

Name: _____ D.O.B: _____ Date of visit: _____

Bed Partner Questionnaire: Ask someone familiar with your sleep to answer the following section about you (spouse, parent, child, ect.) *Name of person filling out this section* _____

Does the patient...	Circle Your Answer Below			
Stop breathing in his/her sleep?	Yes		No	
How often do the pauses in breathing occur?	Every Night		Occasionally	
	Multiple Times per Night			
Snore Heavily?	Yes		No	
Make loud snorting noises during sleep?	Yes		No	
Snore Every Night?	Yes		No	
Snore in the follow positions:	Back	Left Side	Right Side	All Positions
Kick and Jerk Frequently?	Yes		No	
Sleep Walk or Talk During Sleep?	Yes		No	

Comments _____

SLEEP REVIEW OF SYSTEMS

Are you frequently tired or sleepy during the day? Yes No

Have you had any accidents at work due to sleepiness? Yes No

Have you had any near traffic accidents due to sleepiness? Yes No

Has anyone told you that you snore loudly? Yes No

Have you awakened with a dry mouth "cotton mouth"? Yes No

Has anyone told you that you quit breathing or hold your breath at night? Yes No

Do you ever wake up choking or gasping at night? Yes No

Do you ever wake up coughing or with chest pain? Yes No

How many pillows do you sleep on at night? _____

Do you have trouble breathing through your nose at night? Yes No

Do you have trouble breathing through your nose during the day? Yes No

Do you have morning headaches? Yes No

How many times do you get up during night to urinate, on the average? _____

EXCESSIVE DAYTIME SOMNOLENCE

Do you have any sudden episodes of sleepiness during the day? Yes No

Have you ever had periods in which you feel paralyzed while going to sleep or waking up? Yes No

Have you ever had visual hallucinations or dream-like mental images when falling to sleep? Yes No

Have you ever experienced sudden physical weakness during strong emotions? Yes No
(such as your mouth dropping open or legs going limp during laughter or anger)

CHILDHOOD

Did you have childhood sleep problems of any type? Yes No

If yes, Describe _____

RESTLESS LEGS

When you try to relax in the evening, do you ever have unpleasant or restless feelings in your legs? Yes No

If yes, is the restlessness relieved by walking or movement? Yes No

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INSOMNIA

Do you have difficulty initiating sleep at night? Yes No
 Do you have difficulty staying asleep at night? Yes No
 Do you have pain that bothers you at night? Yes No

PARASOMNIAS

Do you wet the bed at night? Yes No
 Do you ever wake up screaming? Yes No
 Do you sleep walk? Yes No
 Do you talk in your sleep? Yes No
 Do you have frequent nightmares? Yes No
 Do you grind your teeth in your sleep? Yes No

TOBACCO

Ever smoked? Yes No If yes, how long? _____ Packs per day? _____
 Do you still smoke? Yes No If no, when did you quit? _____

ALCOHOL/DRUGS

Do you drink alcohol? Yes No
 If yes, how often? _____ days/wk How much on average? _____
 Have you ever had a problem with drinking too much alcohol? Yes No

CAFFEINE and OTHER SUBSTANCES

Regular coffee _____ cups/day Decaffeinated coffee _____ cups/day
 Soft drinks with caffeine? Yes No If yes, How many? _____ per day
 Do you drink tea with caffeine? Yes No If yes, How many cups/glasses _____ per day
 Do you currently use street drugs? Yes No
 Any illicit drug usage in the past? Yes No

REFLUX

Do you often wake with a sour taste or a burning sensation in your chest? Yes No

MEALS/EXERCISE

How many meals do you eat daily? _____ Do you exercise regularly? Yes No

Weight Change last 5 years → Gained _____ lbs. or Lost _____ lbs.

SOCIAL HISTORY

Occupation: _____ () Retired () Disabled
 Marital Status: () Single () Married () Divorced Other: _____
 Number of children: _____
 Who is currently living in your household? _____

SURGICAL HISTORY

Circle all that apply and dates of surgery (year)

Tonsils & Adenoids	Cardiac Bypass	Gall Bladder
Nose or Sinuses	Appendectomy	Hysterectomy
Other:	Other:	Other:

OTHER ILLNESSES

Circle all that apply

Diabetes	High Blood Pressure	Emphysema	Cancer
Stroke	Irregular Heart Beats	High Cholesterol	Kidney Disease
Depression	Coronary Artery Disease	Migraines	Ulcers/ Reflux
Anxiety	Chronic nasal congestion	Thyroid Disease	Cataracts

Other: _____

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REVIEW OF SYSTEMS Circle any symptoms that YOU have

EYES	Blurry vision	Loss of vision	Double vision	Eye pain	Dry eyes
EAR, NOSE, & THROAT	Hearing loss	Ringling	Ear pain	Night time congestion	Dry mouth
	Nosebleeds	Nasal congestion	Obstruction		Sore throat
HEART	Chest pain	Heaviness	Racing or pounding	Palpitations	Swelling
PULMONARY	Short of breath	Wheezing	Cough	Coughing up blood	Phlegm
STOMACH & GI TRACT	Nausea	Trouble swallowing	Constipation	Bright blood in Stools	Heart burn
	Vomiting		Diarrhea	Stools black as Tar	Stomach pain
GENITOURINARY	Trouble Emptying the bladder	Incontinence Urgency	Sexual problems	Night time urination (more than twice____)	Frequent Urination
MUSCLE/SKELETAL	Back pain	Neck pain	Sore Muscles	Swollen Joints	Muscle Cramps
	Twitching muscles	Arm or Leg pain	Stiffness	Arthritis	
SKIN	Itching	Rash	Blisters	Sweating	Dry Skin
NEUROLOGIC	Weakness	Numbness	Tingling	In-coordination	Dizziness
	Light Headedness	Imbalance	Forgetfulness	Headaches	Slurred Speech
		Shaking	Tremors	seizures	
PSYCHOLOGICAL	Personality Changes	Loss of Interest	Angry	Sad	Withdrawn
	Phobias	Depression	Crying Spells	Nervous	Suicidal Thoughts
GENERAL	Weight change	Fatigue	Night sweats	Snoring	Memory loss

ALLERGIES:

List any medication allergies: _____

FAMILY HISTORY Circle the Conditions and then List Affected Family Members

CONDITION	AFFECTED FAMILY MEMBER	CONDTION	AFFECTED FAMILY MEMBER
Diabetes	_____	Narcolepsy	_____
Heart Disease	_____	Daytime Sleepiness	_____
High Blood Pressure	_____	Depression	_____
Stroke	_____	Anxiety	_____
Obesity	_____	Sleep Apnea	_____
Other – Describe	_____		

Please bring a current list of your medications (including vitamins and over the counter medications) or the medications in their original containers.

- Owensboro Heart & Vascular
- Owensboro Primary Care
- Immediate Care Center
- The Hancock Clinic
- The McLean Clinic
- The Muhlenberg Clinic
- Owensboro Advanced Sleep Center
- Owensboro Physical Therapy
- Owensboro Medical Practice Laboratory



OWENSBORO
Medical Practice

DATE: _____

MRN#: _____

Dear Valued Patient,

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information in PRINT. All information is Confidential and is only released with consent.

PATIENT INFORMATION

Patient Name		Date of Birth	Sex	Age
Patient's Social Security Number		Home Telephone Number		Cell Phone Number
Home Address		City	State	Zip
Mailing Address if Different		City	State	Zip
Race: Asian Black/African American More than one race Native Hawaiian or other pacific Islander Other Race Unknown White Hispanic/Latino				
Please Circle all that apply: Married Widowed Single Separated Minor Student Smoker Veteran				
Preferred Language		Primary Care Physician		Email Address
Employer's Name		Work Telephone Number		Driver's License No.
Employer's Address		City	State	Zip

LEGAL GUARDIAN/SPOUSE INFORMATION

Legal Guardian/Spouse Name		Social Security Number		Date of Birth
Employer's Name		Work Telephone Number		
Employer's Address		City	State	Zip

NOTIFY IN CASE OF EMERGENCY

Contact Name (not living with you)		Relationship	Contact Name	Relationship
Home Telephone Number		Date of Birth	Home Telephone Number	Date of Birth

POLICY HOLDER INSURANCE INFORMATION

Primary Policy Holder Name		Secondary Policy Holder Name		
Social Security Number	Date of Birth	Social Security Number	Date of Birth	
Name of Insurance	ID/Group Number	Name of Insurance	ID/Group Number	
Phone Number		Phone Number		

ACCIDENT INFORMATION

Were You Injured on the Job? YES NO		Were you involved in an Auto Accident? YES NO		
Have you Informed Your Employer? YES NO		Claim Number:		
Original Injury Date:		Time of Injury:	State Injury Occurred:	
Worker's Compensation/Auto Insurance Carrier Name		Billing Address		

AUTHORIZATIONS

I hereby authorize examination and any other medical services deemed necessary. I authorize Owensboro Medical Practice to forward results of any tests and/or medical services to medical facilities or insurance companies including Workers Compensations that they may require concerning my case. I authorize and request my insurance company/companies to pay directly to Owensboro Medical Practice, PLLC, the amount due them in my pending claim for medical, surgical or laboratory services. I understand any balance remaining after insurance payment or denial is my responsibility and that interest may be charged on accounts due past 90 days. I agree my records may be used and reviewed during quality assurance programs. I hereby release Owensboro Medical Practice from liability for any loss or damage to property which is brought to or kept in the facility during treatment.

DATE _____ SIGNATURE _____ PRINTED _____



- Owensboro Heart & Vascular
- Owensboro Primary Care
- Immediate Care Center
- The Hancock Clinic
- The McLean Clinic
- The Muhlenberg Clinic
- Owensboro Advanced Sleep Center
- Owensboro Physical Therapy

DATE: _____

CHART #: _____

PATIENT'S NAME: _____

PRIVACY CONSENT FORM FOR DISCLOSURE OF PATIENT INFORMATION FOR THE PURPOSES OF TREATMENT AND PAYMENT

- I consent to Owensboro Medical Practice, PLLC using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me or to carry out Owensboro Medical Practice's health care operations.
- I consent to Owensboro Medical Practice, PLLC using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity.
- I consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Specific Records Expressly Included. I expressly authorize release of the following information for the purposes of treatment, payment and health care operations, if it is part of my protected health information (CHECK ANY OR ALL YOU AGREE TO AUTHORIZE FOR RELEASE):

- Chemical Dependency/Substance Abuse
 - Drugs
 - Alcohol
- Sexually Transmitted Diseases

I further acknowledge Owensboro Medical Practice has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

(LIST FAMILY OR FRIENDS WE CAN DISCUSS REGARDING YOUR MEDICAL CARE AND/OR BILL)

NOTE: This release is applicable for any of the Owensboro Medical Practice entities listed at the top of this form.

RELEASE INFO TO: _____

Please check if office is able to leave message on answering machine or voice mail.

DATE: _____ SIGNATURE: _____