

Montefiore

SLEEP-WAKE DISORDERS CENTER



- ☐ Dr. Michael J. Thorpy
- ☐ Dr. Imran Ahmed
- ☐ Dr. Shelby F. Harris
- ☐ Dr. Shoshana Renee Monderer

Dear Patient: _____ MRN#: _____

Enclosed in this packet you will find the following information regarding your upcoming appointment at The Montefiore Medical Center/Sleep-Wake Disorders Center located at:

3411 Wayne Avenue- Bronx, N.Y. 10467 – Main Floor- in the lobby behind security desk

Scheduled Appointment Date: ____/____/____ Time: ____:____ ☐ A.M. ☐ P.M.

Day(s): ☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY

Please complete the enclosed forms and bring them with you at the time of your appointment.

- 1.) General patient information sheet (phone, email, insurance, primary care doctor, etc.)
- 2.) Travel Instructions to the office.
- 3.) Assignment and Release Form (this must be signed)
- 4.) Office policy wavier (please note it must be signed).
- 5.) Sleep Questionnaire.
- 6.) Sleep Log Sheet. This log is to be completed EVERYDAY for TWO (2) WEEKS prior to your Scheduled Appointment. Bring this log sheet with you so the doctor may review it when you meet. This is to be completed whether or not you are able to sleep and indicate the times you attempted to sleep. This is *very* important and important for us to give you the best care.

PLEASE MAKE SURE THAT ALL INFORMATION ON THE FORMS ARE FILLED OUT AND SIGNED BY THE PATIENT.

If you have any questions regarding any of the forms or need information, please do not hesitate to contact our office (718) 920-4841 and a Sleep Wake Disorders Center staff member will help you.

Please bring all necessary Insurance Cards, Referrals, Authorization and Primary Care Provider information such as: Primary Care Provider name, address, telephone number and fax number. This information is important so that the office can submit your consultation notes to your Primary Care Provider.

****PLEASE ALLOW ADDITIONAL TIME BEFORE YOUR APPOINTMENT FOR PARKING****

Thank you for your cooperation

Sleep-Wake Disorder Center Staff

General Patient Information Sheet

Please complete entire form.

****COMPLETE TODAS LAS SECCIONS DE ESTE FORMULARIO****

- 1.) _____
LAST NAME/APELLIDO FIRST NAME/ PRIMER NOMBRE _____
SOCIAL SECURITY
- 2.) _____
ADDRESS/ DIRECCION APT# _____
TELEPHONE#/TELEFONO
- 3.) _____
CITY/CIUDAD STATE/ESTADO ZIP CODE/ZONA POSTAL _____
CELLULAR #
- 4.) _____
DATE OF BIRTH/FECHA DE NACIMIENTO ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ FEMALE ☐ MALE
- E-MAIL ADDRESS: _____
- 5.) _____
LAST NAME OF RELATIVE/ APELLIDO DE PARIENTE FIRST NAME/PRIMER NOMBRE DE PARIENTE
- 6.) _____
ADDRESS OF RELATIVE/DIRECCION DE PARIENTE CITY/CIUDAD STATE/ESTADO ZIP CODE/ZONAPOSTAL
- 7.) _____
LAST NAME PRIMARY CARE PHYSICIAN (PCP) FIRST NAME PRIMARY CARE PHYSICIAN (PCP)
APELLIDO DE MEDICO PRIMARIO PRIMER NOMBRE DE MEDICO PRIMARIO
- 8.) _____
ADDRESS OF (PCP)/DIRECCION MEDICO PRIMARIO CITY/CIUDAD STATE/ESTADO ZIP CODE/ZONA POSTAL
- 9.) _____
PCP TELEPHONE# / TELEFONO FAX NUMBER SPECIALTY/SPECIALIDAD
- 10.) _____
LAST NAME OF REFERRING PHYSICIAN FIRST NAME OF REFERRING PHYSICIAN
APELLIDO DE MEDICO REFERENTE PRIMER NOMBRE DE MEDICO REFERENTE
- 11.) _____
ADDRESS/DIRECCION CITY/CIUDAD STATE/ESTADO ZIP CODE/ZONA POSTAL
- 12.) _____
TELEPHONE/ TELEFONO FAX NUMBER SPECIALTY/ESPECIALIDAD

PATIENT(S) TELEPHONE NUMBER:

(HOME#) _____/_____/_____ (WORK#) _____/_____/_____

(CELL#) _____/_____/_____ E-mail _____

INSURANCE COVERAGE:

INSURANCE CARRIER NAME: _____

ADDRESS: _____ TELEPHONE#: _____/_____/_____

_____/_____/_____ FAX NUMBER: _____/_____/_____

DATE OF CALL _____/_____/_____ TIME: ____:____ ☐ AM ☐ PM

Directions to SLEEP-WAKE DISORDERS CENTER

3411 Wayne Avenue, Bronx, N.Y. 10467
OFFICE: 718-920-4841 - FAX: 718-798-4352

By Subway

- #4 Train - (Lexington Avenue Woodlawn line) to Mosholu Parkway Station. Walk north on Jerome Avenue and turn right on 208th Street. At the fork, follow 210th Street crossing Bainbridge Avenue where it becomes Wayne Avenue. Office is located on the right hand side right after parking garage.
- D Train - (IND) to 205th Street Station (last stop). Street sign says 206th Street and Bainbridge. Walk north on Bainbridge Avenue and turn right on Wayne Avenue (opposite 210th Street).

By Bus (within the Bronx)

- Bx1 bus stops at Jerome Avenue and 210th Street.
- Bx10, Bx16, Bx28, Bx30 and Bx34 buses stop directly outside Greene Medical Arts Pavilion. Once you get off bus, walk to the corner of Gunhill Road and Bainbridge. Make a right and go down Gunhill Road to the next corner which will be Wayne Avenue. Make a right and the building will be located on your right side.
- Bx10 and Bx28 buses have stops on Jerome Avenue within walking distance of the West Campus.

By Express Bus from/to Manhattan

- MTA stops at Bainbridge Avenue and 210th Street. Call 718-652-8400 for schedules or check online at <http://www.MTA.com/>

***** PARKING is available in the Green Medical Arts Pavilion.**

However, please note that the entrance is located at Wayne Avenue ***

By Car - _For more complete driving directions, visit www.mapquest.com or www.maps.yahoo.com

***** PLEASE ALLOW ADDITIONAL TIME BEFORE YOUR
APPOINTMENT FOR PARKING !!*****

From Westchester

- I-87 to 233rd Street/ Exit 13. Proceed south on Jerome for one-half mile. Road forks at Jerome and Bainbridge Avenue (just before train overpass). Bear left onto Bainbridge Avenue and then a left on Gun Hill Road. Go 1 block and make a right on Wayne Avenue.
- Bronx River Parkway South to 233rd Street/ Exit 10 (Exit 9 closed due to ongoing construction). Turn left onto Webster Avenue. At Gun Hill Road make a right, then left onto Wayne Avenue.
- Saw Mill River Parkway to Mosholu Parkway exit. Turn left onto Gun Hill Road (first light), go pass Montefiore hospital and then turn right onto Wayne Avenue.

From Manhattan

- FDR Drive over Willis Avenue Bridge to I-87/Major Deegan Expressway North to Exit 13/ 233rd Street. Make the first right on Jerome Avenue and proceed south for one-half mile. Road forks at Jerome and Bainbridge Avenue (just before train overpass). Bear left onto Bainbridge Avenue and then a left on Gun Hill Road. Go 1 block and make a right on Wayne Avenue.
- West Side Highway to Henry Hudson Parkway to Mosholu Parkway to Gun Hill Road exit. Turn left onto Gun Hill Road (first light), go pass Montefiore hospital and then turn right onto Wayne Avenue.

From Brooklyn

- Brooklyn-Queens Expressway (BQE) / 278 to the Triboro Bridge to the Bruckner Expressway/278 to the Bronx River Parkway North and exit at Gun Hill Road Exit 9. Turn left onto E. Gun Hill Road, continue several blocks and make onto Wayne Avenue.

From Queens

- Whitestone Bridge to the Cross Bronx Expressway/95 to the Bronx River Parkway North and exit at Gun Hill Road Exit 9. Turn left onto E. Gun Hill Road and then turn left onto Bainbridge Avenue. Greene Medical Arts Pavilion is on the left. For Moses Division Hospital, turn right onto East 210th Street for main entrance.
- Throgs Neck Bridge to the Cross Bronx Expressway/95 to the Bronx River Parkway North and exit at Gun Hill Road Exit 9. Turn left onto E. Gun Hill Road, continue several blocks and make onto Wayne Avenue.
- Triboro Bridge to the Bruckner Expressway/278 to the Bronx River Parkway North and exit at Gun Hill Road Exit 9. Turn left onto E. Gun Hill Road, continue several blocks and make onto Wayne Avenue.

From Newark Airport/New Jersey

- I-95 North/New Jersey Turnpike to George Washington Bridge upper roadway to I-95 North/Cross Bronx Expressway. Take Exit 1C to I-87N/Major Deegan Expressway to Exit 13/ 233rd Street. Make the first right on Jerome Avenue and proceed south for one-half mile. Road forks at Jerome and Bainbridge Avenue. Bear left onto Bainbridge Road and continue to Gunhill Road. Make a left onto Gunhill Road to your next light which is Wayne Avenue. Make a right turn onto Wayne Avenue.

From La Guardia Airport

- Grand Central Parkway West to I-278 East /Triboro Bridge to I-87 North/Deegan Expressway to Exit 13/ 233rd Street. Make the first right on Jerome Avenue and proceed south for one-half mile. Road forks at Jerome and Bainbridge Avenue. Bear left on Bainbridge Avenue and continue to Gun Hill Road. Make a left onto Gunhill Road to your next light which is Wayne Avenue. Make a right turn onto Wayne Avenue.

From JFK Airport

- Van Wyck Expressway/678 to the Whitestone Bridge to the Cross Bronx Expressway/95 (exit at Rosedale Avenue) to the Bronx River Parkway North (and exit at Gun Hill Road Exit 9. Turn left onto E. Gun Hill Road and then turn left onto Wayne Avenue.

On Street Parking:

There is on-street parking available in the West Campus neighborhood. Check the street signs for rules and accessibility.

Public Garages:

- *Moses Division Hospital:* 24-hour valet parking garage at 120 East 210th Street; Tel: 718-920-5691

(Rates subject to change):

Up to 1 hour: \$6	Up to 12 hours: \$12
Up to 2 hours: \$8	Up to 24 hours: \$16

- *Greene Medical Arts Pavilion Parking:* parking garage open from 6:00 A.M. to 11 P.M. daily at 3450 Bainbridge Avenue, entrance on Wayne Avenue; Tel: 718-920-6306.

(Rates subject to change):

Up to 1 hour: \$6	Up to 6 hours: \$12
Up to 2 hours: \$8	Up to 24 hours: \$16
	After 12 hours: \$20

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization for release of information to by the faculty practice of the Montefiore Medical Center:

I hereby authorize and direct the above names Medical Facility/Provider, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representative thereof to examine and make copies of all records relating to such care and treatment.

Date

Signature of Patient or Authorized Representative

Assignment to: The faculty practice of Montefiore Medical Center

I hereby assign, transfer, and set over to the above named, Medical Facility/Provider sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financial liable for my hospital and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said medical facility/hospital.

Date

Signature of Patient or Authorized Representative

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of the medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Date

Signature of Patient or Authorized Representative

MEDICARE WAIVER

Patient Name: _____

Medicare No.: _____

I HAVE BEEN INFORMED BY THE ABOVE PROVIDER THAT ALL OR PART OF THE SERVICES RENDERED TODAY MAY BE DENIED BY MEDICARE PART B AS MEDICALLY UNNECESSARY. I FEEL THESE SERVICES WERE NECESSARY AND HAVE REQUESTED THE ABOVE TO SUBMIT ON MY BEHALF AN ASSIGNED CLAIM FOR THESE SERVICES. IN THE EVENT THAT MEDICARE SHOULD DENY PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT TO THE PROVIDER.

The following procedures are being requested by my doctor: _____

Date

Signature of Patient or Authorized Representative

Patient Name: _____
Social Security #: _____
Date of Service: _____

**SLEEP-WAKE DISORDERS CENTER
AT
MONTEFIORE MEDICAL CENTER**

POLICY REGARDING PHONE CALLS AND CANCELLATIONS

Phone call policy

When a phone call consultation is necessary, time must be spent by our staff recording the message, pulling the chart from our files, presenting it and often discussing the message with a doctor, making a note in the chart and re-filing the chart. The time of our staff and the time of the doctor is an expense that is part of the patient's fee.

If **you** prefer a phone call to discuss your treatment, and the doctor agrees, a charge of **\$50.00** will be made.

If you have not been seen within the last 6 months, and a call is for a **prescription** renewal that does not require a phone conversation with the doctor, a charge of **\$25.00** will be made.

Cancellation and "No Show" policy

Cancellation of an office visit or a sleep study:

More than 2 business days prior to the appointment: no charge

Less than 2 business days prior to the appointment: \$50.00 will be charged

Failing to show for an appointment ("No Show") or lateness to an appointment:

If you are more than 20 minutes late for an office visit, you will be seen if the doctor agrees and has room in his or her schedule to see you.

If you are a "no show" for an office visit: You will be charged one half the usual fee.

If you "no show" for a sleep study: You will be charged \$100.00

MEDICAL INSURANCE USUALLY DOES NOT PAY FOR ANY OF THE ABOVE MENTIONED CHARGES.

Patient Signature: _____

Date: _____

MONTEFIORE



Name: _____

Date: _____

Age: _____

Occupation: _____

Marital Status: _____

**SLEEP-WAKE DISORDERS CENTER
SLEEP QUESTIONNAIRE**

Instructions: Please complete this questionnaire and return it to the clinician who interviews you at the time of your initial evaluation. Your responses will give your doctors an overview to your sleep problems, therefore helping to give you the best services possible in an efficient manner. It is important that you fully answer these questions to the best of your ability. You will notice that most of the questions are “yes/no” with some requiring you to fill in the blank. The questionnaire should take approximately 20 minutes to complete.

If you have additional questions before your initial appointment, please contact our staff at 718-920-4841. We look forward to being able to evaluate your problem and to provide you with therapeutic advice.

NATURE OF SLEEP-WAKE PATTERN

Why are you seeking treatment at this time?

- | | | |
|--|--|--|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Snoring | <input type="checkbox"/> Difficulty staying asleep |
| <input type="checkbox"/> Disruptive behaviors during sleep | <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Other |

How does this problem affect you?

CURRENT SLEEP-WAKE SCHEDULE

- | | |
|--|--|
| What time do you usually turn out the bedroom light on workdays?..... | _____ AM / PM |
| What time do you usually wake up on workdays?..... | _____ AM / PM |
| What time do you usually turn out the bedroom light on weekends?..... | _____ AM / PM |
| What time do you usually wake up on weekends?..... | _____ AM / PM |
| On <i>average</i> , how long after going to bed does it take you to fall asleep? | _____ minutes |
| How long after finally awakening does it take you to get out of bed?..... | _____ minutes |
| How many times do you usually awaken during the night?..... | _____ times |
| What is the <i>average</i> length of time of your awakenings?..... | _____ minutes |
| What do you do during these arousals (check one or more)?..... | <input type="checkbox"/> Go to bathroom |
| Other: _____ | <input type="checkbox"/> Lay in bed |
| | <input type="checkbox"/> Eat/drink |
| | <input type="checkbox"/> Get out of bed |
| Do you awaken earlier than you'd like and have trouble returning to sleep?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| On average, how much sleep in total do you think you get per night? | _____ hrs _____ mins |
| Do you have a regular, nightly routine that you follow every night before getting into bed?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| If yes, what do you do? _____ | |

SNORING/BREATHING WHILE ALSEEP

- | | |
|--|--|
| Do you snore loudly or have you been told you snore loudly?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you ever awaken choking, gasping, or gulping for air?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Do you often awaken with a dry mouth or sore throat?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has anyone ever told you that you have trouble breathing or you stop breathing while asleep? | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Do you ever awaken with headaches?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you use the bathroom frequently at night?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you experience heartburn or acid indigestion?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you ever received any treatment for sleep apnea?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had your tonsils and/or adenoids removed?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Do not write in this column

DAYTIME FUNCTIONING

Do you feel sleepy, sluggish or fatigued most mornings?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you usually feel fatigued and/or sleepy during the day?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you notice problems with attention, concentration or memory during the day?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you tend to fall asleep in inactive situations?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you fallen asleep while driving or while stopped at a traffic light?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you had a motor vehicle accident due to sleepiness or fatigue?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you usually nap during the day?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, how long do you usually nap?	_____ minutes	
What time of day do you usually nap (morning, afternoon, evening).....	_____	
How many naps do you usually take per day?.....	_____	
How many naps do you take per week?.....	_____	
Has your weight changed recently?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If so, how: _____		

WORK HOURS

If you work, what are your usual work hours?.....	_____ to _____
Do you work shifts (evenings, nights, rotating shifts)?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you work multiple jobs?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO

SLEEP ENVIRONMENT

Is there any aspect of your sleep environment that seems to contribute to your sleep problem (e.g. light, temperature, humidity, bed comfort, etc.)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, explain: _____		
Do you sleep with anyone else in the same room or same bed?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you bothered by your bed partner's snoring or movements during sleep?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, do you sleep in the same room or bed with your children?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you sleep in the same bed with a pet?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you usually eat or drink liquid before getting into bed or while in bed?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you tend to watch the clock while in bed?.....	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Have you tried any relaxation exercises to help you sleep or while in bed?
Do you do any of the following while in bed? (check all that apply).....

- ☐ YES ☐ NO
☐ Read
☐ Watch TV
☐ Eat/Drink
☐ Use computer

Do not write in this column

MOVEMENTS WHILE ASLEEP

Do you have painful or unusual feelings in your legs that make it difficult to fall asleep?.....

- ☐ YES ☐ NO

Do you ever experience twitching or jerking of your legs while asleep?.....

- ☐ YES ☐ NO

OTHER SLEEP SYMPTOMS

Upon falling asleep or waking up, have you ever had the experience of seeing things or hearing things that weren't really there?.....

- ☐ YES ☐ NO

When falling asleep or waking up, have you ever been unable to move your arms or legs even though you tried?.....

- ☐ YES ☐ NO

Have you ever experienced sudden muscle weakness while awake that was brought on by an intense emotion?.....

- ☐ YES ☐ NO

Do you start dreaming right after you fall asleep?.....

- ☐ YES ☐ NO

OTHER SLEEP DISTURBANCES

Do you sleepwalk (or have you or have you ever)?.....

- ☐ YES ☐ NO

Do you get nightmares (or have you ever)?.....

- ☐ YES ☐ NO

Do you injure yourself/others while asleep or have you fallen out of bed?.....

- ☐ YES ☐ NO

Do you eat while asleep?.....

- ☐ YES ☐ NO

Do you wet the bed while asleep?.....

- ☐ YES ☐ NO

Do you get night terrors?.....

- ☐ YES ☐ NO

Do you talk during your sleep?.....

- ☐ YES ☐ NO

LIFESTYLE FACTORS

Do you have caffeine (soda, coffee, chocolate, tea) within 6 hours of bedtime?.....

- ☐ YES ☐ NO

Do you use caffeine to help you stay awake?.....

- ☐ YES ☐ NO

How many alcoholic drinks do you have per day?.....

_____ drinks

Do you use alcohol to help you fall asleep?.....

- ☐ YES ☐ NO

Do you smoke?.....

- ☐ YES ☐ NO

If yes, how many cigarettes, cigars, pipes do you smoke per day?.....

Do you smoke just before bed or during the night?.....

- ☐ YES ☐ NO

Do you use any illicit drugs (marijuana, heroin, crack, cocaine)?..... ☐ YES ☐ NO
 Do you use any illicit drugs to help you fall asleep?..... ☐ YES ☐ NO
 Do you eat a large meal two hours before bedtime?..... ☐ YES ☐ NO

Do not write in this column

MEDICATION USE

Please list all prescription and over-the-counter medications that you currently use.

Medication Name	Dose	Reason Used	Used to treat a sleep problem (yes/no?)	Prescribing Doctor

MEDICAL/PSYCHIATRIC HISTORY

What is your height?..... _____ ft _____ in
 What is your current weight?..... _____ pounds
 Have you ever had surgery?..... ☐ YES ☐ NO
 If yes, what: _____

 Have you ever been treated for any psychiatric problems?..... ☐ YES ☐ NO
 If yes, what: _____
 Are you currently being treated by a psychologist/psychiatrist?..... ☐ YES ☐ NO
 If so, whom? _____

Have you had any of the following medical problems? (please check any that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Deviated nasal septum | <input type="checkbox"/> Headache | <input type="checkbox"/> Environmental allergies |
| <input type="checkbox"/> Chronic congestion | <input type="checkbox"/> Seizure | <input type="checkbox"/> Medication allergies |
| <input type="checkbox"/> Broken nose | <input type="checkbox"/> Nerve damage | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Broken jaw | <input type="checkbox"/> GERD | <input type="checkbox"/> Ulcers/gastrointestinal problems |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Overweight | <input type="checkbox"/> Kidney/renal disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| | | <input type="checkbox"/> Other: _____ |

FAMILY AND SOCIAL HISTORY

Please give the following family information:

	Age	Illnesses
Mother:	_____	_____
Father:	_____	_____

Number of brothers/sisters: _____ Number of children: _____

Does anyone in your family have any sleep problems?..... ☐ YES ☐ NO

If so, who and what: _____

Has anyone in your family ever been treated for any serious medical problems?... ☐ YES ☐ NO

If yes, what: _____

Has anyone in your family ever been treated for any psychiatric problems?..... ☐ YES ☐ NO

If yes, what: _____

MOOD SYMPTOMS (PHQ-9/GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(check one in each column)

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
Thoughts that you would be better off dead or hurting yourself in some way?				

Over the last 2 weeks, how often have you been bothered by the following problems?
(check one in each column)

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

For the following questions, please check appropriate answer.

1. Please check (i.e., last 2 weeks) the severity of your insomnia problem(s) (if any).

a. Difficulty falling asleep ☐None ☐Mild ☐Moderate ☐Severe ☐Very Severe

b. Difficulty Staying ☐None ☐Mild ☐Moderate ☐Severe ☐Very Severe
asleep

c. Problem waking up too ☐None ☐Mild ☐Moderate ☐Severe ☐Very Severe
early

2. How satisfied/dissatisfied are you with your current sleep pattern? (check one)

☐ Very satisfied ☐ Very satisfied ☐ Neutral ☐ Dissatisfied ☐ Very dissatisfied

4. How noticeable to others do you think your sleeping problem is in terms of impairing the quality of your life? (check one)

☐ Not at all noticeable ☐ A little ☐ Somewhat ☐ Much ☐ Very much noticable

5. How worried/distressed are you about your current sleep problem? (check one)

☐ Not at all worried ☐ A little ☐ Somewhat ☐ Much ☐ Very much worried

EPWORTH SLEEPINESS QUESTIONNAIRE

This questionnaire will help your physician to measure your general level of daytime sleepiness
How likely are you to doze off or fall asleep in the situations described below, *in contrast to just feeling tired*?

This refers to your usual way of life in recent times.

Even if you haven't 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
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (eg, a theater or a 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 a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3