

HeMacinto **Sound Sleep Center**

343 East Main Street Suite 106 San Jacinto, CA 92583
 Tel: (951) 654-5592 Fax: (951) 654-0839
info@hemacintosleep.com

Patient General Health Questionnaire

Patient Name: _____ Date of Birth: _____ Sex: M / F
 Height: _____ Weight: _____ Weight last year: _____ Waist: _____ Neck Size: _____
 Emergency Contact: _____ Phone: _____ Relation: _____

Check any of the following symptoms you have had in the past 12 months:

- | <i>Yes</i> | <i>No</i> | | <i>Yes</i> | <i>No</i> | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> | Frequent heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Passing out | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Sudden loss of vision or strength | <input type="checkbox"/> | <input type="checkbox"/> | Frequent constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Inability to speak | <input type="checkbox"/> | <input type="checkbox"/> | Frequent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss or ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | Rectal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Black Stools | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness for more than 2-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty urinating |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Cough for more than 2-4 weeks | <input type="checkbox"/> | <input type="checkbox"/> | Urinating more than twice a night |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> | Pain in joints or bones |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath or wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Unusual bruising or bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing | <input type="checkbox"/> | <input type="checkbox"/> | Swelling in feet or ankles |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain, tightness or pressure | <input type="checkbox"/> | <input type="checkbox"/> | Change in wart, mole or skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular or sudden, fast heartbeat | <input type="checkbox"/> | <input type="checkbox"/> | Weight loss of more than 5 lbs. |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing or food "sticking" | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____ |

Past Medical History

- | | | |
|---|---|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chemical dependency or abuse | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> COPD | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> TIA “Light Stroke” | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Stomach or colon problems | <input type="checkbox"/> Back or joint problems (arthritis) | |
| <input type="checkbox"/> Other: _____ | | |

Female Premenstrual Syndrome Menopause Other: _____

Male Prostate problems Erectile dysfunction/impotence Other: _____

Family History

Has an immediate blood relative had any of the following?

- | | | | | | | | |
|--------------------------|--------------------------|-----------------|-------|--------------------------|--------------------------|-----------------|-------|
| Yes | No | Relation | | Yes | No | Relation | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Narcolepsy | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other | _____ |

Current Medications	Reason	How Long have you been taking

Epworth Sleepiness Scale

Use the following scale to select the most appropriate number for the situation

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

Sitting and reading -----	0	1	2	3
Sitting inactive in a public place-----	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 permitted-----	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-----	0	1	2	3
Watching TV-----	0	1	2	3

With the help of a bed partner please circle one of the following as it applies to a typical night.

Snoring	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Observed pauses in breath	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Restless or interrupted sleep	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Awaken short of breath gasps, or snorts	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Awaken coughing	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Difficulty falling asleep	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Leg or body jerks	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Teeth grinding	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Vivid dreams	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Headache	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Acid indigestion	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Night sweats	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Heart palpitations	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Night time urination	<input type="checkbox"/> Nightly	<input type="checkbox"/> Weekly	<input type="checkbox"/> Rarely	<input type="checkbox"/> Never
Refreshed with morning wake up	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Dry mouth in morning wake up	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Sore jaw with morning wake up	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

To the best of my knowledge all of the above information is true and correct.

Patient's Signature

Date

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Pre-Sleep Questionnaire

Patient Name: _____ DOB: _____

Do you feel today has been an unusual day? Yes No

If yes, please explain _____

How much sleep did you have last night? _____ Hours

Did you take a nap today? Yes No

If yes, how long was your nap _____ Hours?

Approximately what time was your last full meal? _____

Did you drink any caffeine or alcohol today? Yes No

If yes, list type, amount, and time consumed _____

How are you feeling now?

Alert and wide awake Relaxed and awake A little foggy, not great Sleepy, ready for bed

List any medications you have taken today? (Include OTC or prescription)

Medication Name	Amount/Dose	Approximate Time Taken

Any physical complaints? _____

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Authorization for Services Provided, Payment Agreement, and Release of Information

Patient Name: _____ Social Security Number: _____

Age: _____ Date of Birth: _____ Sex: M / F Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact: _____ Phone: _____ Relation: _____

Type of Insurance: HMO PPO Medicare TriCare Other: _____

Name of Insurance Carrier: _____

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I hereby authorize Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. to submit a claim to my insurance carrier or it's intermediaries for all covered services rendered by the physician rendering the covered services for the next twelve (12) months period. Our office will file your claims to your insurance carrier(s) as a courtesy to you. Your insurance coverage is a contract between you and your insurance carrier, thus your entire account balance, including those charges filed to your insurance company, remains your responsibility; thus you are responsible for follow-up communication with your insurance company, should there be a problem in processing a claim. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of fees and charges not directly reimbursed to Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D., by any insurance policy, self-insurance program, or other benefit plan. I also authorize Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. to furnish complete information to my insurance carrier. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for deductible, coinsurance, and non-covered services. I request that payment of authorized Medicare benefits be made either to my or in behalf of Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any other information needed to determine these benefits or the benefits payable to the related service. To the best of my knowledge all of the above information is true and correct. I acknowledge I have read the notice of privacy practices.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____