Pro Sleep Care
TODAY'S SLEEP SOLUTION

Medical History Questionnaire

22330 Hawthorne Blvd. Suite 214 Torrance, CA. 90505 Tel: 760.779.1444 Fax: 888.816.5060

Patient Information

First Name_____ Middle_____ Last Name _____
Street Address _____City_____ State_____ Zip_____
Home Phone _____ Work Phone _____ Ext. _____Cell Phone _____
Employment Status__Full time__Part Time__Other Employer Name _____
Email _____
Date of Birth _____ Soc Sec # _____ Gender __Male __Female
Marital Status __Married__Single__Divorced__Other Spouse Name_____
Medical Doctor Name _____ Phone_____Fax_____
Emergency Contact name _____Relationship _____Phone _____

Medical Insurance Information (If Possible Include a copy of front & back of insurance card)

Primary Insurance Name _____Insurance Phone#_____
Full Name of Insured _____ Relationship to Patient _____
Insured Birth Date _____Insured Employer Name _____
Primary Insurance I.D. #_____Policy/Group # _____

Secondary Insurance Name_____Secondary Ins. Phone#_____
Full Name of Inured _____Relationship to Patient_____
Insured Birth Date _____ Insured Employer Name _____
Secondary Insurance I.D. # _____ Policy/Group #_____

Patient Notices and Acknowledgements

Assignment of Benefits: I request that payment of authorized insurance benefits (if any) be made on my behalf to Pro Sleep Care ("PSC") for any services furnished to me by PSC. I hereby authorize PSC to release to the applicable insurer (if any) and its agents any medical information needed to determine the scope of benefits payable for rendered services. I acknowledge that I will be responsible for any deductible, coinsurance and/or co-payment amount that my insurance may require.

Privacy: I hereby authorize PSC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me in order to carry out the provision of diagnostic sleep services, durable medical equipment/oral appliance and payment for such services. I have received a copy of the Notice of Privacy Standards (HIPAA) which more fully describes the uses and disclosures that can be made of my individually identifiable health information in order to carry out the provision of provided services and payment for such services. I understand that I may revoke this consent at any time by notifying PSC in writing, but if I revoke my consent, such revocation will not affect any actions that PSC took before receiving my revocation. I understand that PSC has reserved the right to change its privacy practices and that I can obtain such changed notice upon request. I understand that I have the right to request that PSC restricts how my individually identifiable health information is used and/or disclosed in order to carry out the provision of Home Sleep Testing (HST), Durable Medical Equipment (DME) and payment for such services. I understand that PSC does not have to agree to such restrictions, but that once such restrictions are agreed to PSC must adhere to such restrictions.

Liability Release: I authorize access to all of my insurance information and medical records necessary for billing the related healthcare services. I hereby give permission to release any medical information or insurance information in order to file any insurance claims. I release Pro Sleep Care and its agents from any liability claims or damages that may arise from the disclosure of such information and pursuit of payment. I also assign any benefits paid on me or my dependant to be paid directly to the provider and payment for services on me or my dependant behalf are my sole responsibility. I understand that a separate bill for interpretation may be sent for the interpreting physician.

Receipt of Documents: I hereby acknowledge receipt of Pro Sleep Care's Notice of Privacy Practices (HIPAA).

I certify that I have read and understand the above information; understand my responsibilities; and have access to a copy of this form.

Patient's Signature: _____ **Date:** _____

Print Patient's Name: _____

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This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the source of your problem. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

LIST ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION

Y◯ N◯	**Antibiotics**	Y◯ N◯	**Latex**	Y◯ N◯	**Sedatives**
Y◯ N◯	**Aspirin**	Y◯ N◯	**Local anesthetics**	Y◯ N◯	**Sleeping pills**
Y◯ N◯	**Barbiturates**	Y◯ N◯	**Metals**	Y◯ N◯	**Sulfa drugs**
Y◯ N◯	**Codeine**	Y◯ N◯	**Penicillin**	Y◯ N◯	**Iodine**
Other	_____				

LIST ANY MEDICATION CURRENTLY BEING TAKES

Medication Name	**Dosage \ Frequency**	**Reason**

MEDICAL HISTORY: (Please indicate dates on items marked current or past)

Height: _____ Weight: _____ Neck Size: _____

Medical Condition	**Never**	**Current**	**Past**	**Date**	**Medical Condition**	**Never**	**Current**	**Past**	**Date**
Acid reflux	◯	◯	◯		Bruising easily	◯	◯	◯	
Adenoids	◯	◯	◯		Cancer	◯	◯	◯	
Anemia	◯	◯	◯		Chemotherapy	◯	◯	◯	
Arteriosclerosis	◯	◯	◯		Chronic cough	◯	◯	◯	
Arthritis	◯	◯	◯		Chronic fatigue	◯	◯	◯	
Asthma	◯	◯	◯		Chronic pain	◯	◯	◯	
Medical Condition	**Never**	**Current**	**Past**	**Date**	**Medical Condition**	**Never**	**Current**	**Past**	**Date**
Bleeding easily	◯	◯	◯		COPD	◯	◯	◯	
High blood press	◯	◯	◯		Depression	◯	◯	◯	
Low blood press	◯	◯	◯		Diabetes	◯	◯	◯	
Jaw joint surgery	◯	◯	◯		Tremors – shakes	◯	◯	◯	
Kidney problems	◯	◯	◯		Muscle spasms	◯	◯	◯	
Low energy	◯	◯	◯		Muscular dystrophy	◯	◯	◯	
Meniere's disease	◯	◯	◯		Nasal allergies	◯	◯	◯	
Menstrual cramps	◯	◯	◯		Propped up sleeping	◯	◯	◯	

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Multiple sclerosis	◯	◯	◯		Nervousness	◯	◯	◯	
Muscle aches	◯	◯	◯		Neuralgia	◯	◯	◯	
Impaired Cognition	◯	◯	◯		Numbness	◯	◯	◯	
Ischemic Heart Disease	◯	◯	◯		Osteoarthritis	◯	◯	◯	
Cardiac Arrhythmias	◯	◯	◯		Osteoporosis	◯	◯	◯	
On Oxygen yes\no 24hr	◯	◯	◯		Mood Disorder	◯	◯	◯	
Diagnosed with OSA	◯	◯	◯		Adenoidectomy	yes	no		
CPAP Usage yes\No	◯	◯	◯		Tonsillectomy	yes	no		
Non Compliance CPAP	yes	no			Wt. Gain since OSA DX	yes	no		
				Pulmonary Hypertension		◯	◯	◯	

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired? This refers to your usual way of life in recent times. Even if you have not done so some of these things recently try to work out how they would have affected you.

Epworth Sleep Scale Choose the most appropriate response for each situation.	Never Would Doze off	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
1. Sitting and reading	◯ **0**	◯ **1**	◯ **2**	◯ **3**
2. Watching TV	◯ **0**	◯ **1**	◯ **2**	◯ **3**
3. Sitting inactive in a public place	◯ **0**	◯ **1**	◯ **2**	◯ **3**
4. As a passenger in a car for an hour without a break	◯ **0**	◯ **1**	◯ **2**	◯ **3**
5. Laying down to rest in the afternoon when circumstances permit	◯ **0**	◯ **1**	◯ **2**	◯ **3**
6. Sitting and talking with someone	◯ **0**	◯ **1**	◯ **2**	◯ **3**
7. Sitting quietly after lunch without alcohol	◯ **0**	◯ **1**	◯ **2**	◯ **3**
8. In a car, while stopped for a few minutes	◯ **0**	◯ **1**	◯ **2**	◯ **3**
Totals				
			Total of all questions :	

Patient Symptoms **Check all that apply**				
Snoring	◯Yes ◯No	Family history of sleep Apnea	◯Yes ◯No	
Excessive daytime sleepiness	◯Yes ◯No	Hypertension / high blood pressure	◯Yes ◯No	
Awaken with headache or dry mouth	◯Yes ◯No	Diabetes	◯Yes ◯No	
Depression, fatigue or inability to concentrate	◯Yes ◯No	Witness apnea, gasping, choking	◯Yes ◯No	
History of heart disease	◯Yes ◯No	History of stroke	◯Yes ◯No	

Note:

Patient's Signature: _____ Date: _____

Print Patient's Name: _____