authorized Medicare or other insurance benefits be made either to me or on my behalf to (Provider) for any services furnished me by that provider. I authorize any holder of medical information about me to release to the HCFA/Health Insurance Carrier and its agents any information needed to determine these benefits or the benefits payable for related services. Further I agree that I am financially responsible for charges incurred that are not covered by my insurance.

Signature	**DATE**