Sleep Questionnaire

Today’s date: ___/___/_____  MR#________________________

Patient name: ___________________________ Age: _____ DOB: ___/___/_____

Marital status: _________________________ Gender: M F Height:____ft____in Weight:_______ lbs

Ethnicity: ______________________________ Referred by: _______________________

Reason for the visit: □ Insomnia □ Sleep apnea □ Other: _______________________

Have you been previously evaluated for a sleep disorder? □ No □ Yes

Have you ever had an overnight sleep study? □ No □ Yes

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Slight</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

- Sitting and reading
- Watching TV
- Sitting inactive in a public place (example: a theater or meeting)
- As a passenger in a car for 1 hour without a break
- Lying down to rest in the afternoon when circumstances permit
- Sitting and talking to someone
- Sitting quietly after lunch without alcohol
- In a car (driving) while stopped for a few minutes in traffic

II. Questionnaire:

Do you snore? □ No □ Yes □ Don’t know

Your snoring is: □ Slightly louder than breathing □ As loud as talking □ Louder than talking □ Very loud

Has your snoring ever bothered other people? □ No □ Yes

Do you have high blood pressure, or take medication for high blood pressure? □ No □ Yes

Please check the appropriate box:

<table>
<thead>
<tr>
<th>How often do you snore?</th>
<th>Nearly every day</th>
<th>3-4 times a week</th>
<th>1-2 times a week</th>
<th>1-2 times a month</th>
<th>Never or nearly never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 □</td>
<td>2 □</td>
<td>3 □</td>
<td>4 □</td>
<td>5 □</td>
</tr>
</tbody>
</table>

- Has anyone noticed that you quit breathing during your sleep?
  - 1 □

- During your wake time, do you feel tired, fatigued or not up to par?
  - 1 □

- Have you ever nodded off or fallen asleep while driving a vehicle? □ No □ Yes
  - If yes, how often does it occur?
    - 1 □

- Do you have headaches after waking up?
  - 1 □

- Do you have a dry mouth at night?
  - 1 □
III. Sleep Habits – Please answer questions based on an average night of sleep:

<table>
<thead>
<tr>
<th></th>
<th>Bedtime</th>
<th>Time to fall asleep</th>
<th>Wake time</th>
<th>Out of bed time</th>
<th>Approximate sleep duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekdays:</td>
<td>_____ AM/PM</td>
<td>_____ min</td>
<td>_____ AM/PM</td>
<td>_____ AM/PM</td>
<td>_____ hours</td>
</tr>
<tr>
<td>Weekends:</td>
<td>_____ AM/PM</td>
<td>_____ min</td>
<td>_____ AM/PM</td>
<td>_____ AM/PM</td>
<td>_____ hours</td>
</tr>
</tbody>
</table>

Do you consider yourself a night owl? □ No □ Yes
Do you consider yourself a morning person? □ No □ Yes
Do you take medication or a supplement to help you sleep? □ No □ Yes: __________ Dose: __________
Do you need an alarm clock to wake up in the morning? □ No □ Yes
How many naps do you take per week? __________ What is the average duration of each nap? __________
Are these naps refreshing? □ No □ Yes Do you dream during naps? □ No □ Yes

Check the answer that best describes how often you experience each situation:

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Less than 2 times a week</th>
<th>2-4 times a week</th>
<th>At least 5 times a week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking sleeping pills to help you sleep</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having trouble falling asleep</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having very restless sleep</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waking up several times at night</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having trouble getting back to sleep</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waking up earlier than you wanted to</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waking up in the morning unrefreshed</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling sleepy despite adequate sleep</td>
<td>1□</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling fatigued despite adequate sleep</td>
<td>1 □</td>
<td>2□</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have unusual behaviors during sleep? □ No □ Yes
If yes: □ Nightmares □ Sleepwalking □ Bedwetting □ Other: ________________________________
Do you grind or clench your teeth at night? □ No □ Yes If yes, do you use a dental guard? □ No □ Yes
Have you ever been told by others that you act out your dreams? □ No □ Yes
Have you ever felt paralyzed when you first wake up or when you are falling asleep? □ No □ Yes
Have you ever experienced episodes of muscle weakness, loss of muscle strength or limp muscles in any part of your body during the following situations:

- When you laugh □ No □ Yes
- When you are angry □ No □ Yes
- When hearing or telling a joke □ No □ Yes
- When tense or under stress □ No □ Yes

Have you ever had the sensation of seeing or hearing things when waking up or falling asleep? □ No □ Yes
IV. RLS - Please check the appropriate box:

- Do you kick your legs at night, prior to or during sleep? □ No □ Yes
- Do you ever experience a desire to move your legs due to discomfort or disagreeable sensations in your legs? □ No □ Yes
- Do you sometimes feel the need to move to relieve the discomfort, for example by walking or rubbing your legs? □ No □ Yes
- Are these symptoms worse later in the day or at night? □ Not applicable □ No □ Yes
- Are these symptoms worse when you are at rest, with at least temporary relief by activity? □ Not applicable □ No □ Yes

V. CPAP (for CPAP users only - skip this section if you do not use CPAP):

- How many nights per week do you use your CPAP? ________ nights/week
- How many hours per night do you use your CPAP? ________ hours/night
- While using CPAP, are any of the following problems present?
  - □ Snoring
  - □ Dry mouth/dry nose
  - □ Mask marking the face
  - □ Gasping or choking
  - □ Stuffy or running nose
  - □ Bridge of nose discomfort
  - □ Witnessed apnea
  - □ Ear pain/ear popping
  - □ Skin sore or acne from mask
  - □ Unrefreshing sleep
  - □ Irritated, dry or red eyes
  - □ Machine noise

VI. SOCIAL HABITS: Profession/Job: _____________________________________________

- Occupational Status: □ Actively working □ Retired □ Disabled □ Shift worker
- Are you sedentary (no more than 10 minutes of uninterrupted physical activity) during the day? □ No □ Yes
- Do you exercise for more than 30 minutes at least two times a week? □ No □ Yes
- Do you smoke or have you ever smoked? □ No □ Yes
  - If so, how many cigarettes a day? ________ For how long? ________________
  - If you quit smoking, how long ago did you quit? ________________
- How many cups of coffee do you drink each day? ________________
- How many ounces of other caffeinated beverage (e.g. soda, tea, energy drinks) do you drink a day? ________________
- Do you think you are sensitive to caffeine? □ No □ Yes
- Do you drink alcoholic beverages? □ No □ Yes
  - Types of drinks: ________ Amount: ________ per week/day
- Do you use any recreational drugs? □ No □ Yes □ Decline to answer

VII. Family History - Please check the box if you have more than 1 family members with the following:

- □ Sleep Apnea □ Restless Legs □ Night type □ Morning type □ Narcolepsy

VIII. Medications - Please check the box if you take any of the following medications on a regular basis:

- □ Aspirin □ Blood pressure pills □ Insulin
- □ Cholesterol pills □ Sedatives □ Oxygen
- □ Blood thinners □ Tylenol, Advil, painkillers
- □ Sleep medications (name): _________________________________________________
- Other medications and dosage: _________________________________________________

Please list any allergies: ______________________________________________________ □ none known
Please list any major surgeries you have had: ____________________________________
IX. Review of Systems - Please check the appropriate box for a medical problems or symptom that you have:

- □ Weight gain: _______ lbs
- □ Weight loss: _______ lbs
- □ Previous head or facial trauma
- □ Headaches
- □ Lack of energy
- □ Previous nasal fractures
- □ Mandibular fracture
- □ Sinus problems
- □ Nasal polyps
- □ Chronic rhinitis/postnasal drip
- □ Problems with nasal breathing
- □ Removal of tonsils/adenoids
- □ Increased neck size
- □ Bumps or nodes on your neck
- □ Wheezing
- □ Asthma, COPD or emphysema
- □ Arthritis/joint aches
- □ Back pain/ Muscle aches
- □ High blood pressure
- □ Stent (cardiac)/bypass
- □ Heart failure
- □ Heart attack
- □ Cardiac arrhythmia
- □ Itching/ skin problems
- □ Allergies
- □ Easily bruised
- □ Anemia
- □ Thrombosis
- □ Irregular heart beat/palpitations
- □ Pacemaker
- □ Leg edema
- □ Shortness of breath
- □ Seizure disorder
- □ Stroke/TIA
- □ Blurred/double vision
- □ Ringing or buzzing in ears
- □ Loss of memory
- □ Loss of balance
- □ GERD/heartburn
- □ Peptic ulcers
- □ Bowel problems/colitis
- □ Anxiety
- □ Depression
- □ Suicide attempts
- □ Diabetes or high blood sugar
- □ Thyroid problems
- □ Kidney failure
- □ Night-time urination
- □ Prostate problems *(men only)*
- □ For women only:
  - □ Currently pregnant
  - □ Irregular menstrual periods
  - □ Menopausal

X. Research Information

The Weill Cornell Medical College Center for Sleep Medicine is committed to excellence in research, teaching, patient care, and the advancement of the art and science of medicine. Part of our mission is to conduct cutting edge research in order to improve the health care of the nation and the world both now and for future generations, and to provide the highest quality of clinical care for our patients. Data collected from patients may be used in an unidentified manner to conduct quality performance assessments and exploratory research analyses. As a patient of the Center for Sleep Medicine you may be eligible to participate in some of the ongoing research efforts. If you would like to hear more about our studies and consider participating in a research study conducted by our Center, please check the appropriate box. Please note that the Center will never use your private health information without your express consent.

- □ Yes, I allow the Center’s staff to contact me regarding potential research studies in the future. This does not represent any commitment from my part to participating in research.
- □ No, I would not like to be contacted about research studies

_________________________  ________________  ________________
Name (printed)  Signature  Date

Diagnoses: ___________________________  ___________________________  ___________________________
(Primary)  (Secondary)  (Tertiary)

Plan: ___________________________________________________________________________________

Clinician’s signature: ___________________________  Date: ___________________________
Weill Cornell Medicine Center for Sleep Medicine Financial Policy

Welcome to the Weill Cornell Medicine Center for Sleep Medicine. The following is a statement of our Insurance and Financial policies.

Weill Cornell Medicine Center for Sleep Medicine Responsibilities:

The Weill Cornell Medicine Center for Sleep Medicine will bill your insurance company for professional services and/or testing. The utmost care will be given to your claim to ensure maximum usage of your benefits.

Self-pay patients please be advised that payment is due at the time of service.

The Weill Cornell Medicine Center for Sleep Medicine does not take assignment, and you will be responsible for the balance that your insurance has not covered. Our clinician’s participate in many of the major managed care plans and every effort will be made to schedule you with a provider participating in your plan.

Patient Responsibilities:

Please be advised that it is your responsibility to obtain insurance referrals. If you do not have a referral you may have to reschedule your appointment.

The Weill Cornell Medicine Center for Sleep Medicine is not responsible if your insurance company does not pay for your professional services and/or testing. You are financially responsible for non-covered services, co-payments, co-insurance payments, and deductibles.

If you choose to see a provider out of your insurance plan you will be considered a self-pay patient.

It is your responsibility to make certain that the Weill Cornell Medicine Center for Sleep Medicine has updated insurance information to avoid costly medical bills.

In case you elected to pay out of pocket for a test that your insurance has denied coverage for or authorization is pending, by initializing here, you acknowledge that you will be financially responsible for costs of the service provided by the Weill Cornell Medicine Center for Sleep Medicine. Initials: ____________.

The fees due at the time of service are the following co-payments, co-insurance payments, deductible payments, and self pay fees.

I understand and agree with following the above policies.

Signature ____________________________  Print Name ____________________________  Date ________
Authorization To Disclose Health Information Via E-Mail

Patient Name: _____________________________________________  MRN#: ______________________
Street: ___________________________________________________  DOB:     ______________________
City: ____________________________ ST: ____  Zip: ____________ Phone:    _____________________

This authorization covers protected health information (PHI) disclosed by Weill Cornell Medical College (WCMC) personnel to a patient or a patient’s representative through e-mail communication. It expires when the need to communicate via e-mail is no longer necessary, when the patient changes his/her e-mail address, or if the patient revokes it.

**************************************************************************************************************************************

To be completed by patient or patient’s representative:

My signature at the bottom of this form is authorization for WCMC to disclose the health information of the above-named patient via e-mail. It also confirms my understanding that:

• Information sent via e-mail is not considered secure. There is the possibility of re-disclosure of the personal health information or the risk that it may be disclosed or seen by an unintended recipient, such as any person who has access to your e-mail account. Re-disclosure may no longer be protected by law.
• I should not use e-mail for any urgent or time-sensitive medical questions or issues
• Once transmitted, I am responsible for safeguarding the information I receive
• I have the right to revoke this authorization at any time before information is disclosed by submitting to the Privacy Office a WCMC Revocation of Release of Medical Information Form # PO012B. A revocation will not apply to information that has already been released as a result of this authorization
• To initiate e-mail communication, I will send an e-mail from my e-mail address, containing my request for information, to the WCMC party at the e-mail address below
• I am responsible for notifying the WCMC party listed below if my e-mail address changes and completing another authorization in order to communicate using a different address
• If I am communicating via e-mail about someone else, I attest that I am responsible for that person’s care or payment and will indicate my relationship to the patient below
• WCMC will not condition treatment or payment upon receipt of an authorization

The e-mail address I wish to use is:  _________________________________________________________  

____________________________________________________________   _____________________
Patient/Representative Signature                 Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____________________________________________________________  ______________________
Print name           Relationship to patient

**************************************************************************************************************************************

To be completed by WCMC:

Name of WCMC party (please print):  ____________________________________________________________
WCMC e-mail:  ____________________________________________________________

WCMC, please indicate date completed: ____________, retain a copy of this request in the patient’s file, and provide a copy of the original to the requestor
Authorization To Use or Disclose Protected Health Information (PHI)

Patient Name: _____________________________________________  MRN#: ______________________
Street: ___________________________________________________  DOB: ______________________
City: _____________________________________________________  Phone: _____________________
ST: ___________________________ Zip: _____________________  NYP#: ________________________
(if available)

I authorize the release of the following health information:

☐ Entire medical record
☐ Diagnostic Tests  Date(s): ___________________________________________
☐ Doctor's Notes (from Dr. ____________)  Date(s): _______________________
☐ Lab Results  Date(s): ___________________________________________
☐ Pathology Reports ____ Specimens ____  Date(s): _______________________
☐ Radiology Reports ____ Images  Date(s): _______________________
☐ Include Alcohol/Drug Treatment information (initial here) ________
☐ Include Mental Health information (initial here) _______
☐ Include HIV-Related information (initial here) ________
☐ Medical Record/Information from outside the institution brought to the practice by me (explain):

☐ All of the above with the exception of: __________________________________________________________
☐ Other: ______________________________________________________________________________________

Who will release/disclose information: Name: _______________________________________________________
Address: _____________________________________________________________
City, State, Zip: ___________________________________________________________

Who will receive information: Name: _____________________________________________________________
Address: _____________________________________________________________
City, State, Zip: ___________________________________________________________

Reason for Disclosure: __________________________________________________________________________

This authorization expires: ( ) specific time frame __________________, ( ) when record is received, ( ) other (explain)

I understand that:
• By signing this form, I am authorizing the use/disclosure of protected health information as indicated above.
• I am signing this form voluntarily. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
• I may revoke this authorization at any time by completing a “Request to Revoke an Authorization” form, which is available at Weill Cornell Medicine’s Privacy Office. I understand that I may revoke this authorization except to the extent that action has been taken based on this authorization.
• If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal/state law. Weill Cornell Medicine shall not be held liable for any consequences resulting from re-disclosure.
• If the information to be released contains any information about HIV/AIDS, alcohol or substance abuse, mental health, or psychiatric notes, state or federal regulations may have additional compliance requirements.
• I may request a copy of this signed form.
• Weill Cornell Medical College may charge an administrative fee to cover the cost of labor, copying, or postage. The doctor’s office will inform me of any charges and arrange for payment.

Patient/Representative Signature ___________________________ Date ________________

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

Print name ___________________________ Relationship to patient ___________________________