ADVANCED CENTER for SLEEP DISORDERS

REVIEW OF SYSTEMS

Patient' Name (Last) ____________ (First) ____________ (Middle) ________

For an "EXTENDED" system review, at least 2 systems	For a "COMPLETE" system review, at least 10 systems (Dictate responses to pert. Systems), then "All other systems negative"

- Are you experiencing any of these symptoms at the present?

*** CONSTITUTIONAL SYMPTOMS**

Good general health lately __ No __ Yes
Recent weight change __ No __ Yes
Fever __ No __ Yes
Headaches __ No __ Yes

*** EYES**

Eye disease or injury __ No __ Yes
Wear glasses/contact lens __ No Yes
Blurred or double vision __ No Yes
Glaucoma __ No Yes

*** EARSNOSE/MOUTH/THROAT**

Hearing loss or ringing __ No __ Yes
Earaches or drainage __ No __ Yes
Chronic sinus problem or rhinitis __ No __ Yes
Nose bleeds __ No __ Yes
Mouth sores __ No __ Yes
Bleeding gums __ No __ Yes
Bad breath or bad taste __ No __ Yes
Sore throat or voice change __ No __ Yes
Swollen glands in neck __ No __ Yes

*** CARDIOVASCULAR**

Heart trouble __ No __ Yes
Chest pain or angina pectoris __ No __ Yes
Palpitation __ No __ Yes
Shortness of breath w/ walking or lying flat __ No __ Yes
Swelling of feet, ankles, or hands __ No __ Yes

***RESPIRATORY**

Chronic or frequent coughs __ No __ Yes
Spitting up blood __ No __ Yes
Shortness of breath __ No __ Yes
Asthma or wheezing __ No __ Yes

*** GASTROINTESTINAL**

Loss of appetite __ No __ Yes
Change in bowel movements __ No __ Yes
Nausea or vomiting __ No __ Yes
Frequent diarrhea __ No __ Yes
Painful bowel movements or constipation __ No __ Yes
Rectal bleeding or blood in stool __ No __ Yes
Abdominal pain or heartburn __ No __ Yes
Peptic ulcer (stomach or duodenal) __ No __ Yes

*** MUSULOSKELETAL**

Joint pain __ No __ Yes
Joint stiffness or swelling __ No __ Yes
Weakness of muscles or joints __ No __ Yes
Back pain __ No __ Yes
Cold extremities __ No __ Yes

*** INTEGUMENTARY (skin, breast)**

Rash or itching __ No __ Yes
Change in skin color __ No __ Yes
Change in hair or nails __ No __ Yes
Varicose veins __ No __ Yes
Breast pain __ No __ Yes
Breast lump __ No __ Yes
Breast discharge __ No __ Yes

*** NEUROLOGICAL**

Frequent or reoccurring headaches __ No __ Yes
Light headed or dizzy __ No __ Yes
Convulsions or seizures __ No __ Yes
Numbness or tingling sensations __ No __ Yes
Tremors __ No __ Yes
Paralysis __ No __ Yes
Stroke __ No __ Yes
Head injury __ No __ Yes

*** PSYCHIATRIC**

Memory loss or confusion __ No __ Yes
Nervousness __ No __ Yes
Depression __ No __ Yes
Insomnia __ No __ Yes

*** ENDOCRINE**

Glandular or hormone problem __ No __ Yes
Thyroid disease __ No __ Yes
Diabetes __ No __ Yes
Excessive thirst or urination __ No __ Yes
Heat or cold tolerance __ No __ Yes
Skin becoming dryer __ No __ Yes
Change in hat or glove size __ No __ Yes

*** HEMATOLOGIC/LYMPHATIC**

Slow to heal after cuts __ No __ Yes
Bleeding or bruising tendency __ No __ Yes
Anemia __ No __ Yes
Phlebitis __ No __ Yes
Past transfusion __ No __ Yes
Enlarged glands __ No __ Yes

OVER

ADVANCED CENTER for SLEEP DISORDERS

REVIEW OF SYSTEMS

Patient' Name (Last) ____________ (First) ____________ (Middle) ________

*** GENITOURINARY**

Frequent urination	___ No	___ Yes
Burning or painful urination	___ No	___ Yes
Blood in urine	___ No	___ Yes
Change in force of stream in urination	___ No	___ Yes
Incontinence or dribbling	___ No	___ Yes
Kidney stones	___ No	___ Yes
Sexual difficulty	___ No	___ Yes
Male- testicle pain	___ No	___ Yes
Female- pain with periods	___ No	___ Yes
Female- irregular periods	___ No	___ Yes
Female- vaginal discharge	___ No	___ Yes

Female- # pregnancies # miscarriages

Female- Date of last pap smear ____ / ____ / ____

Female- age menstrual periods started ____________

Female- age of first pregnancy ____________

Female- last menstrual period ____ / ____ / ____

*** ALLERGIC/IMMUNOLOGIC**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	___ No	___ Yes
Morphine, Demerol, or other narcotics	___ No	___ Yes
Novocain or other anesthetics	___ No	___ Yes
Aspirin or other pain remedies	___ No	___ Yes
Tetanus antitoxin or other serums	___ No	___ Yes
Iodine or other antiseptic	___ No	___ Yes

List other drugs /meds that you are allergic to:

List other drugs /meds that you are allergic to:

MEDICAL HISTORY	For a "Pertinent" history, at least 1 specific item for ANY ONE of the 3 histories.	For a "Complete" history, at least 1 specific item for EACH ONE of the 3 histories.

*** Patient MEDICAL history**

Diabetes	___ No	___ Yes
Hypertension	___ No	___ Yes
Cancer	___ No	___ Yes
Stroke	___ No	___ Yes
Heart Trouble	___ No	___ Yes
Arthritis/gout	___ No	___ Yes
Convulsions	___ No	___ Yes
Bleeding Tendency	___ No	___ Yes
Acute infections	___ No	___ Yes
Venereal Disease	___ No	___ Yes
Hereditary defects	___ No	___ Yes
Pnueumonia	___ No	___ Yes

Have you had any surgeries? ___ No ___ Yes

If yes, write name of surgery(s) and when.

Have you been hospitalized before? ___ No ___ Yes

If yes, list for what reason and when.

*** FAMILY medical history**

			Mother		
Diabetes	__ No	__ Yes	Diabetes	__ No	__ Yes
Htyn.	__ No	__ Yes	Htyn.	__ No	__ Yes
Cancer	__ No	__ Yes	Cancer	__ No	__ Yes
Heart troubles	__ No	__ Yes	Heart troubles	__ No	__ Yes
Arthritis	__ No	__ Yes	Arthritis	__ No	__ Yes

Please write down any medical problems in grandparents.

*** Patient SOCIAL history**

Marital Status: ____ Single ____ Married ____ Separated ____ Divorced ____ Widowed

Use of Alcohol: ____ Never ____ Rarely ____ Moderate ____ Daily

Use of Tobacco: ____ Never ____ Previously, but quit Current pecks/day ____

Use of Drugs: ____ Never Type/frequency ____________

Excessive exposure at home or work to: __ Fumes __ Dust __ Solvents __ Air-borne particles __ Noise

Date: ____________ Patients Signature ____________

Physician Signature ____________ Date: ____________

Advanced Center for Sleep Disorders

Patient History Questionnaire

Name________________________________ Date______________ Age___________

Weight____________ Height____________ Sex______ Occupation________________________

Date of Birth________________

My Main Sleep Complaint Is

______Trouble sleeping at night

______Unwanted behaviors during sleep,
Explain:______________________

______Being sleepy all day

______Other, explain:______________________
____

Sleep Schedule, Environment, and Hygiene

Work: Shift begins______AM/PM

Shift Ends______AM/PM

Usual bedtime______AM/PM

Usual wake time______AM/PM

Number of awakenings______

Naps per week______

Please check all that apply to you:

______Have Headaches on awakening
______Sore throat or dry mouth on awakening
______Bitter/sour mouth taste or heartburn
______Loud & disruptive snoring
______Stop breathing during sleep
______Wake up gasping for air
______Difficulty waking in the morning
______Don't feel tired at bedtime
______Function best in evening
______Jaw aches in the morning
______Sudden awakening with intense anxiety or dread
______Difficulty breathing through nose
______Sleep problem varies with menstrual cycle or was related to menopause
______Chest pains or rapid heartbeat
______Chronic cough
______Relative died of crib death
______Family members fall asleep during the day or have sleep apnea
______Sweat during sleep
______Snoring
______Snoring is worse on back
______Nightmares
______Feel refreshed on waking or after naps
______Sleep better in unfamiliar settings
______Bed partner disturbs sleep
______Hyperactivity as a child or teen
______Difficulty with erections
______Shortness of breath
______Swelling of your feet
______Cough with wheezing or sputum
______Family members snore loudly
______Weight has been stable
______Feel excessively sleepy in the daytime
______Feel sudden muscle weakness when Laughing, angered, or been surprised
______Accident or near-miss accident due to falling asleep while driving

Advanced Center for Sleep Disorders

Patient History Questionnaire

Excessive Sleepiness

______Feel tired and fatigued while awake
______Feel sleepiness is associated with weight gain
______Sleepiness is a result of poor night time sleep
______Unable to move body when falling asleep or waking
______Can't function without caffeine or energy drinks
______Vivid dreams when falling asleep or waking up
______Confused at times in the morning
______Fall asleep inappropriately
______Feel groggy/foggy on awakening
______Take naps during the day

Insomnia

______Fall asleep initially without difficulty
______Takes long time to fall asleep
______Have frequent awakenings during the night
______Frequently check the clock when not able to sleep
______Awaken long before it is necessary
______Have difficulty going back to sleep
______Bothered by wakening too early
______Worrying keeps me awake or wakes me up

Movement

______Bed covers extremely messy on awakening
______Kicking or twitching during sleep
______Grind teeth in sleep
______Legs numb, burn, or tingle at night
______Leg jerks during sleep
______Restless sensation in legs
______Bed wetting in adulthood

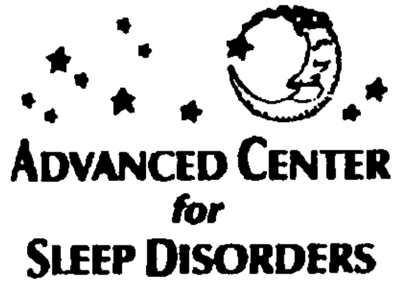
Parasomnias

______Wake up at night feeling really scared
______Sleep walking as an adult/child
______Bed wetting as an adult/child
______Hurt self or others while sleeping
______Sleep talking as an adult/child
______Banging or shaking head during sleep
______Act out dreams

ADVANCED CENTER
for
SLEEP DISORDERS

PRESCRIPTION LIST

PRESCRIPTION NAME	DOSAGE	HOW OFTEN



EPWORTH SLEEPINESS SCALE

Name ______________________________ Date ________________

Nearly 1 in 20 adults experience excessive sleepiness or ES[1*]

Always tired? Can't focus? Having trouble staying awake?

Find out now if your sleepiness is excessive.

It's easy. **The Epworth Sleepiness Scale (ESS)** has 8 routine daytime situations that you rate on a scale from 0 to 3, based on your likelihood of dozing off or falling asleep in each situation. Write the number that corresponds with your answer for each situation in the "My score" box. You then add up your score.

Situation	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	My Score
Sitting & reading	0	1	2	3	
Watching television	0	1	2	3	
Sitting inactive in a public place – for example, a theater or meeting	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3	
In a car, while stopped in traffic	0	1	2	3	
				Total Score:	

The ESS is a simple survey that you can take to measure your general level of sleepiness. A total score of 10 or more on the ESS suggests the need for further evaluation. It is important for your doctor to identify if you have an underlying sleep disorder.

*Prevalence varies across studies

Total Score
10+

A total score of 10 or more suggests that you may be experiencing ES and may need further evaluation by your doctor. For example, your doctor may determine that you have an underlying sleep disorder that is causing you to be excessively sleepy.

The ESS should not be used to make your own diagnosis. It is intended to be a tool to help you identify your own general level of sleepiness. It is important to remember that sleepiness may be caused by an underlying condition that can be diagnosed and treated

If your score is 10 or more, please share this information with your doctor. Be sure to describe all of your symptoms, as clearly as possible, to help with your diagnosis.

ADVANCED CENTER FOR SLEEP DISORDERS

PATIENT REGISTRATION FORM

Patient Information (Please Print)

Name (Last) ______________________ (First) ______________________ (M.I.) ______

Address ____

City ______________________ State ____________ ZIP ____________

Home Phone: ( ) ______________________ Cell ( ) ______________________

Employed? Y/N Employer ______________ Work Phone ( ) ______________ Call work: Y/N ___

Marital Status ______ Married ______ Single ______ Divorced ______ Widowed ______ Other

Social Security Number ______ - ______ - ______ Date of Birth ____ / ____ / ____ Female ___ Male ___

Emergency Contact Name ______________ Relationship ______________ Phone# ______________

Primary Care Physician ______________________ Referred by ______________________

First and Last Name Please First and Last Name Please

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ White

☐ Black or African American ☐ Other Race ☐ Other Pacific Islander ☐ Unreported/Refused to Report

Ethnicity ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refused to Report

Language ☐ English ☐ Other ☐ Refused to Report

Email Address ____

I give this office permission to speak to ______________________ regarding my medical/account info

Responsible Party: NOTE: The person stated here must sign consent on back

Name (Last) ______________________ (First) ______________________ (M.I.) ______

Address ____

City ______________________ State ____________ ZIP ____________

Home Phone: ( ) ______________________ Cell ( ) ______________________

Employed? Y/N Employer ______________ Work Phone ( ) ______________ Call work: Y/N ___

Marital Status ______ Married ______ Single ______ Divorced ______ Widowed ______ Other

Social Security Number ______ - ______ - ______ Date of Birth ____ / ____ / ____ Female ___ Male ___

Primary Insurance:

Policy Holder ______ Self ______ Spouse ______ Parent ______ Other (specify) ______________

Subscriber's Name ______________ Date of Birth ____ / ____ / ____ Social Sec# ___ - ___ - ___

Policy holder address if different than patient ______________________________

ID Number ______________ Group Number ______________ Co-pay ______________

Secondary Insurance:

Policy Holder ______ Self ______ Spouse ______ Parent ______ Other (specify) ______________

Subscriber's Name ______________ Date of Birth ____ / ____ / ____ Social Sec# ___ - ___ - ___

Policy holder address if different than patient ______________________________

ID Number ______________ Group Number ______________ Co-pay ______________

Please read and sign the back of this form

PERSONAL MEDICAL RELEASE

I, the undersigned hereby authorized the Advanced Center for Sleep Disorders to release and / or discuss my medical information (including test results and plan of care) with the following individuals.

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

This will remain in effect until I notify the office of my desire to make changes/or terminate this authorization.

Patient Signature ______________________ Date ____________

Witness Signature ______________________ Date: ____________

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

ADVANCED CENTER FOR SLEEP DISORDERS/ CENTER FOR FAMILY MEDICINE
6073 E. BRAINERD ROAD
CHATTANOOGA, TN 37421
PHONE: 423-648-8008 FAX: 423-475-6151

Patient Name:______________________________ Date of Birth:______________
Address:____
Phone Number:____________________ Social Security Number:________________

Requestor: Dr. Anuj Chandra; Dr. Lotika Pandit

REQUESTING RECORDS FROM:
Provider:______________________________ Fax:____________________
Address:______________________________ Phone:____________________

Please select all the specific documents that apply to your request:

☐ Sleep Study Consult Notes ☐ Sleep Studies

☐Clinical Notes	☐Radiology Reports	☐Nurse Notes	☐Emergency Room
☐Progress Notes	☐Lab Reports	☐Operative Reports	☐Doctor Consults
☐Pathology Reports	☐Physician Orders	☐Other:____________________	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, HIV testing, HIV results, or AIDS information. ___________(initials)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary. If I refuse to sign, my records cannot be release.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Purpose of this disclosure:____

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative: Date:

X______________________________ ______________

ADVANCED CENTER FOR SLEEP DISORDERS

I, the undersigned, hereby consent to and authorize the administration and performance of all treatments, the administration of any needed anesthetics: the performance of such procedures as may be deemed necessary or advisable in the treatment of the patient, the use of prescribed medication; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory test, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I hereby authorize Advanced Center for Sleep Disorders (ACSD) to release medical information to any of my physicians or insurance companies that may be pertinent to my case. I hereby authorize payment directly to ACSD for benefits of services rendered otherwise payable to me. I hereby authorize the release of my records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for services provided.

I understand that ACSD bills insurance claims as a courtesy and if for any reason the insurance fails to pay within 30 days from date of service, the balance may become the guarantors' responsibility for payment.

I understand that a deposit may be required before service is rendered according to the procedure and the amount of deductible and/or out of pocket amounts not met with my insurance company.

I understand and agree that any balance remaining after the insurance company pays, will be due within 30 days after first statement billing.

ACSD policy, Failure to pay according to that payment plan will cause the agreement to be null void and actions to collect the debt will be pursued according to ACSD Policy.

I also may choose to pay the balance in full within 60 days and receive a discount according to ACSD policy.

I understand that any balance due after 90 days will be subject to collections actions and that there will be a collection fee and/or attorney fees added to the balance if collection action is needed to collect the unpaid balance.

A photocopy of this authorization shall be considered as valid as original.

I fully understand that there may be a fee of $50 for a no-show or an appointment not cancelled 24 hours before my appointment time.

I have read, understand, and agree to the above statements.

Patient's name (please print) ______________________________

Signature of Responsible Party: ______________________________

Responsible Party's name (please print): ______________________________

Date: _____ /_____ /_______

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient, you have certain rights and understanding your rights will help get the best possible care. You have the right:

1. To be treated with respect and dignity.
2. To be informed of our care needs in order to make appropriate decisions.
3. To establish a surrogated decision-maker as permitted by law.
4. To expect a reasonably safe environment.
5. To help plan your care and make changes to it.
6. To expect that teaching materials and aids will be written or presented in a manner that you can understand.
7. To be informed of the office billing process.
8. To have access to your medical records.
9. To have your records kept confidential beyond the office except when express consent had been given.
10. To expect that services be provided in a timely manner, including prompt attentions to acute problems.
11. To have visual and informational privacy.
12. To know the professional status of their caregiver.
13. To have another agency contacted if needed services are not available through this office.
14. To refuse services.
15. To communicate your complaints to the Office Manager and expect to receive a follow-up without negative repercussions or changes in service.
16. To be given information on advance directives and assistance in making these decisions as requested.
17. To be assured that acceptance, as a patient, will not be based on whether or not an advance directive has been given.

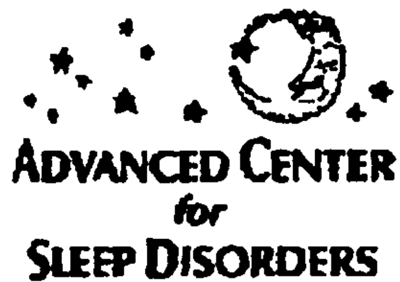
Each patient receiving services through this office has the following responsibilities:

1. To arrive on time for schedules appointments and cancel, when necessary, with a telephone call.
2. To participate in planning of your care.
3. To provide timely payment of any service requested and delivered by this office which is not covered under insurance.
4. To be under the supervision of an office physician.
5. To notify the office staff of any pertinent changes in insurance, employment changes, demographic information or relationships with other care/services providers.
6. To inform the office at the time of an appointment of any physical or mental impairment requiring special accommodations.
7. To follow the recommend treatment plan.
8. To accept responsibility if treatment is refused.
9. To ask questions if directions and procedures are not understood.

Upon your initial visit to the office, you will be asked to read and sign a statement of Patient rights and Responsibilities.

One copy of the signed statement will be filed in your medical chart; the other copy will be given to you.

Signature ______________________________ **Date:** ________________



PATIENT CONSENT FORM

(Please Read and Sign)

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments.
- Administration of any needed anesthetics.
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed, medication.
- Performance of diagnostic procedures/test and cultures.
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I consent to continual treatment per specific diagnosis as recommend. The consent will remain in full force until revoked in writing.

I understand that the **Advance Center for Sleep Disorders** may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that the **Advance Center for Sleep Disorders** will use and disclose me information for the purposes of treatment, payment, and healthcare operations as described in the **Notice of Privacy Practices.**

A photocopy of this consent shall be considered as valid as the original.

Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assigned the benefits payable for the services to the Advance Center for Sleep Disorders.

I acknowledge that I have been given the **Notice of Privacy Practices.** I understand that if I have questions or complaints that I should contact the Privacy Official.

Patient Initial: ______________________________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature: ______________________________

Date: ______________________________