Northshore Sleep Medicine
Lisa Shives M.D.

Name: ______________________ Patient ID #: ______________ Sex: [ ]M [ ]F

Address: ______________________ Date of Birth: ______________________

Address: ______________________ Social Security #: ______________________

City,State, Zip: ______________________ Marital Status: [ ]Married [ ]Single [ ]Divorced [ ] Widowed

Phone: ______________ [ ]Home [ ]Work [X]Mobile

E-Mail Address ______________________

Phone: ______________ [ ]Home [ ]Work [X]Mobile

EMERGENCY CONTACTS

Name *Relationship* *Phone*

____

____

RESPONSIBLE PARTY

[ ]Same as Patient

Name: ______________________

Address: ______________________

Address2: ______________________

City,State, Zip: ______________________

Referring Physican ______________________

Primary Physician: ______________________

EMPLOYMENT INFORMATION

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [X]Other

Employer: ______________________

INSURED PARTY EMPLOYMENT

Employer: ______________________

INSURANCE INFORMATION

PRIMARY INSURANCE:

[ ]Patient [ ]Spouse [ ]Insured Party

Ins Company: ______________________

Co-Pay Amt: ______________________

Relationship to Patient: ______________________

Social Security #: ______________________

Insured ID: ______________________

Policy Group: ______________________

Date of Birth: ______________________

Insured Party: ______________________

Insured Phone: ______________________

SECONDARY INSURANCE:

[ ]Patient [ ]Spouse [ ]Insured Party

Ins Company: ______________________

Co-Pay Amt: ______________________

Relationship to Patient: ______________________

Social Security #: ______________________

Insured ID: ______________________

Policy Group: ______________________

Date of Birth: ______________________

Insured Party: ______________________

Insured Phone: ______________________

I hereby authorize Northshore Sleep Medicine to release any medical records related to my care in order to obtain payment for medical services rendered on my behalf. I also authorize Northshore Sleep Medicine to submit all charges for services rendered to me and assign any benefits payable to Northshore Sleep Medicine. I understand that I am responsible for any portion of my bill not covered by insurance companies, governmental agencies or their intermediaries, or third party payors. I understand that co-pays and balances are due at the time of the visit. This information is valid for (1) one year and will be updated annually. I have read and understand the Patient Responsibilities provided to me. **HIPAA** I hereby acknowledge receipt of the physician's Joint Privacy Notice. I understand that Northshore Sleep Medicine has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Signature____ Date______________________

11/09/2009

NORTHSHORE SLEEP MEDICINE
Lisa Shives, MD, Medical Director
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Evanston, Illinois 60203
Tel: 847.674.3600 Cell: 773-914-4961
Fax: 847.674.3639

I, ________________________________, authorize Northshore Sleep Medicine to use my data for research purposes with the guarantee that all identifying markers will be removed.

________________________________ ____________

Patient Signature Date

I, ________________________________, authorize Northshore Sleep Medicine to release my health information to other health providers as is necessary for my optimal healthcare.

________________________________ ____________

Patient Signature Date

I, ______________________________, authorize Northshore Sleep Medicine to obtain my health information from other providers as necessary for my optimal healthcare.

________________________________ ____________

Patient Signature Date

Northshore
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BED PARTNER QUESTIONNAIRE

Name of Patient: ______________________________ Date: ________________

Check any of the following behaviors you have observed the patient doing while asleep:

- ☐ Loud Snoring
- ☐ Light Snoring
- ☐ Twitching of legs or feet
- ☐ Pauses in breathing
- ☐ Grinding teeth
- ☐ Sleep talking
- ☐ Sleepwalking
- ☐ Bedwetting
- ☐ Sitting up in bed while still asleep
- ☐ Head rocking or banging
- ☐ Kicking with legs
- ☐ Getting out of bed while still asleep
- ☐ Biting tongue
- ☐ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

____

____

____

____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, how many times during the night and whether it occurs every night.

____

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If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed.

____

____

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____

____

Name: ______________
Date: ______________

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best 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	_______
Watching TV	_______
Sitting inactive in a public place (e.g., a theater or meeting)	_______
Sitting as a passenger in a car, for an hour without a break	_______
Lying down to rest in the afternoon when your schedule permits it	_______
Sitting and talking to someone	_______
Sitting quietly after a lunch without alcohol	_______
Sitting in a car, while stopped for a few minutes in traffic	_______

Reference: Johns, MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991; 14:540-5.

Northshore Sleep Medicine
History and Physical

Patient Name: ____________________________ Date: _______ Phone #:______________

Sex: ___ Age: ______ DOB: _________ Insurance: _____________________________

Email: ____

Referring Physician: ____________________ Location/Phone #: ________________

Family Physician: _______________ Location/Phone #: ____________________

Please complete the following form by filling in the blanks and circling appropriate responses

My main sleep complaint(s) are:

☐ Trouble sleeping at night For how many months/years? _________________

☐ Feeling tired/sleepy all day For how many months/years? _________________

☐ Snoring For how many months/years? _________________

☐ Restless Legs Syndrome For how many months/years? _________________

☐ Unwanted behaviors during sleep (explain) _________________________________

☐ Other, please explain ____

To be completed by physician:
Chief Complaint

____

____

____

____

____

Sleep Pattern

	Work Days/Weekdays	Off Days/Weekends
Typical Bedtime:	________________	________________
Typical amount of time it takes to fall asleep:	________________	________________
Typical number of awakenings per night:	________________	________________
List any activities that you normally do during nighttime awakenings i.e., restroom, eat, watch TV, etc:	________________	________________
Typical amount of time to fall Back asleep after awakening:	________________	________________
Typical wake up time:	____________am/pm	____________am/pm
	Work Days/Weekdays	Off Days/Weekends
Desired wake up time:	____________am/pm	____________am/pm
How do you usually wake up? (i.e. alarm clock)	________________	________________
Typical time you get out of bed?	____________am/pm	____________am/pm
Total hours of sleep per night?	________________	________________
Number of naps per day?	________________	________________

Review of Sleep Habits/Sleep Environment

- ☐ My bedroom is not dark enough
- ☐ My bedroom is not quiet enough
- ☐ I have temperature problems in my bedroom
- ☐ I usually watch TV or read in bed prior to sleep
- ☐ I use the computer in bed
- ☐ I play video games in bed

- ☐ I listen to music
- ☐ I listen to relaxation tapes
- ☐ I use "white noise" or soothing sounds/music
- ☐ I regularly drink alcohol within 2-3 hours of bedtime
- ☐ I drink alcohol before bedtime to help me fall asleep
- ☐ I smoke prior to bedtime or when I awaken during the night
- ☐ I eat a snack at bedtime
- ☐ I often travel across 2 or more time zones

Sleep – Review of Systems

- ☐ I have trouble falling asleep
- ☐ I often wake up during the night
- ☐ I am unable to return to sleep easily if I wake up during the night
- ☐ I have thoughts that start racing through my mind when I try to fall asleep
- ☐ I wake up early in the morning, and I am still tired but unable to return to sleep
- ☐ I experience nightmares as an adult
- ☐ I have tingling sensations in my legs when I try to fall asleep
- ☐ I sweat a great deal during sleep
- ☐ I cannot sleep on my back
- ☐ I have been told that I stop breathing while I sleep
- ☐ I wake up at night choking, smothering, or gasping for air
- ☐ I have been told that I snore
- ☐ I have been told that I snore only when sleeping on my back
- ☐ I have been awakened by my own snoring
- ☐ I often wake up with headaches

- ☐ I have uncomfortable feelings in my legs and/or arms when I lie down or sit quietly at night
- ☐ I have to move my legs or walk around to relieve the uncomfortable feelings
- ☐ I am a restless sleeper
- ☐ I have been told that I kick or jerk my legs and/or arms during sleep
- ☐ I have a hard time falling asleep because of my leg movements
- ☐ I have talked in my sleep as an adult
- ☐ I have walked in my sleep as an adult
- ☐ I grind my teeth in my sleep
- ☐ I have acted out my dreams while asleep
- ☐ I have hurt myself or others while acting out my dreams
- ☐ I have a tendency to fall asleep during the day
- ☐ I am tired a lot
- ☐ I am often sleepy when I should be alert
- ☐ I have had "blackouts" or periods when I am unable to remember what just happened
- ☐ I have fallen asleep while driving, at a stoplight, or stopped in traffic
- ☐ I have had an auto accident as a result of falling asleep while driving
- ☐ I fall asleep while watching TV
- ☐ I fall asleep during conversations
- ☐ I fall asleep in sedentary situations
- ☐ I perform(ed) poorly in school because of sleepiness
- ☐ I have had injuries as a result of sleepiness
- ☐ I feel sleepiness has impaired me either professionally or socially

- ☐ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ☐ I have had an inability to move while falling asleep or when waking up
- ☐ I have had hallucinations or dreamlike images or sounds falling asleep or waking up.

General – Review of Systems

Please circle any of the conditions/symptoms you have had in the past month to a significant degree:

Frequent headaches	Fainting/passing out	Sudden loss of vision
Sudden loss of strength	Inability to speak	Hearing loss/ringing in ear(s)
Nosebleeds	Nasal congestion	Post nasal drip
Seasonal allergies	Hoarseness for more than 2-4 weeks	Cough for more than 2-4 weeks
Coughing up blood	Shortness of breath or wheezing	Swelling of feet/ankles
Chest pain, tightness, or pressure	Irregular, sudden, or fast heartbeat	Difficulty swallowing food or “sticking” sensation
Frequent heartburn	Abdominal pain	Frequent constipation
Frequent diarrhea	Rectal bleeding/ black stools	Difficulty urinating/ incontinence
Blood in urine	Urinating >2 times/night	Pain in joints/bones
Unusual bruising/ bleeding	Epilepsy/seizures	Change in wart, mole, skin growth
Unwanted weight loss of > 5-10 lbs		

Medical History

<u>Past Sleep Evaluation and Treatment</u>

- ☐ I have had a previous sleep disorder evaluation

- ☐ I have had a previous overnight sleep study
- ☐ I have had a daytime nap study
- ☐ I have been prescribed a CPAP or bi-level PAP machine for home use
- ☐ I have had surgical treatment for a sleep disorder
- ☐ I have previously been prescribed medication for a sleep disorder
- ☐ I have previously been treated for a sleep disorder

Past Medical History

Please circle any of the following conditions that you have or have been treated for in the past:

Stroke	TIA (mini stroke)	Blackouts/fainting
Seizures	Nasal polyps	Deviated septum
Hearing impairment	Hypo/hyper thyroid	Reflux/Heartburn
High Blood Pressure	Congestive heart failure	Heart disease
Heart Valve disease	Cardiac arrhythmia	Atrial fibrillation
Cardiac arrest	Heart attack/MI	Pulmonary hypertension
Blood Clots	COPD	Asthma
Emphysema	Bronchitis	Liver disease
Hepatitis	Jaundice	Anemia
Stomach problems	Diabetes	High Cholesterol
Colon/bowel problems	Kidney disease	Back pain
Cancer	Arthritis	Chronic pain
Fibromyalgia	Chronic fatigue syndrome	Depression
Severe anxiety	Alcoholism	Chemical dependency or abuse

Females LMP _________ Menopausal: Age _____ How long ________

- ☐ Premenstrual syndrome

Males

- ☐ Prostate problems
- ☐ Erectile dysfunction
- ☐ Impotence

Past Surgical History

- ☐ Tonsillectomy/adenoidectomy
- ☐ UPPP
- ☐ Other head or neck
- ☐ Cardiovascular
- ☐ Pulmonary
- ☐ Brain/spine

List any other surgeries and their dates ____

____

____

Medications

Please list all medications that you take and the doses. If you have a list, please attach it.

____

____

____

____

Allergies

Please list ANY allergies you may have (food, medications, etc)

____

____

Social History

Do you drink caffeine? Yes No

If yes:

What	*Amount*
Coffee	______cups per day/week
Tea	______cups per day/week
Soda/Pop	______cans/bottles per day/week
Energy drinks	______ per day/week

Do you smoke?	Yes No		
If yes:	*What*	*Amount per day*	*Number of years*
	Cigarettes	______	______
	Cigars	______	______
	Pipe	______	______
Do you drink?	Yes No		
If yes:	*What*	*Amount*	*Frequency*
	Beer	______	daily/weekly/ monthly
	Wine	______	daily/weekly/ monthly
	Liquor	______	daily/weekly/ monthly
Do you use illegal drugs?	Yes No		
If yes:	*What type?*	*Amount*	*Frequency*
	Cocaine	______	______
	Marijuana	______	______
	Heroin	______	______
	Ecstasy	______	______
	Other		
	______	______	______
Do you use herbal/health food store remedies?	Yes No		
If yes:	*Name*	*Amount*	*Frequency*
	______	______	______
	______	______	______
	______	______	______

Marital status Single Married Divorced Widowed

Sleep status Sleep alone Share a bed with someone

Share a bedroom, but have separate beds

Share a dwelling, but have separate bedrooms

Employment Status Employed Unemployed Retired

If employed: Occupation ______________________________

Usual work days ___________________________

Usual work hours ___________________________

- ☐ My job requires I drive a vehicle
- ☐ I work with dangerous equipment or substances
- ☐ I am a shift worker on rotating shifts
- ☐ I am a permanent or long-term 2nd or 3rd shift worker
- ☐ I am currently a student

Family History

Has any immediate family member (parents, siblings, children) had any of the following?

	Yes/No	**Relation**
Sleep Problems		
Sleep apnea	______	______________________________
Narcolepsy	______	______________________________
Insomnia	______	______________________________
Restless legs	______	______________________________
Acting out dreams	______	______________________________
Sleep talking/ walking	______	______________________________
General		
Cancer	______	______________________________
Diabetes	______	______________________________

Hypertension ______ ______________________________

Heart Disease ______ ______________________________

Thyroid ______ ______________________________

Stroke ______ ______________________________

Anxiety ______ ______________________________

Depression ______ ______________________________

Other: ____

To be completed by physician:

Physical Exam

Age: _______ Height: ________ Weight: ________ BMI: ___________

Neck circumference: ________ BP: _______ HR: _______ RR: ______

_______ O2 SAT

Head/OP

☐ Anicteric sclera ☐ Icteric sclera

Septal deviation: yes no Nares abnormal: yes no

☐ OP clear ☐ OP exudate

Tongue: moist dry macroglossia yes no

Mallampati scale: ___________ Tonsils: ___/4

Dentition: Good Fair Poor Dentures yes no

☐ Retrognathia yes no

Neck

NL size Large Short

☐ w/ carotid bruit ☐ w/o carotid bruit ☐ w/ LAD ☐ w/o LAD

Lungs

☐ CTAB ☐ w/ crackles ☐ w/ wheeze ☐ w/ consolidation

CV

☐ Regular rate ☐ Tachy ☐ Brady ☐Regular rhythm ☐ Irregular rhythm

☐ w/ rubs ☐ w/ murmurs ☐ w/ gallops

Abdomen

☐ Soft ☐ Firm ☐ Non-tender ☐ Tender ☐ Distended

☐ Non-distended ☐ NL bowel sounds ☐ Hypoactive bowel sounds

☐ Hyperactive bowel sounds

Extremities

☐ Warm ☐ Cool ☐ Well perfused ☐ Cyanosis

☐ Clubbing ☐ Edema

Neuro Exam

☐ Alert ☐ Oriented x ___ ☐ Verbal ☐ Non-verbal

☐ Ambulatory ☐ Non-ambulatory ☐ Focal ☐ Strength ____/5

☐ Bradykinesia ☐ Gait ______________________________

Assessment and Plan

____

____

____

____

____

____

☐ OSA explained ☐ Insomnia explained ☐ RLS/PLMD explained
☐ Narcolepsy explained ☐ RBD explained ☐ Cautioned against drowsy driving
☐ Cautioned against heavy sedation ☐ CPAP therapy explained
☐ PSG ordered ☐ PSG followed by MSLT
Completing physician ______________________________

Date ____________

Financial Policy

Help Us Help You

We welcome you to our practice. So that we may provide you with the quality care you deserve, we appreciate your cooperation with the following payment policy.

1. Please come to your appointment with your health insurance card and picture ID.
2. Co-payments are required at the time of service.
3. If you do not have a current insurance card you will be considered self-pay.
4. We accept Visa, Master Card and Discover credit cards, as well as cash and checks.
5. Whether we have a contract with your insurance or not, we will bill your insurance as a courtesy and you will be responsible for the balance unless you request to be self-pay. We make every effort to help you understand your insurance plan, but please understand that this is your responsibility as is the payment of co-pays, co-insurance and deductible.
6. **Please call to cancel all appointments ahead of time as there is a $30 no-show fee if you do not give us at least 24 hours notice of your inability to keep an office appointment. If you fail to give us 24 hours notice of cancellation for a sleep study, then the fee is $100.**
7. Please be advised that due to co-pays, co-insurance and deductibles, “a covered item or service” does not mean that it will be covered at a 100%.
8. Please be aware that as we are in network with most providers, we accept your insurance company’s contracted rate. We have not set the final prices for the services.
9. Our billing service, Health PCP, is available to address your payment concerns and insurance issues. Call Christine Fischer at 866.844.7749.

We at Northshore Sleep Medicine are committed to meeting your healthcare needs and thank you for following our payment policy. We appreciate the opportunity to care for you and your family.