ADULT HISTORY

PLEASE MAIL OR FAX AS SOON AS POSSIBLE TO AN ADDRESS BELOW

SANTA CLARITA
Tel:661-799-1428
Fax:661-799-0968
25050 Peachland
Suite 125
Santa Clarita, CA
91321

Personal

Patient Name:_____Date:_____

Address:_____

Date of Birth:_____Height:_____Weight:_____

Gender:____Home Phone:(____)_____Cell Phone:(____)_____

Work Phone:(____)_____Email:_____

Social Security #_____Referring Physician_____

Chief Complaint

Please Explain:

Trouble falling asleep _____

Sleepy all day _____

Unwanted behaviors while sleeping _____

Other _____

	Yes	No
****Do you need extra assistance (use of restroom, getting dressed, etc.)*	☐	☐
****Are you currently on Oxygen day/ night*	☐	☐

Please give details of your personal habits:

Tobacco _____

Alcohol _____

Caffeine_____

Medication:

Name of Drug	Dosage	Doses per day	Reason

Allergies **Please give details, describe your reaction**

NYX Sleep Disorders Center Solutions For Sleep

ADULT HISTORY

Previous Sleep Study? (date) _____ current settings _____

Surgeries / Operations ***Please give details, date***

_____

Other Medical Problems ***Please give details, date***

_____

Family History **Does anyone in your family have a sleep disorder,**
List significant family illnesses, give details

_____

_____

_____

EPWORTH SLEEPINESS SCALE

Referring to your usual way of life, how likely are you to doze off or fall asleep during the following situations? Or refer to a specific time when the following does apply! *0=No Chance, 1=Slight Chance, 2=Moderate Chance, 3=High Chance*	**0**	**1**	**2**	**3**
Sitting and reading				
Watching TV				
Sitting, in a public place (e.g. A theater or meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances allow it				
Sitting down and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped in traffic for a few minutes				

Total Score:

ADULT HISTORY

Sleep Questionnaire

Sleep – Wake Schedule:

Bedtime? _____

Awakening time? _____

Alarm clock? _____

Do you wake up during the night? (yes,no) _____

How many times? _____

For how long? _____

How long does it take you to fall asleep? _____

Disturbed Sleep:	**Yes**	**No**
Do you snore?		
Have you lost your bed partner because of this?		
Have breathing pauses been observed?		
Have you been told your limbs kick or twitch?		
Talk in your sleep?		
Walk in your sleep?		
Act out vivid or violent dreams?		

Insomnia:	**Yes**	**No**
Do you have trouble falling asleep?		
How long does it take you?	_____	
How many nights per week?		
If you wake up during the night, do you		
Have trouble going back to sleep?		
How long does it take you?	_____	
How many nights per week?		
Do you have an aching, uncomfortable or squirmy sensation in your legs, which keep you from sleeping?		
Are you a light sleeper, easily awakened?		

Past Sleep History:	**Yes**	**No**
Did your current sleep problem begin in childhood?		
Were you considered hyperactive or hyper kinetic as a child or teenager (Attention Deficit Disorder)?		

ADULT HISTORY

Sleep Questionnaire - continued

Daytime Sleepiness:	**Yes**	**No**
Are you sleepy or tired all day?		
Have you had accidents or near accidents because of sleepiness?		
Have you "come to" or suddenly become alert and found yourself doing things without being aware of having started them remembering how you got there?		
Have you experienced sudden weakness in the legs or body in general, while awake, perhaps after being startled or in an emotional situation?		
Have you had hallucinations or dream like images		
While awake?		
While falling asleep?		
Do you take naps during the day?		
How many days per week?	_____	
How long are the naps?		
Are they refreshing?		
Do you dream during your naps?		
Did you fall asleep, or fight the urge to fall asleep in school as a child or adolescent?		

Spouse, Roomate or Bed Partner Questionnaire:

To be filled out by your spouse, roommate or partner about you.	**Never**	**Occasionally**	**Frequently**
Does he / she stop breathing?			
Does his / her legs or body twitch or kick?			
Does he / she grind his / her teeth?			
Does he / she walk in his / her sleep?			
Does he / she sit up in bed while not awake?			
Does he / she become rigid or shake during sleep?			

ADULT HISTORY

Insurance Information

PRIMARY INSURANCE:

Company Name: _____

Mailing Address: _____ Zip Code: _____

City/State: _____ Relationship to Patient: _____

Name of Subscriber: _____ Subscriber's DOB: _____

Policy Number: _____ Group # _____

ID Number: _____ Effective Date: _____

SECONDARY INSURANCE COMPANY:

Company Name: _____

Mailing Address: _____ Zip Code: _____

City/State: _____ Relationship to Patient: _____

Name of Subscriber: _____ Subscriber's DOB _____

Policy Number: _____ Group #: _____

ID Number: _____ Effective Date: _____

Payment Policy: *Payment is due at the time services are rendered unless other arrangements have been made. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance. Our Policy allows a maximum of 90 days for insurance companies to pay claims. If this does not occur, you will be expected to pay the balance to NYX.*

Patient Authorization: *I hereby authorize the release of any medical information necessary to process my insurance claim. I hereby authorize payment of medical benefits to the named provider for services rendered. I also authorize Palmetto GBA to release information regarding Medicare claims submitted by the named provider.*

This office requires a 48-hour advance notice of cancellation when a sleep study has been scheduled. If not given, NYX reserves the right to charge a $175 non-refundable fee to the person responsible for the patient listed above and/or decide if the patient will be re-scheduled for a later date.

SIGNED:_____ **DATE:**_____

(Patient or Guardian if Minor)