DO NOT OMIT ANY REQUESTED INFORMATION

PATIENT FULL NAME: _____ **DOB** _____

Email Address: _____ Age _____ SS #_____

Street Address_____City/State/Zip_____

Phone Numbers: Home (____)_____Cell (_____)_____ Work (_____)_____

Preferred number for reminder: _____ **Phone or Text (please circle preferred method)**

Employer_____Occupation_____ **Full Time / Part time**

Please circle: Male / Female **Race:** _____ **Please Circle**: Single / Married / Widowed / Divorced

SPOUSE / GUARDIAN

Name_____Age_____DOB_____SS #_____

Phone Numbers: Home (____)_____Cell (_____)_____ Work (_____)_____

Employer_____Occupation_____

EMERGENCY CONTACT

Name_____ Phone (____)_____ Relation _____

INSURANCE

PRIMARY INSURANCE _____ **Group #**_____ **ID #**_____

Insured's Name_____ DOB_____ SS #_____

SECONDARY INSURANCE _____ **Group #**_____ **ID #**_____

Insured's Name_____ DOB_____ SS #_____

Primary Care Physician_____ **Phone (_____)**_____

Referred By_____ **Phone (_____)**_____

PHARMACY

Name_____ Phone (_____)_____

It is the policy of this office to keep all medical records confidential. There may be occasions when you need this information released to another office/person. Please answer the following questions and authorize us to give your confidential information in these situations:

1. May we leave your medical information, including test results, on an answering machine, or give it to another person, such as a spouse, adult child or caregiver? YES _____ NO _____

Name(s) and relationship to patient: _____

2. May we give pertinent information to your primary care doctor, the doctor who referred you here, or a doctor we refer you to? YES _____ NO _____

3. May we leave detailed appointment reminders or voice / texts messages to call us back on your answering machine at home, work, or cell phone, or with whoever answers the phone? YES _____ NO _____

Patient Signature _____ **Date** _____

Name: _____ **DOB:** _____ **Date:** _____

Occupation: _____

Reason for your visit today (Please include dates): _____

_____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent time. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to **choose the "most appropriate number"** for each situation.

0 = would "never doze" **2 = "moderate" chance of dozing**
1 = "slight" chance of dozing **3 = "high" chance of dozing**

CHANCE OF DOZING / SLEEPING (Please circle the most appropriate number)	SITUATION
0 1 2 3	Sitting and reading
0 1 2 3	Watching T.V.
0 1 2 3	Sitting, inactive in a public place (theatre 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 when circumstances permit
0 1 2 3	Sitting and talking to someone
0 1 2 3	Sitting quietly after lunch without alcohol
0 1 2 3	In a car while stopped for a few minutes in traffic
TOTAL: _____	**(Add each number up and give a total out of 24)**

SLEEP HISTORY:

Do you have or has anyone noticed that you have the following symptoms?

[ ] Snore [ ] Stop breathing while sleeping / gasping for air [ ] Have restless sleep

[ ] Have morning headaches [ ] Grinding teeth during sleep [ ] Talk in sleep

[ ] Take medication for sleep [ ] Night sweats [ ] Frequent nightmares / vivid dreams

[ ] Have creeping or crawling in legs [ ] Acting out / talking during sleep

What is your typical Sleep Schedule on **work days?**

Bedtime: _____ Rise time: _____ How long to fall asleep: _____

What is your typical Sleep Schedule on **off days?**

Bedtime: _____ Rise time: _____ How long to fall asleep: _____

Do you routinely sleep with children or pets in your bed? [ ] YES [ ] NO _____

In the past, how many hours did you sleep, per night, on average? _____

Do you work shifts or irregular hours? [ ] YES [ ] NO

How many times do you wake up during the night? _____

Is your nighttime sleep refreshing? [ ] YES [ ] NO

Do you take naps? [ ] YES [ ] NO How long are they? _____ What time do you nap? _____

Review of Symptoms: Please check box if you have had any of the following in the past few weeks.

Check here if all negative. [ ]

Psychiatric:	**Genitourinary:**	**Gastrointestinal:**
[ ] Depression	**[ ] Frequent urination at night**	**[ ] Heartburn**
[ ] Anxiety		**[ ] Reflux**

ENT:	**Respiratory:**	**Musculoskeletal:**
[ ] Sinus congestion @ night	**[ ] Coughing or wheezing**	**[ ] Back pain**

SOCIAL HISTORY

[ ] Married [ ] Single [ ] Divorced (Year _____) [ ] Widowed (Year _____)

Do you use tobacco? [ ] Yes [ ] No How many years _____
[ ] Former Smoker Quit / Date _____
(Circle) Cigarettes / Cigars / Pipe / Chew Daily amount _____

Do you drink alcohol? [ ] Yes [ ] No Daily amount _____

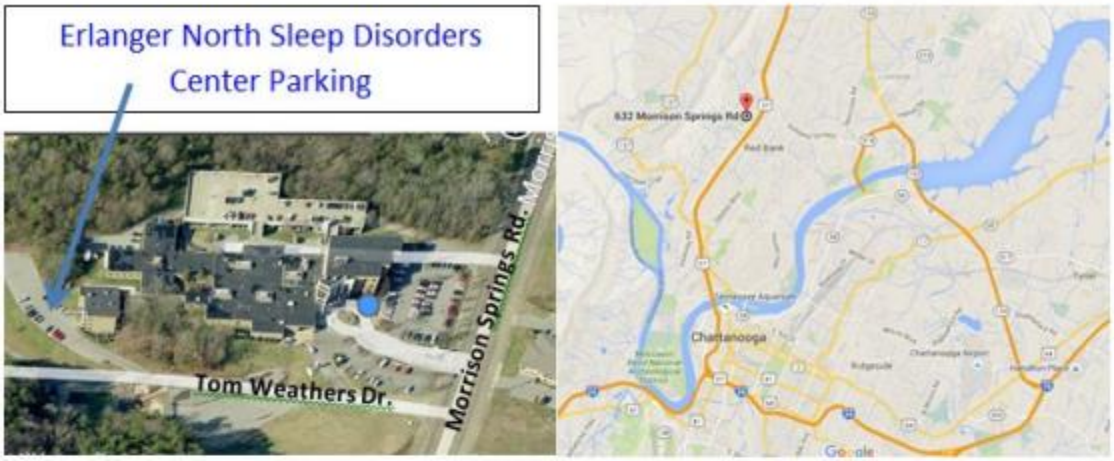
Do you drink caffeinated drinks (coffee, tea, soda)? [ ] Yes [ ] No

If so, how many cups per day? _____

Do you use Cannabis in any form? [ ] Yes [ ] No

If so, what type? _____

How often? _____



Erlanger North Sleep Disorders Center
628 Morrison Springs Rd.
Chattanooga TN, 37415

From Chattanooga:

Take I-75 South to I-24 West to US-27 North
Approx 5 miles after you go over the river, take the Redbank / Morrison Springs Rd. exit.
Go left at the bottom of the ramp (back under the Highway)
At the second traffic light take a left onto Tom Weathers Dr. Our parking lot will be on the right across from the swimming pool.
The Sleep Disorders Center is located just off of the elevator on the 3rd floor.

From Soddy-Daisy:

Take US-27 South toward Chattanooga
Take the Redbank / Morrison Springs Rd. exit.
Go right at the bottom of the ramp
At the first traffic light take a left onto Tom Weathers Dr. Our parking lot will be on the right across from the swimming pool.
The Sleep Disorders Center is located just off of the elevator on the 3rd floor.