EvergreenHealth

SLEEP DISORDERS CENTER

NEW PATIENT INFORMATION

Last Name: _____ **First Name:** _____**Middle Initial:** _____

Birth Date: _____ **I identify my gender as:** ☐ Male ☐ Female ☐ Transgender ☐ Other_____

Primary Language: _____ **Do you need an Interpreter?** ☐ Yes ☐ No

Primary Care Provider: _____ **Clinic Name** (if not EvergreenHealth)**:** _____

Preferred pharmacy name and location: _____

Ethnicity: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ American Native/Alaskan Native
☐ Native Hawaiian/Pacific Islander ☐ Prefer not to answer

Are you Hispanic? ☐ Yes ☐ No ☐ Prefer not to answer

Mailing Address: _____ **Unit/Apt:** _____

City: _____ **State:** _____ **Zip Code:** _____

Physical Address (if different from mailing)**:** _____

Primary Phone: _____ **Can we leave a detailed message?** ☐ Yes ☐ No

Alternate Phone: _____ **Can we leave a detailed message?** ☐ Yes ☐ No

Primary Email Address: _____

Have you signed up for 'MyNavigator'? (Evergreenhealth's patient portal) ☐ Yes ☐ No

Do you have: ☐ Living will ☐ Advanced directive ☐ Mental health advanced directive ☐ Durable power of attorney

Emergency Contact: _____ Relation: _____ Birth Date: _____

Primary Phone: _____ Alternate Phone: _____

Primary Insurance: _____

Policy Holder Name (if not patient): _____Relation: _____Birth Date: _____

Secondary Insurance: _____

Policy Holder Name (if not patient): _____Relation: _____ Birth Date: _____

Place patient label here

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HEALTH HISTORY QUESTIONNAIRE

Please answer the following questions to the best of your ability and bring the ***completed*** paperwork to your appointment. Thank you!

Patient Name: _____ **Date Of Birth:** _____
Person filling out questionnaire: ☐ Patient ☐ Other_____
Why are you being seen in the Sleep Disorders Center today? _____
_____
When did the issue (s) start? _____
Who referred you to EvergreenHealth's Sleep Disorders Center? _____

Sleep habits:
On week days:
What time do you go to bed? _____ How long does it take to fall asleep? _____
What time do you wake up? _____ Do you use an alarm? ☐ Yes ☐ No
How many hours do you sleep on average? _____
On weekends:
What time do you go to bed? _____ How long does it take to fall asleep? _____
What time do you wake up? _____ Do you use an alarm? ☐ Yes ☐ No
How many hours do you sleep on average? _____

How likely are you to doze off or fall asleep in the following situations? (Check most appropriate box)

Situation	0=Never	1=Slight	2=Moderate	3 = High
Sitting and reading				
Watching TV				
Sitting in a public place (theater, meeting)				
As a passenger in a car for an hour with no 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 in traffic				

Have you ever had (check all that apply)**:**
☐ Stroke ☐ Diabetes ☐ COPD/Asthma ☐ Neuropathy ☐ Collapsed lung ☐ Chronic pain
☐ Hypertension ☐ Heart Attack ☐ Heart Failure ☐ Atrial Fibrillation ☐ Migraines
☐ Other _____

Place patient label here

Please answer the following questions:	Yes	No
Have you ever been diagnosed with sleep apnea? If yes, when were you diagnosed?_____ Where were you diagnosed?_____	☐	☐
Do you currently use CPAP?	☐	☐
Have you ever used CPAP?	☐	☐
Have you experienced skin irritation from your CPAP mask?	☐	☐
Have you experienced dry eyes from your CPAP mask leaking?	☐	☐
Have you used an oral appliance or mouth guard to treat sleep apnea?	☐	☐
Have you ever had surgery for snoring or sleep apnea?	☐	☐
Have you had a tonsillectomy?	☐	☐
Have you had nasal surgery?	☐	☐
Do you snore?	☐	☐
Do you experience daytime sleepiness?	☐	☐
Do you experience daytime fatigue?	☐	☐
Do you experience problems with memory or focus during the day?	☐	☐
Has anyone told you that you stop breathing during sleep?	☐	☐
Have you awoken with gasping, coughing, shortness of breath?	☐	☐
Do you awaken with heart palpitations?	☐	☐
Do you awaken to urinate at night? If so how many times? _____	☐	☐
Do you awaken with a headache?	☐	☐
Do you awaken with a dry mouth or sore throat?	☐	☐
Do you awaken with reflux/heartburn?	☐	☐
Do you awaken with chest pain/angina?	☐	☐
Do you grind your teeth? If so, do you wear a night guard? _____	☐	☐
Has your weight changed in the last 5 years? If so, by how much? _____	☐	☐
Have you ever been diagnosed or treated for Restless Leg Syndrome?	☐	☐
Have you ever been diagnosed with Narcolepsy?	☐	☐
Do you experience hallucinations when falling asleep or awakening?	☐	☐
Do you have muscle paralysis or weakness during laughter or anger?	☐	☐
Have you awoken with muscle paralysis?	☐	☐
Have you ever been diagnosed or treated for insomnia?	☐	☐
Do you sleepwalk?	☐	☐
Do you act out dreams?	☐	☐
Have you ever been diagnosed or treated for depression?	☐	☐
Have you ever been diagnosed or treated for anxiety?	☐	☐
Are you or could you be pregnant? If so how many weeks? _____	☐	☐
Does joint or back pain interrupt your sleep?	☐	☐
Do you experience night sweats?	☐	☐
Do you feel unusually cold at night?	☐	☐

Place patient label here

Are you: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic partner
Do you have children? ☐ Yes ☐ No **If yes, what age:** _____
Do you have pets in your bedroom? ☐ Yes ☐ No

Are you employed? ☐ Yes ☐ No ☐ Retired ☐ Student - Grade level: _____
Current Occupation: _____
What shift do you work? ☐ Day ☐ Evening ☐ Night ☐ From home/varied

How many alcoholic drinks do you <u>drink in 1 day</u>? Beer: _____ Wine: _____ Liquor: _____
How many caffeinated beverages do you <u>drink in 1 day</u>? Coffee:____ Espresso:____ Soda:____
Have you ever used tobacco products? ☐ Yes ☐ No
If you quit, when did you last use them? _____ How many packs/times per day? _____

This section refers to immediate family members only. Please check the box if any close relatives (mother, father, brother, sister, grandparent) **have had these conditions or illnesses:**

☐ Sleep Apnea Relative:_____ ☐ Restless Leg Syndrome Relative:_____ ☐ Narcolepsy Relative:_____ ☐ Sleep Walking Relative:_____
☐ Insomnia Relative:_____ ☐ Parkinson's Disease Relative:_____ ☐ Stroke Relative:_____ ☐ Heart Disease Relative:_____
☐ High blood pressure Relative:_____ ☐ Mental/emotional problems Relative:_____ ☐ Diabetes Relative:_____ ☐ Asthma Relative:_____

Have you ever or do you currently take medications (prescription or over the counter) to help you fall or stay asleep? If so, please list those medications below.

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

What other medications do you currently take? (Include vitamins, supplements, over-the-counter medications)

Medication Name	Dose (mg)	Frequency	Year started

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

Place patient label here