PATIENT REGISTRATION FORM

Welcome to our sleep center. We are committed to providing comprehensive care for all sleep problems. We encourage you to ask questions and provide feedback. Please assist us by providing the following information. All information is confidential and will be released only with your consent.

FOR OFFICE USE ONLY		
UID No. for Patient :	Date	Appointment Time

Please fill in the blanks below

PATIENT INFORMATION			
Patient's Name :			
Date of Birth :	Age :	☐ Male ☐ Female	☐ Married ☐ Single
Occupation :			
Residential Address :			
City, State :	Country :	Pin Code :	
E-Mail :	Mobile :	Home Phone :	
Referred by ☐ Physician ☐ Self ☐ Others, Please specify			
If referred, referring Physician's Name & Speciality :			

In case of emergency, notify:

Name :	Relationship :	Phone :

RESPONSIBLE PARTY INFORMATION (If form Completed by Patient Representative)		
Name :	Relationship :	Phone :
Occupation :		
Residential Address :		
City :	State :	Pin Code :

PATIENT QUESTIONNAIRE

Name: _____

Age: _____ **Sex :** _____

I. SLEEP HISTORY

a) What is the primary reason for seeking the medical advice? .....

b) Have you ever had a sleep consultation or a sleep study before? .....

c) What time do you usually go to bed?
.....

d) How long does it take you to fall asleep? ..... minutes

e) While you are either falling asleep or waking up do you experience

Dream like images (Hallucinations)? ☐ Yes ☐ No

Feel Paralyzed? ☐ Yes ☐ No

f) Do you have difficulty sleeping during the night? ☐ Yes ☐ No

If yes,

A. How often do you usually wake up at night **?** .....

B. When falling asleep, do you experience "restless legs" **?**

(A feeling of crawling, aching or inability to keep legs still) ☐ Yes ☐ No

C. Have you ever been told that while asleep you

Snore? ☐ Yes ☐ No

Quit breathing? ☐ Yes ☐ No

Choke? ☐ Yes ☐ No

Thrash about / have excessive leg jerking movements? ☐ Yes ☐ No

Walk? ☐ Yes ☐ No

Grind your teeth? ☐ Yes ☐ No

g) What time do you usually wake up? .....

h) When you wake up do you feel**:**

refreshed? ☐ Yes ☐ No

experience headaches? ☐ Yes ☐ No

i) Do you feel tired or fatigued during day time? ☐ Yes ☐ No

If yes, how often do you feel tired or fatigued after your sleep?

☐ Nearly every day ☐ 1-2 times a week ☐ 3-4 times a week ☐ Nearly Never

j)Do you fall asleep when you are trying not to do? ☐ Yes ☐ No

k) Have you faced any road / work related accidents or near misses because you were feeling sleepy? ☐ Yes ☐ No

l) Have you ever fallen asleep while waiting in a line, For example:

To pay your electricity or telephone bills? ☐ Yes ☐ No

If yes, how frequently?

☐ Nearly every visit ☐ In 1-2 visits ☐ In 3-4 visits ☐ Nearly Never

m) Do you watch television / work with computers till late night? ☐ Yes ☐ No

n) Do you attend / make calls from your mobile, before or during sleep? ☐ Yes ☐ No

o) Do you do any regular exercise? ☐ Yes ☐ No

If yes, please state the routine …….....

p) Nature of work :- ☐ Desk Work ☐ Physical Exertion ☐ Mind Exertion ☐ Traveling ☐ Home making ☐ Not employed ☐ Shift work

Others please specify:-

II. HAVE YOU EVER USED ANY OF THE FOLLOWING?

Dependencies / Habituations	No	Yes	Substance	Frequency
Caffeine			Coffee Tea Soda	
Alcohol, Cigarette			Alcohol Cigarette	
Street Drugs			Marijuana Narcotics Cocaine	

III. SPECIFY IF YOU EVER HAD THE FOLLOWING PROBLEMS (Past Medical History)

Disease	No	Yes	Please Explain
Asthma / Chronic Lung Disease			
Thyroid Problems			
Seizures / Epilepsy			
Broken Nose			
Nasal Sinus Problems			
Unusual Dental Problems			
High Blood Pressure			
Heart Disease			
Stroke			
Diabetes			
Depression			
Psychiatric Treatment			
Gained Weight			
Menstrual Irregularities			
Impotence			
Others (if any)			

IV. FAMILY MEDICAL HISTORY (If any)?

Indicate if any of your family members such as mother, father, brothers, sisters or children have any medical conditions .....

.....

V. LIST MEDICATION ALLERGIES (IF ANY):

VI. LIST CURRENT MEDICATIONS (Please list including those used for sleeping)

Medication	Medication Name	Dosage Frequency	Reason
Prescription			
Non-Prescription			
Oxygen Therapy (how much, continuous / nightly, name of home care / company)			

VII. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Please use the following scale and circle the most appropriate number in 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 in a relatively quiet place and reading	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (e.g. a classroom, meeting or theatre)	0	1	2	3
As a passenger in a car or bus for an hour without a break	0	1	2	3
Lying down to rest during the day	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you did not have alcohol)	0	1	2	3
Stopping for a few minutes in the traffic, while driving	0	1	2	3
Total (numerical value)				

Form completed by:

☐ Patient ☐ Family Member, Relationship to the patient .....☐ Others

If others, Please specify: ……

_____ _____ _____

PATIENT / GUARDIAN'S SIGN & NAME **RELATIONSHIP** **DATE**

* Note : If the patient is a minor, this form must be filled and signed by Patient's Parent or Guardian.