Patient Demographics and Insurance

Last Name: _____First:_____ M: _____

Address: _____ Apt #:_____City:_____ State: _____ Zip: _____

DOB: _____ SS# _____Home #_____ Cell #_____

E-Mail: _____

Sex: ☐ *Male* ☐*Female* **Marital Status:** ☐*Married* ☐*Single* ☐*Divorced* ☐*Widowed* ☐*Separated*

Employer/School: _____ Position: _____

Address: _____ City: _____State: _____Zip:_____

Referring/Primary Dr. Info

Primary Dr.: _____ Phone#: _____

Address: _____ City: _____State: _____Zip:_____

Medical Pharmacy Info

Name: _____ Phone#: _____

Address: _____ City: _____State: _____Zip:_____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____State: _____Zip:_____

Medical Insurance Information

Primary Ins: _____ Insurance ID#: _____ Ph. #:_____

Address: _____ City:_____ State: _____ Zip: _____

Insured Party: ☐Self ☐Spouse ☐Other_____

Secondary Ins: _____ Insurance ID#: _____ Ph. #:_____

Address: _____ City: _____ State: _____ Zip: _____

Insured Party: ☐Self ☐Spouse ☐Other_____

_____ _____ _____

PATIENT/AUTHORIZED REPRESENATIVE SIGNATURE | DATE | PRINTED NAME

Patient Name: _____ Date:_____

To prepare for you annual wellness exam, please fill out this questionnaire:

	YES	NO	SOMETIMES	For Office Use Only
1. Do you get low blood pressure or ever feel faint?	_____	_____	_____	
2. Have you ever smoked?	_____	_____	_____	
3. Do you have diabetes?	_____	_____	_____	
4. Do you have a family history of diabetes?	_____	_____	_____	
5. Do you have high blood pressure?	_____	_____	_____	
6. Do you have a family history of high blood pressure?	_____	_____	_____	
7. Do you ever experience leg cramping or leg pain?	_____	_____	_____	
8. Do you ever experience dizziness or light headedness?	_____	_____	_____	
9. Do you think you sweat too much?	_____	_____	_____	
10. Do you ever have chest pain?	_____	_____	_____	
11. Do you ever experience shortness of breath?	_____	_____	_____	
12. Do you have pain in any of your joints?	_____	_____	_____	
13. Have you recently experienced back pain?	_____	_____	_____	
14. Have you recently experienced headaches?	_____	_____	_____	
15. Have you tried to lose weight with no result?	_____	_____	_____	
16. Do you experience leg cramps at rest?	_____	_____	_____	
17. Have you ever tried to grab an object and missed?	_____	_____	_____	
18. Do you have a family history of cancer?	_____	_____	_____	
19. Have you ever experienced swelling, numbness, Or tingling in your legs or arms?	_____	_____	_____	

Medication List

Sleep Questionnaire

Cuestionario del Sueño

Patient information

Informacion del Paciente

Name: _____ **Date:** _____

Nombre *Fecha*

1.	**Do you snore loudly or have been told that you snore?** *Usted ronca fuerte o le han adicho que ronca?*	**YES [ ] NO [ ]**
2.	**Do you ever awaken with a sensation of gasping or choking?** *Alguna vez se despierta con una sensacion de ahogo?*	**YES [ ] NO [ ]**
3.	**Has anyone ever noticed that you stop breathing during your sleep?** *Alguien ha notado que usted deja de respirar mientras duerme?*	**YES [ ] NO [ ]**
4.	**Do you often wake up with a dry mouth?** *Se despierta a menudo con la boca seca?*	**YES [ ] NO [ ]**
5.	**Do you find your sleep to be non-refreshing?** *Encuentra usted que su Sueño no es refrescante?*	**YES [ ] NO [ ]**
6.	**Do you often feel tired, fatigued, or sleepy during the daytime?** *Se siente usted cansado(a), fatigado(a), o con mucho Sueño durante el dia?*	**YES [ ] NO [ ]**
7.	**Do you ever fall asleep or nod off in situations where you did not intend to?** *Alguna vez se a quedado dormido(a) en situaciones en las que no tenia la intencion?*	**YES [ ] NO [ ]**
8.	**Do you have (or are being treated for) high blood pressure and or/diabetes?** *Usted tiene o alguna vez a recibido tratameinto para la presion arterial alta or diabetes?*	**YES [ ] NO [ ]**
9.	**Will you be interested in speaking with a sleep educator?** *Usted estaria interesado (a) en hablar con un educador en enfermedades se dormir?*	**YES [ ] NO [ ]**

*This questionnaire utilizes portions of the Berlin questionnaire, Epworth Sleepiness Scale (ESS), and STOP-BANG questionnaire, which are widely recognized by the AASM as diagnostic tools for obstructive sleep apnea (OSA).