

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.

Never	Slight	Moderate	High	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting and reading
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watching TV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting inactive in a public place (example: a theater or meeting)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a passenger in a car for 1 hour without a break
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying down to rest in the afternoon when circumstances permit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting and talking to someone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting quietly after lunch without alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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

<i>Please check the appropriate box :</i>	Nearly every day	3-4 times a week	1-2 times a week	1-2 times a month	Never or nearly never
How often do you snore?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Has anyone noticed that you quit breathing during your sleep?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
During your wake time, do you feel tired, fatigued or not up to par?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Have you ever nodded off or fallen asleep while driving a vehicle? <input type="checkbox"/> No <input type="checkbox"/> Yes <u>If yes</u> , how often does it occur?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Do you have headaches after waking up?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Do you have a dry mouth at night?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

III. Sleep Habits – Please answer questions based on an average night of sleep:

Bedtime _____ AM/PM Time to fall asleep _____ min Wake time _____ AM/PM Out of bed time _____ AM/PM Approximate sleep duration _____ hours
Weekdays: _____ AM/PM _____ min _____ AM/PM _____ AM/PM _____ hours
Weekends: _____ AM/PM _____ min _____ AM/PM _____ AM/PM _____ hours

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

<i>Check the answer that best describes how often you experience each situation:</i>	<i>Never</i>	<i>Less than 2 times a week</i>	<i>2-4 times a week</i>	<i>At least 5 times a week</i>
Taking sleeping pills to help you sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Having trouble falling asleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Having very restless sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Waking up several times at night	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Having trouble getting back to sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Waking up earlier than you wanted to	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Waking up in the morning unrefreshed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Feeling sleepy despite adequate sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Feeling fatigued despite adequate sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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?

- | | | |
|---|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Dry mouth/dry nose | <input type="checkbox"/> Mask marking the face |
| <input type="checkbox"/> Gasping or choking | <input type="checkbox"/> Stuffy or running nose | <input type="checkbox"/> Bridge of nose discomfort |
| <input type="checkbox"/> Witnessed apnea | <input type="checkbox"/> Ear pain/ear popping | <input type="checkbox"/> Skin sore or acne from mask |
| <input type="checkbox"/> Unrefreshing sleep | <input type="checkbox"/> Irritated, dry or red eyes | <input type="checkbox"/> 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:

- | | | |
|--|--|----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Blood pressure pills | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Cholesterol pills | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Tylenol, Advil, painkillers | |
| <input type="checkbox"/> Sleep medications (name): _____ | | |

Other medications and dosage: _____

Please list any allergies: _____ none known

Please list any major surgeries you have had: _____

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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 _____

**Weill Cornell Medical College (WCMC)
Privacy Office
Forms**

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 psychiatry 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