

Patient Profile

PATIENT INFORMATION

Name: _____
Address: _____
Address: _____
City, State, Zip: _____
Phone: _____ [] Home [] Work [X] Mobile
Phone: _____ [] Home [] Work [X] Mobile

Patient ID #: 1254 Sex: [] M [] F
Date of Birth: _____
Social Security #: _____
Marital Status: [] Married [] Single [] Divorced [] Widowed

EMERGENCY CONTACTS

Name Relationship Phone

RESPONSIBLE PARTY

[X] Same as Patient

Name: _____
Address: _____
Address2: _____
City, State, Zip: _____

Referring Physician: _____

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 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 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 described in this Notice. I also understand that a copy of any Revised Notice will be provided to me or made available upon request.

Signature _____ Date _____

NORTHSHORE SLEEP MEDICINE
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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 PEDIATRIC SLEEP MEDICINE
SCREENING QUESTIONNAIRE**

1. Does the child have large tonsils?
2. Does the child snore, gasp, or stop breathing while sleeping?
3. Does the child sleep with a hyperextended (arched) neck?
4. Does the child sweat a lot during the night?
5. Has the child stopped growing at a normal rate?
6. Is the child overweight?
7. Does the child have trouble with bedwetting (over age 5)?
8. Does the child have behavior problems, such as aggressiveness, hyperactivity, or defiance?
9. Does the child have academic problems, such as difficulty sitting still, paying attention, or organizing and completing tasks?
10. Has anyone suggested that the child be evaluated for ADHD?

If you have answered yes to any of these questions, your child may have a serious sleep disorder.

Questionnaire developed by
Lisa Shives, M.D.
Northshore Sleep Medicine©

Northshore Sleep Medicine

Pediatric History and Physical Sleep Evaluation Questionnaire

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

Child's Information

Child's Name:	Child's Gender: Male Female
Child's Birthdate:	Child's Age:
Child's Racial/Ethnic Background <input type="checkbox"/> Black/ African– American <input type="checkbox"/> Asian– American <input type="checkbox"/> White– Caucasian <input type="checkbox"/> Native–American <input type="checkbox"/> Hispanic-Latino <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other: _____	Mother's Name: _____ Father's Name: _____ Pediatrician: _____ Other Physician: _____

What are your major concerns about your child's sleep?

What things have you tried to help your child's problem?

Sleep History

Weekday Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period
on weekdays (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on weekday nights: _____ : _____

The child's usual waketime on weekday mornings: _____ : _____

Weekend/Vacation Sleep Schedule

Write in the amount of time child sleeps during a 24-hour period
During weekends and vacations (add daytime and nighttime sleep): _____ hours _____ minutes

The child's usual bedtime on weekend/vacation nights: _____ : _____

The child's usual waketime on weekend/vacation mornings: _____ : _____

Current Sleep Symptoms cont...

		(f) do not know					
		(e) always (6 to 7 nights/days a week)					
		(d) often (3 to 5 nights/days a week)					
		(c) sometimes (1 to 2 nights/days a week)					
		(b) Not often (less than 1 night/day a week)					
		(a) Never (does not happen)					
8.	Nightmares	a	b	c	d	e	f
9.	Sleepwalking	a	b	c	d	e	f
10.	Sleeptalking	a	b	c	d	e	f
11.	Screaming in his/her sleep	a	b	c	d	e	f
12.	Kicks legs in sleep	a	b	c	d	e	f
13.	Wakes up at night	a	b	c	d	e	f
14.	Gets out of bed at night	a	b	c	d	e	f
15.	Trouble staying in his/her bed	a	b	c	d	e	f
16.	Resists going to bed at bedtime	a	b	c	d	e	f
17.	Grinds his/her teeth	a	b	c	d	e	f
18.	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19.	Wets bed	a	b	c	d	e	f

Current Daytime Symptoms

		(f) do not know					
		(e) always (6 to 7 nights/days a week)					
		(d) often (3 to 5 nights/days a week)					
		(c) sometimes (1 to 2 nights/days a week)					
		(b) Not often (less than 1 night/day a week)					
		(a) Never (does not happen)					
1.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime Sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon waking	a	b	c	d	e	f

Pregnancy/ Delivery

Pregnancy	Normal	Difficult					
Delivery	Term	Pre-Term	Post-Term				
Child's Birthweight:							
Only Child?	Yes	No	If no, 1st	2nd	3rd	4th	5th 6th 7th

Medical and Psychiatric History

Frequent Nasal Congestion	Yes	Age of Diagnosis :
Trouble breathing through his/her nose	Yes	Age of Diagnosis :
Sinus Problems	Yes	Age of Diagnosis :
Chronic Bronchitis or cough	Yes	Age of Diagnosis :
Allergies	Yes	Age of Diagnosis : Allergic to what:
Asthma	Yes	Age of Diagnosis :
Frequent Colds or Flus	Yes	Age of Diagnosis :
Frequent Ear Infections	Yes	Age of Diagnosis :
Frequent Strep Throat Infections	Yes	Age of Diagnosis :
Difficulty Swallowing	Yes	Age of Diagnosis :
Acid Reflux (Gastroesophageal Reflux)	Yes	Age of Diagnosis :
Poor or Delayed Growth	Yes	Age of Diagnosis :
Excessive Weight	Yes	Age of Diagnosis :
Hearing Problems	Yes	Age of Diagnosis :
Speech Problems	Yes	Age of Diagnosis :
Vision Problems	Yes	Age of Diagnosis :
Seizures/ Epilepsy	Yes	Age of Diagnosis :
Morning Headaches	Yes	Age of Diagnosis :
Cerebral Palsy	Yes	Age of Diagnosis :
Heart Disease	Yes	Age of Diagnosis :
High Blood Pressure	Yes	Age of Diagnosis :
Sickle Cell Disease	Yes	Age of Diagnosis :
Genetic Disease	Yes	Age of Diagnosis :
Chromosome Problem (e.g., Down's)	Yes	Age of Diagnosis :
Skeleton Problem ((e.g., Dwarfism)	Yes	Age of Diagnosis :
Cranofacial Disorder (e.g., Pierre-Robin)	Yes	Age of Diagnosis :
Thyroid Problems	Yes	Age of Diagnosis :
Eczema (Itchy Skin)	Yes	Age of Diagnosis :
Pain	Yes	Age of Diagnosis :

Past Psychiatric/ Psychological History

Autism	Yes	Age of Diagnosis :
Developmental Delay	Yes	Age of Diagnosis :
Hyperactivity/ ADHD	Yes	Age of Diagnosis :
Anxiety/ Panic Attacks	Yes	Age of Diagnosis :
Obsessive Compulsive Disorder	Yes	Age of Diagnosis :
Depression	Yes	Age of Diagnosis :
Suicide	Yes	Age of Diagnosis :
Learning Disability	Yes	Age of Diagnosis :
Drug Use/ Abuse	Yes	Age of Diagnosis :
Behavioral Disorder	Yes	Age of Diagnosis :
Psychiatric Disorder	Yes	Age of Diagnosis :
Psychiatric Admission	Yes	Age of Diagnosis :

Please list any additional psychological, psychiatric, emotional, or behavioral problems diagnosed or suspected by a physician/psychologist.

Social History:

Death in the family Divorce Relocation New Sibling

Current Medical History

Please list any medications your child currently takes:

Medicine	Dose	How Often?
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1.

2.

3.

4.

Long-Term Medical Problems

If your child has long-term medical problems, please list the three you think are most important

1.

2.

3.

Surgeries/Hospitalizations

Has your child ever had his/her tonsils removed?	Yes	Age of Surgery:
Has your child ever had his/her adenoids removed?	Yes	Age of Surgery:
Has your child ever had ear tubes?	Yes	Age of Surgery:

Please list any additional hospitalizations or surgeries:

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Health Habits

Does your child drink caffeinated beverages? (e.g., Coke, Pepsi, Mountain Dew, Iced Tea)

No Yes Amount per day:

School Performance

Current School Performance (if school-aged)

Your Child's Grade:					
Has your child every repeated a grade?					
Is your child enrolled in any special education class?					
How many school days has your child missed so far this year?					
How many school days did your child miss last year?					
How many school days was your child late so far this year?					
How many school days was your child late last year?					
Child's grades this year:	Excellent	Good	Average	Poor	Failing
Child's grades last year:	Excellent	Good	Average	Poor	Failing

Family Information

Mother	Father
Age:	Age:
Marital Status: Single Divorced Separated Married Widowed Remarried	Marital Status: Single Divorced Separated Married Widowed Remarried
Education:	Education:
Work: Unemployed Part-Time Full-Time	Work: Unemployed Part-Time Full-Time
Occupation:	Occupation:

Persons Living In Home

Name:	Relationship	Age:

Family Sleep History

Does anyone in the family have a sleep disorder?

If yes, mark the disorder (s):

Insomnia	Mother	Father	Brother/Sister	Grandparent
Snoring	Mother	Father	Brother/Sister	Grandparent
Sleep Apnea	Mother	Father	Brother/Sister	Grandparent
Restless Leg Syndrome	Mother	Father	Brother/Sister	Grandparent
Periodic Limb Movement Disorder	Mother	Father	Brother/Sister	Grandparent
Sleepwalking/Sleep Terrors	Mother	Father	Brother/Sister	Grandparent
Sleep Talking	Mother	Father	Brother/Sister	Grandparent
Narcolepsy	Mother	Father	Brother/Sister	Grandparent
Other:	Mother	Father	Brother/Sister	Grandparent

Referral

Who asked that your child be seen by a sleep specialist?

<input type="checkbox"/>	Pediatrician/ Family Physician
<input type="checkbox"/>	Child's Parent or Guardian
<input type="checkbox"/>	Surgical Specialist (e.g., ENT)
<input type="checkbox"/>	Pediatric Specialist (e.g., Allergist, Neurologist, Pulmonologist)
<input type="checkbox"/>	Mental Health specialist (e.g., Psychiatrist, Psychologist, Social Worker)
<input type="checkbox"/>	School Teacher, Nurse, Counselor
<input type="checkbox"/>	Child himself/herself
<input type="checkbox"/>	Other:

To be completed by physician:

Physical Exam:

Age: _____ Height: _____ Weight: _____ BMI: _____
 Neck circumference: _____ BP: _____ HR: _____ RR: _____
 _____ O2 SAT

Head/OP:

Mid Face Hypoplasia

Septal deviation:

OP clear

Yes No

OP exudate

Nares abnormal:

Nasal Crease

Yes No

Mouth Breathing

Tongue:

Mallampati scale: _____ Moist Dry

Macroglossia: Yes No

Tonsils: ____/4

Dentition:

Good Fair Poor

Retrognathia Yes No

Micrognathia Thyromegaly

Neck:

NL size Large Short

w/LAD w/o LAD

Skin:

Eczema

