Z SLEEP
DIAGNOZTICS

Patient Name _____ Date of Birth_____

Communication Log

Each entry check patient name and D.O.B

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Authorizations

Please review documents and Initial

_____ Financial Responsibility and Authorization of Benefits: I request that payment of authorized Medicare/other insurance company benefits be made to Z Sleep Diagnoztics, LLC for services/treatment provided to me. I hereby assign to Z Sleep Diagnoztics, LLC all insurance benefits and payments to which I am entitled from whatever source for services/treatment provided by Z Sleep Diagnoztics, LLC. If I have no coverage in effect, or payment is denied by my insurance, then I assume all responsibility of payment due to Z Sleep Diagnoztics, LLC for services rendered. I acknowledge that Z Sleep Diagnoztics, LLC supplies the technical component of this sleep study **and that a separate physician will bill for the interpretation.**

_____ Release of Information: I authorize any holder of medical or other information about me to release to Z Sleep Diagnoztics, LLC any information requested by them for treatment, payment or healthcare operations. I permit a copy of this authorization be used in place of the original.

_____ Consent to Diagnostic Procedure and Video Consent and Release I have been provided with and reviewed the consent to diagnostic procedure release.

_____ Acknowledgement and Review/Receipt of Privacy Practices I have been provided a copy of the Notice of Privacy Practices of Z Sleep Diagnoztics, LLC and understand that I have a right to read the Notice of Privacy Practices prior to signing this document. The document describes the types and uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of healthcare operations of Z Sleep Diagnoztics, LLC. Z Sleep Diagnoztics, LLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the practices by calling the office at Z Sleep Diagnoztics, LLC and requesting a revised copy be sent in the mail.

_____ Patient Rights and Responsibilities

Signature _____ Date _____

Patient Printed Name_____ Date_____

Signature of Witness _____ Date _____

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Pre-study Questionnaire

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?
0= would never dose 1= slight chance 2= moderate 3= high

_____ Sitting and reading
_____ Watching TV
_____ Sitting, inactive in a public place
_____ As a passenger in a car for more than an hour without a break
_____ Lying down to rest in the afternoon when circumstances permit
_____ Sitting and talking with someone
_____ Sitting quietly after lunch without alcohol
_____ In a car, while stopping for a few minutes in traffic

_____ **Total**

Sleep Schedule

What time do you go to bed on **weekdays**? _____ AM or PM
What time do you get up on **weekdays**? _____ AM or PM
What time do you go to bed on **weekends**? _____ AM or PM
What time do you get up on **weekends**? _____ AM or PM

Do you take naps? ☐yes ☐no
If yes, how often do you nap?
_____ times per week

Are you a shift worker? ☐yes ☐no If yes, what kind of shift do you work?

Check for each problem you *currently have*:

☐	loud snoring	☐	teeth grinding
☐	frequent awakenings at night	☐	morning headaches
☐	choking for breath at night	☐	morning dry mouth
☐	I've been told I stop breathing when asleep	☐	sleep walking
☐	leg-kicking during sleep	☐	sleep terrors
☐	crawling feeling in legs when trying to sleep	☐	tongue biting in sleep
☐	trouble falling asleep	☐	bed wetting
☐	trouble staying asleep	☐	acting out dreams
☐	fear of being unable to fall asleep	☐	feeling paralyzed when falling asleep
☐	racing thoughts when trying to sleep	☐	dreamlike images when falling asleep
☐	waking too early	☐	uncontrollable daytime sleep attacks
☐	sweating a lot at night	☐	falling asleep unexpectedly
☐	waking up with heartburn	☐	falling asleep at work
☐	waking up to urinate	☐	falling asleep while driving
☐	nightmares	☐	I use sleeping pills to aid in sleep
☐	muscle tension when trying to fall asleep	☐	I use alcohol to help me sleep
☐	pain interfering with sleep	☐	I get "weak knees" when I laugh

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Please list hospitalizations within the last five years.

Reason for hospitalization: Date

1. List your current average for each category

_____ cups of regular coffee per day
_____ cups of tea per day
_____ ounces of soda or other caffeinated beverage per day
_____ cans of beer per day (12 oz)
_____ glasses of wine per day
_____ alcoholic drinks per day (1-2 oz straight or mixed)

2. Do you use tobacco products? ☐ Yes ☐ No ☐ Quit (How long ago_____months/years)
If so, how much per day? _____

3. What is your relationship status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Living with someone

4. What is your occupation?

BEDTIME Questionnaire

1. Has today been an unusual day in any respect? ☐ Yes ☐ No
If yes, please explain: _____

2. How much sleep did you have last night? _____ Hours

3. Did you take a nap today? ☐ Yes ☐ No
If yes, how long did you nap? _____ Minutes

4. Please indicate if you had alcohol, coffee, tea or soft drinks today. Specify approximate amounts and times
Type_____ Amount _____Time _____

5. Do you have any physical complaints right now? Yes No
If yes, please explain: _____

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Morning Questionnaire

How long do you think it took you to fall asleep last night? _____

How would you say your sleep last night compares with your typical night?

☐ Better ☐ Same ☐ Worse

Did you get enough sleep?

☐ Too little ☐ Just right ☐ Too much

Were you bothered by sleeping in the lab?

☐ Yes ☐ No

Please add any additional comments you might have:

_____

_____

Patient Evaluation

Your experience at Z Sleep is very important to us! Please help us improve our patient care by completing our evaluation.

How would you rate your experience with scheduling our study?

☐ Excellent ☐ Good ☐ Average ☐ Poor

How would you rate the professionalism of our staff?

☐ Excellent ☐ Good ☐ Average ☐ Poor

How would you rate the cleanliness of your room?

☐ Excellent ☐ Good ☐ Average ☐ Poor

Did the technician adequately explain the procedure?

☐ Yes ☐ No

Did you have the opportunity for a CPAP/Mask trial prior to your sleep study?

☐ Yes ☐ No

How did you hear about us?

☐ Doctor ☐ Online ☐ Mail ☐ Family/Friend ☐ Other:_____

Would you recommend our services to friends and family?

☐ Yes ☐ No – If not, please tell why: _____

Suggestions for improvement:

_____

_____

Patient Name: _____ **Date:** _____

Thank you for taking the time to help us improve!

Patient Name:_____
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History and Physical

Patient Name: _____ Age: _____ Sex: _____

**Please print legibly*

Height: _____ Weight: _____

Presenting Symptoms

- ☐ Snoring
- ☐ Difficulty Sleeping
- ☐ Observed Apneas
- ☐ Excessive Daytime Sleepiness
- ☐ Memory Loss
- ☐ Hypoxia
- ☐ Choking/Gasps during sleep
- ☐ Leg Restlessness
- ☐ Falling asleep while driving
- ☐ Other_____

Health History

- ☐ Diabetes
- ☐ Anemia
- ☐ High Blood Pressure
- ☐ Acid Reflux
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Heart Disease or CHF
- ☐ Thyroid Disease
- ☐ Heart Attack
- ☐ Angina
- ☐ Emphysema or COPD
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Tuberculosis
- ☐ Head Trauma
- ☐ Severe Headaches
- ☐ Epilepsy
- ☐ Runny or blocked nose
- ☐ Fainting
- ☐ Hormonal Problem
- ☐ Depression
- ☐ Urological Problem
- ☐ Anxiety Disorder
- ☐ Problems w/alcohol
- ☐ Problems w/Drugs

Medications: (use back if needed)

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: _____ **Supplemental Oxygen** _____**LPM**

Do you currently use CPAP at home? _____ **Pressure** _____ **Mask** _____ **Years**

Special Needs:

- ☐ Walker
- ☐ Wheelchair
- ☐ Incontinent

Office Use Only

Information Obtained By: _____ **Scheduled Test Date:** _____

Approved for PSG/Titration/MSLT: _____ **Date:** _____

Patient Name:_____
Date of Birth:_____