



Sleep Consultants, Inc.

1521 Cooper Street ♦ Fort Worth, Texas 76104 ♦ (817) 332-7433 ♦ Fax (817) 336-2159

*Comprehensive Care of Sleep Disorders
Diagnosis, Treatment, Follow-up, Education, Research*

Patient care and business functions at 1521 Cooper Street
Sleep Laboratory - 909 8th Avenue, Fort Worth, TX 76104
Email: information@sleepconsultants.com
Internet: <http://www.sleepconsultants.com>

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Pulmonary/Sleep Consultant

Michael Smith, Ph.D.
Physiology Consultant
University of North Texas
Health Science Center

Dear Patient:

You have an appointment with Dr. _____ on _____ at _____ a.m./p.m. This is your initial appointment only which takes about an hour. If testing is needed, it will be scheduled for a later date. *Please note that your appointment is at our Harris Southwest office at 6100 Harris Parkway, Suite 285, not at the Cooper Street location.*

We want to take this opportunity to welcome you to the practice and thank you for choosing us to provide your health care. We appreciate your trust in us and look forward to keeping you healthy.

Please complete the enclosed information BEFORE your scheduled appointment and bring the completed forms with requested information including current insurance card(s), all your medications (including inhalers, over-the-counter medications, herbs) and your CPAP or BiPAP machine if you are using one.

The Sleep and Health questionnaires are used to conduct this appointment so it is very important that this is completely filled out ahead of time. **If this is not filled out before you arrive you may be asked to reschedule.** It would be helpful to bring someone with you who is familiar with your sleep habits.

Many patients seen in our offices have sensitive respiratory conditions. Please avoid use of scented body spray, perfume, cologne, aftershave, or anything with a heavy scent.

If a referral is required, you will need to bring your referral and/or referral information to the office at the time of your visit. If we do not have this referral, you will not be seen by the doctor. The referral needs to be made out to the doctor named above. Any sleep testing is done at the 909 8th Avenue location and is billed by Sleep Consultants, Inc. If you have any question concerning your benefits, please call your insurance company.

If you need to reschedule your appointment, please call us at 817-263-5864 as early as possible, but no later than 24 hours prior, or you will be subject to a late cancellation/missed appointment charge of \$25.00.

Sincerely,

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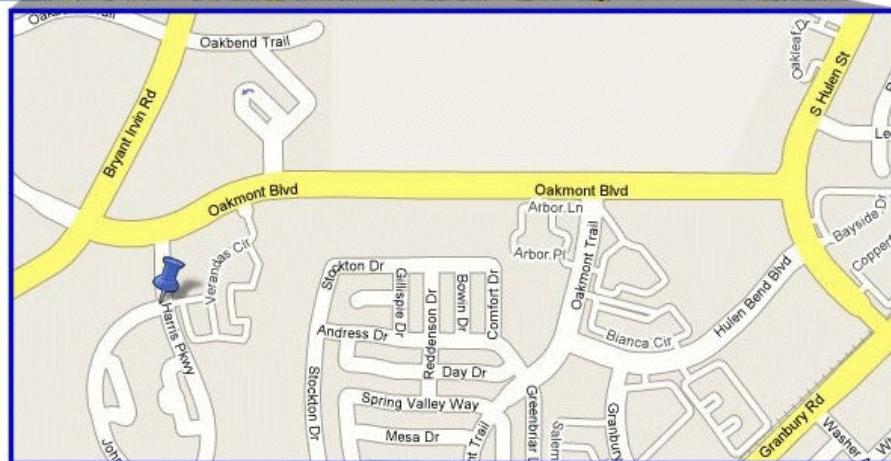
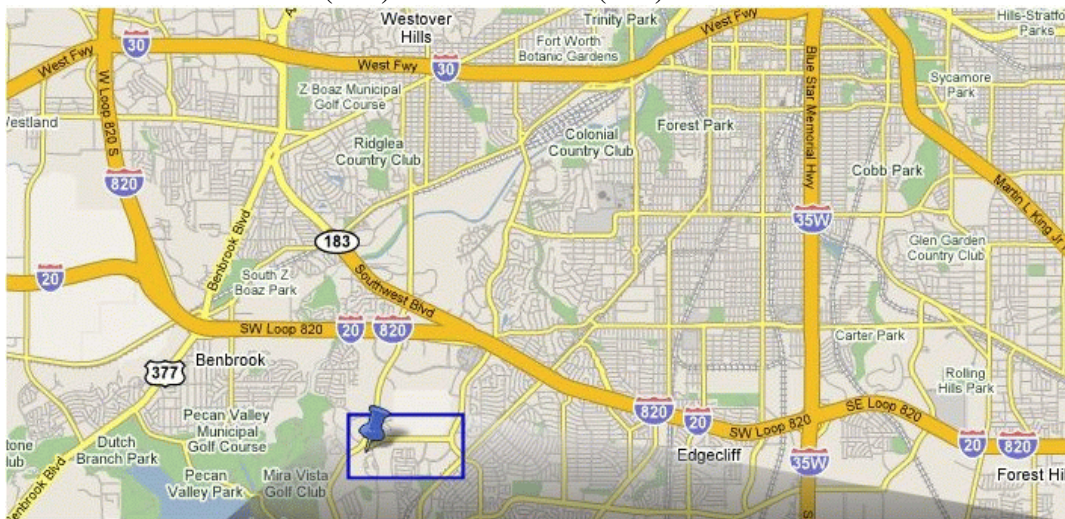
Texas Pulmonary & Critical Care Consultants, P.A.

Sleep Consultants, Inc.

6100 Harris Parkway, Suite 285

Fort Worth, TX 76132

(817) 263-5864 / fax (817) 263-3791



From Burleson or Waco :

Proceed to I-35W North driving toward Fort Worth. Take exit (45A) to merge into I-20/820W toward Abilene. Take the Bryant Irvin Road exit. Turn left onto Bryant Irvin Rd. Go south on Bryant Irvin Rd. Turn left onto Oakmont Blvd. Turn right onto Harris Parkway. Go one block and the hospital will be on your right. Pull into the main parking lot. Follow signs to the Plaza section of the hospital. (This will be the north side of the hospital). When you enter the plaza, turn left to the bank of elevators. Take the elevator to the second floor. From the elevator, go right to suite 285. We are located on the right side at the end of the hall.

From Abilene:

Proceed to I-20E/ US80-E driving East toward Fort Worth. Continue to follow I-20 E. Take the Bryant Irvin Road exit. Turn left onto Bryant Irvin Rd. Go south on Bryant Irvin Rd. Turn left onto Oakmont Blvd. Turn right onto Harris Parkway. Go one block and the hospital will be on your right. Pull into the main parking lot. Follow signs to the Plaza section of the hospital. (This will be the north side of the hospital). When you enter the plaza, turn left to the bank of elevators. Take the elevator to the second floor. From the elevator, go right to suite 285. We are located on the right side at the end of the hall.

PATIENT REGISTRATION FORM

Date: _____

Patient Name _____ Birth Date _____ Sex _____

Home Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Social Security Number _____

Patient Employer _____ Work Phone _____

Employer Address _____
Street City State Zip

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____ Religious Preference: _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Work Phone _____ Address _____

Referred By _____ Phone _____ Fax _____

Address _____
Street City State Zip

Primary Care Physician _____ Phone _____ Fax _____

Address _____
Street City State Zip

List other physicians you are currently seeing _____

Notify in case of emergency: (Do not list anyone who lives with you)

Name _____ Phone _____ Relationship _____

Address _____
Street City State Zip

Have you signed a: Living Will: Yes No DNR (Do Not Resuscitate): Yes No (Please provide a copy)

Durable Power of Attorney: Yes No Date signed: _____ (Please provide a copy)

Pharmacy _____ Phone _____

Are you currently using a DME (Durable Medical Equipment) Company? Yes No

If yes, which one? _____ Phone _____

If no, who does your insurance company require you to use? _____

Who does your insurance company require you to use for: Lab _____ X-ray _____

Is this a work-related illness? Yes No Date of illness or injury _____ Date last worked _____

Cause of accident, if any _____

Only with your written request will we release information regarding your medical condition to a family member. Do you wish information to be released to a family member? Yes No

Please list family members by name and relationship to you. _____

I hereby authorize release of my medical records from _____ to the physician(s) indicated below.

Arlington - North
Joseph Austin, Jr., M.D., FCCP
Jack G. Gilbey, Jr., M.D., FCCP
Luis F. Guerra, M.D., FCCP
Mitchell C. Kuppinger, M.D., FCCP
David H. Plump, M.D., FCCP
Tony H. Su, M.D., FCCP

Bedford
Gary L. Jones, M.D., FCCP
James T. Siminski, M.D., FCCP
Donald L. Washington, Jr., M.D.
Burleson
Dereje S. Ayo, M.D.
Henry S. Cunningham, M.D., FCCP

Fort Worth - Medical District 2
Steven Q. Davis, M.D.
Roger Gleason, M.D., FCCP
John T. Pender Jr., M.D., FCCP
David S. Hernandez, M.D.

Grapevine
R. L. "Lin" Cash, Jr., M.D., FCCP
Timothy G. Schroeder, M.D., FCCP

Arlington - South
E. Duane Dilley, M.D., FCCP
Phan Nguyen, M.D.

Fort Worth - Medical District 1
John R. Burk, M.D., FACP
Stuart D. McDonald, M.D., FCCP
Kerim F. Razack, M.D., FCCP

Fort Worth - Southwest
Kevin G. Connelly, M.D., FCCP
Huy X. Duong, D.O.
David Maldonado, III, M.D.

Mansfield
John L. Tiu, M.D.

North Richland Hills
David R. Herrmann, M.D., FCCP
Madhu S. Kollipara, M.D.

Sleep Consultants, Inc.
Donald E. Watenpaugh, Ph.D.

Signature of Patient or Responsible Party _____

Date _____

FINANCIAL POLICY

PRIMARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Relationship to patient _____
Insured's Birth Date _____ SSN _____ Sex _____
Claims Mailing Address _____
_____ Phone No. _____

SECONDARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Relationship to patient _____
Insured's Birth Date _____ SSN _____ Sex _____
Claims Mailing Address _____
_____ Phone No. _____

Responsible Party Name _____ Phone _____ Relationship _____
Address _____
Street City State Zip

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance Form before seeing the doctor. Full payment or copayment (if applicable) is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express.

Regarding Insurance

We cannot bill your insurance company unless you give us your insurance information. If we are nonparticipating with your insurance, and they have not paid the balance within 90 days, the balance will be transferred to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. These charges will be your responsibility. Our office makes every effort to obtain referral authorizations from the Primary Care offices for patients on HMOs. Should we not be able to obtain a referral, charges will be your responsibility.

Out of Network Billing

The physicians may not be participating physicians with your insurance plan, and if not, benefits may be reduced as such. You will be responsible for any unpaid charges and/or balances. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's (excluding Medicare) arbitrary determination of usual and customary rates.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge for missed office and oximetry appointments at the rate of \$25.00 and a separate charge for sleep testing at the rate of \$200.00. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party

Date

Research Consent

I give permission for clinical and physiologic data from my medical records to be used for educational and research purposes. I understand that my identity and contact information (name, SS#, birth date, address, etc.) will never be attached to or processed with such data.

Signature of Patient or Responsible Party

Date

PATIENT HEALTH QUESTIONNAIRE

To our patients: We appreciate your cooperation in completing this health status profile. We are committed to providing a thorough evaluation during your visits and you can participate today by answering the following questions as they pertain to your general health. (A member of our staff is available to assist you if you have difficulty completing this form. Questions left blank may be discussed privately with the doctor.)

If you have any of the following symptoms, please circle all that apply.

- cough wheezing abnormal x-ray sore throat snoring
spitting blood lump shortness of breath chest pain
fever hoarseness daytime sleepiness insomnia
seizures indigestion/heartburn/reflux posterior nasal drainage/sinusitis leg twitches/discomfort

Health History:

Have you had any health problems in these areas:

Table with 2 columns: Health Problem, DATE, TYPE. Rows include Mental health, Epilepsy, Head or nervous system, Nose/throat/mouth, Heart/circulation, Breathing, Tuberculosis, Stomach, Kidneys, Allergies, Other, and Previous EEGs.

Have you ever been diagnosed by a member of the medical profession as having, or have you ever received treatment from a member of the medical profession because of:

- 1. Any immune deficiency disorder including AIDS or AIDS-related complex (ARC).
2. Generalized lymphadenopathy syndrome (GLS).
3. A blood test showing evidence of antibodies to the AIDS (HTLV-III) virus.

If you circled any of the above, please provide full details.

Surgical History:

List all surgeries:

Other Hospitalizations:

Blank lines for other hospitalizations.

List hobbies/social activities you presently enjoy:

Family History:

	Age	Medical Problems	Or	Age	Cause of Death
Father	_____	_____		_____	_____
Mother	_____	_____		_____	_____
Siblings	_____	_____		_____	_____
(Note if brother or sister)	_____	_____		_____	_____
	_____	_____		_____	_____
Children	_____	_____		_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____
Grandchildren	_____	_____		_____	_____
	_____	_____		_____	_____
	_____	_____		_____	_____

Has anyone in your family had (please circle):

Thyroid disease Diabetes Hypoglycemia (low blood sugar) Tuberculosis

Has anyone in your family had sudden attacks of physical weakness or paralysis when laughing, angry, or in other emotional situations? _____

Vital statistics: Height: _____ feet _____ inches. Neck size: _____ inches.

Weight loss or gain: Current weight: _____ Maximum weight: _____ When: _____

AGE	WEIGHT	AGE	WEIGHT
20	_____	50	_____
30	_____	60	_____
40	_____	70	_____

Use space below for any additional comments you may wish to make about your health, intake of drugs, medicines, or alcohol.

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

Signature _____

Date _____

SLEEP QUESTIONNAIRE: Completed by: _____ Date: _____

Please complete the questionnaire as it will help the doctor in his evaluation of your problems. As some questions are personal, if you choose to leave the answers blank and discuss them with your doctor on a personal basis, that is acceptable.

Patient Name _____ Occupation _____ Age _____

Number and type of pets _____

Number of children _____ Ages of children _____

List any significant illnesses of your children:

Briefly describe your sleep complaint. Tell when and how it began.

(continue on last page if necessary)

1. Are you in good health as far as you know? YES NO Exceptions: _____

2. How much of these beverages do you consume? Place a 0 in blank if none.

Coffee	_____ cups/day	_____ cups after 6 p.m.
Decaf Coffee	_____ cups/day	_____ cups after 6 p.m.
Tea (hot or cold)	_____ glasses/day	_____ glasses after 6 p.m.
Carbonated Drinks	_____ cans/bottles/day	_____ cans/bottles/after 6 p.m.
Beer, wine, liquor (circle one)	_____ drinks before 6 p.m.	_____ drinks after 6 p.m. _____ drinks at bedtime

3. Usual bedtime on workdays _____ a.m./p.m. Days off _____ a.m./p.m.

4. How long does it take to go to sleep on workdays _____ minutes. Days off _____ minutes

5. Usual time to get up on workdays _____ a.m./p.m. Days off _____ a.m./p.m.

6. How much sleep do you feel you get each night? _____ hours

7. Number of awakenings per night _____

8. Number of bathroom trips per night _____

9. How long does it take you to become fully alert and functional in the morning? _____ minutes _____ hours

INSTRUCTIONS: Circle YES or NO or fill in blanks as indicated. Circle NO if the problem is very infrequent. Place an X beside any question you do not understand or cannot answer by a simple yes or no.

- 10. **Yes No** Are you unable to fall asleep at night? mild severe
- 11. **Yes No** Are you unable to remain asleep at night? Number of times you awake _____
- 12. **Yes No** Do you use an alarm clock to wake up in the morning?
- 13. **Yes No** Do you have a problem with inability to get up in the morning?
- 14. **Yes No** Is it easy for you to get out of bed in the morning?
- 15. **Yes No** Do you feel you get too little sleep at night?
- 16. **Yes No** Do you feel you get too much sleep at night?
- 17. **Yes No** Do you feel your sleep/wake schedule is unsatisfactory?

- 18. **Yes No** Do you feel that the quality of your sleep is unsatisfactory? (that is, no matter how much sleep you get, you do not wake up feeling rested).
- 19. **Yes No** Are you usually sensitive to cold or heat ?
- 20. **Yes No** Does your pulse ever beat too fast or too hard (palpitations) during the day?
- 21. **Yes No** Do you crave certain types of food example: sweets, salt)?
- 22. **Yes No** Are you short of breath during the day?
- 23. **Yes No** Do your ankles swell up during the day?
- 24. **Yes No** Do you have high blood pressure?
- 25. **Yes No** Do you have anemia or any other blood problem(s)?
- 26. **Yes No** Do you have chest pain during the day or night?
- 27. **Yes No** Do you have kidney or urinary trouble?
- 28. **Yes No** Have you ever had cancer or a tumor?
- 29. **Yes No** Do you have problems with your skin, nails, or hair?
- 30. **Yes No** Do you have trouble with your bowels or liver?
- 31. **Yes No** Do you have thyroid problems?
- 32. **Yes No** Do you have low blood sugar (hypoglycemia)?
- 33. **Yes No** Do you sleep a lot or take many naps during the day?
- 34. **Yes No** Do you feel extremely drowsy or sleepy during the day?
- 35. **Yes No** Do you have to drink a lot of coffee or tea to stay awake during the day?
- 36. **Yes No** Do you feel extremely tired or fatigued during the day even when you are not sleepy?
- 37. **Yes No** Do you have feelings during the day that you "just don't want to do anything"?
- 38. **Yes No** Is your daytime performance in work or recreation less efficient than you would like it to be?
- 39. **Yes No** Do you yawn very frequently during the day?
- 40. **Yes No** Do you feel distracted and unable to concentrate during the day?

41. Do you fall asleep during these situations: *(Rate your chance of dozing: 0=never, 1=slight, 2=moderate, 3=high)*

- _____ Sitting and reading
- _____ Watching TV
- _____ Sitting inactive in a public place (e.g. a theater or meeting)
- _____ As a passenger in a car for an hour without a break
- _____ Lying down to rest in the afternoon when circumstances permit
- _____ Sitting and talking to someone
- _____ Sitting quietly after a lunch without alcohol
- _____ In a car, while stopped for a few minutes in traffic

- 42. **Yes No** Do you have uncontrollable urges to fall asleep during the day or find yourself falling asleep when you do not want to?
- 43. **Yes No** Have you had accidents or near accidents when driving a car because you felt extremely sleepy or were having trouble concentrating?
- 44. **Yes No** Have you ever been in unusual, unpleasant, or embarrassing situations because you felt extremely sleepy or were having trouble concentrating?
- 45. **Yes No** Would you like to be able to nap at particular times of the day?

46. Do you function BEST in the: (check blanks that apply)

- _____ MORNING
- _____ AFTERNOON
- _____ EVENING
- _____ NEVER

47. Do you function WORSE in the:

- _____ MORNING
- _____ AFTERNOON
- _____ EVENING

- 48. **Yes No** Do you drink alcoholic beverages regularly?
- 49. **Yes No** Do you feel you have a drinking problem?
- 50. **Yes No** Is your sleep satisfactory when you drink alcohol?
- 51. **Yes No** Do you take sedatives regularly? (sleeping pills)
- 52. **Yes No** If yes, is your sleep satisfactory when taking sedatives?
- 53. **Yes No** Do you take other drugs at night?
- 54. **Yes No** Do you drink any beverage during the night? (alcohol, coffee, tea, cola, water, etc)
- 55. **Yes No** Are you aware of any breathing abnormalities or problems with breathing associated with your sleep?
- 56. **Yes No** Have you ever been told you snore?
- 57. **Yes No** Does your snoring disturb others in your home?
- 58. **Yes No** Do you sometimes wake up feeling like you are choking or gasping for breath?
- 59. **Yes No** If you snore, does your snoring get worse after drinking alcohol?
- 60. **Yes No** Have you dreamed of drowning or being suffocated?
- 61. **Yes No** Do you have hay fever or sinus congestion frequently?
- 62. **Yes No** Do you still have your tonsils?
- 63. **Yes No** Do you have palpitations or rapid heart beat during the night?
- 64. **Yes No** Do you wake up with a headache?
- 65. **Yes No** Do you sweat excessively during sleep?
- 66. **Yes No** Do you wake to use the bathroom at night? number of times _____
- 67. **Yes No** Do your limbs or does your whole body twitch occasionally when falling asleep?
- 68. **Yes No** Is your sleep often "restless" and "disturbed"?
- 69. **Yes No** Do you ever fall out of bed?
- 70. **Yes No** Have you ever wet the bed during sleep as an adult?
- 71. **Yes No** Do you have pain in the neck, spine, muscles, or joints during the night?
- 72. **Yes No** Do you have other kinds of pain during the night?
- 73. **Yes No** Do you have muscular aches and pains during the day?
- 74. **Yes No** Do you have significant muscular weakness, incoordination or dizziness?
- 75. **Yes No** Do you have pain in your joints during the day?
- 76. **Yes No** Do you have any other type of chronic pain?
- 77. **Yes No** Have you ever been tested for arthritis?
- 78. **Yes No** Do you have arthritis?
- 79. **Yes No** Do you have a crawling feeling or discomfort in your legs or thighs that increases in intensity?
- 80. **Yes No** Do you have a demanding need to move the legs or body to relieve this feeling?

81. **Yes No** Do you get relief of these symptoms by activity (walking, stretching, bending) at least temporarily?
82. **Yes No** Do these symptoms worsen when sitting or lying down, especially in the late evening or night?
83. **Yes No** Do you eat a meal within 2 hours of going to bed?
84. **Yes No** Do you have a hiatal hernia?
85. **Yes No** Do you awaken with a sour or bitter taste in your mouth?
86. **Yes No** Do you wake up at night with "heartburn"?
87. **Yes No** Does gas bother you when you are trying to sleep, or do you wake up during the night with gas pains?
88. **Yes No** Do you cough frequently at night?
89. **Yes No** Do you wake up with a sore throat frequently?
90. **Yes No** Do you wake at night with nausea frequently?
91. **Yes No** Do you have times during the day when your memory completely fails you (blackouts)?
92. **Yes No** Have you ever "come to" and discovered that you have performed some complex activity (i.e. driving car) without remembering it?
93. **Yes No** Do you sometimes have illusions that something is happening that really isn't happening?
94. **Yes No** Do you have hallucinations or dream-like mental images during the day?
95. **Yes No** Do you have attacks of sudden physical weakness or paralysis during the day, when laughing, angry or in other emotional situations?
96. **Yes No** Do you have hallucinations or dream-like mental images when you are falling asleep or waking up?
97. **Yes No** Do you feel paralyzed when falling asleep or as you are waking up?
98. **Yes No** Do you often have frightening dreams or nightmares?
99. **Yes No** Have you had the same dream on different nights?
100. **Yes No** Do you have night terrors or wake up screaming?
101. **Yes No** Are you afraid of the dark?
102. **Yes No** Are you afraid to go to sleep?
103. **Yes No** Have you ever had a convulsion (fit, epilepsy) at night?
104. **Yes No** Have you ever had convulsions (fit, epilepsy) during the day?
105. **Yes No** Do you tend to awaken (suddenly) during the night or in the morning with an unpleasant feeling of fear, anxiety, worry, depression, unhappiness or confusion? (Underline those that apply)
106. **Yes No** Are you taking stimulants (Ritalin, "uppers", NoDoz) during the day?
107. **Yes No** If you are taking stimulants, do you feel your performance is satisfactory when taking them?
108. **Yes No** Have you ever had a significant injury to your head?
109. **Yes No** Do you suffer from fainting spells or loss of consciousness during the day?
110. **Yes No** Do you ever have double vision or blurred vision?
111. **Yes No** Do you sleep walk?
112. **Yes No** Do you talk in your sleep?
113. **Yes No** Have you been told that you make moaning sounds in your sleep?
114. **Yes No** Do you grind your teeth during sleep?
115. **Yes No** Do you wake up during the night feeling thirsty?
116. **Yes No** Do you wake up during the night feeling hungry?
117. **Yes No** Are you bothered by itching sensations during the night?
118. **Yes No** Have you ever been told that you bang your head against the bed at night?
119. **Yes No** Have you ever been told that you make rolling/rocking movements in sleep?
120. **Yes No** Do you have problems with reaching an orgasm (climax) during sex?
121. **Yes No** Do you feel that your interest in sex is less than is normal?

122. **Yes No** MEN Do you wake up with penile erections that are painful?
123. **Yes No** MEN Do you have problems obtaining or sustaining a penile erection?
124. **Yes No** MEN Do you have problems ejaculating?
125. **Yes No** WOMEN Are your menstrual periods in any way abnormal or irregular?
126. **Yes No** WOMEN Are you pregnant?
127. **Yes No** WOMEN Are you past the menopause (change in life), are you having menopausal symptoms now?
128. **Yes No** WOMEN Do you have daytime complaints that vary with the stage of your menstrual cycle?
129. **Yes No** Do you have daytime sleep complaints that seem to go in cycles or only appear at certain times? Examples: only in the evening, every 10 days, when you sleep away from home, etc.)
130. **Yes No** Do you often feel depressed, sad, or "blue" during the day?
131. **Yes No** Have you ever considered or attempted suicide?
132. **Yes No** Do you often feel guilty or inadequate during the day?
133. **Yes No** Do you sometimes have feelings during the day that your personality has changed or that you often tend to be unusually irritable and "just not yourself"?
134. **Yes No** Do you frequently feel anxious or worried during the day?
135. **Yes No** Do you frequently feel fearful during the day?
136. **Yes No** Do you frequently feel disoriented and confused during the day?
137. **Yes No** Do you tend to lie awake at night feeling depressed, worried, anxious, fearful, unhappy or disoriented/confused)?
138. **Yes No** Do you tend to lie awake at night with thoughts racing through your mind?
139. **Yes No** Have you ever had treatment/therapy by a psychiatrist or clinical psychologist?
140. **Yes No** Do you have severe headaches or migraines during the day?
141. **Yes No** Do you usually sleep with a bed partner?
142. **Yes No** Are you awake at night because of your bed partner? (because of your partner's noise or movement)
143. **Yes No** Are you awake during the night because some other person or animal requires assistance?
144. **Yes No** Are you awake at night because of other noise?
145. **Yes No** Are you awake at night because of heat or cold?
146. **Yes No** Are you awake at night because of light?
147. **Yes No** Do you tend to have uncontrollable eye flickering?
148. **Yes No** Do your eyes burn or feel dry and gritty during the day?
149. **Yes No** Do you rub your eyes frequently during the day?
150. **Yes No** Do your eyes frequently water or tear during the day?
151. **Yes No** Do you consider that your sleep/wake schedule is unusually irregular?
152. **Yes No** Is your sleep/wake schedule (or symptoms) different during the weekend from workdays?
153. **Yes No** Is your sleep/wake schedule (or symptoms) different during the holidays from workdays?
154. **Yes No** Did you have a problem with your sleep as a child?
155. **Yes No** Did you have a worse problem with your sleep at some other time in the past?
156. **Yes No** Do you have difficulty in adjusting your sleep to east/west or west/east travel?
157. **Yes No** Does your occupation involve shift-work, night-work or travel across time zones?

158. Do you find that your present sleep/wake schedule is inconvenient, inappropriate or unsatisfactory? (cannot get to sleep until late at night and then have trouble getting up in time for work; fall asleep so early I cannot get anything done in the evening with my family)

159. Is there a particular sleep/wake schedule you would prefer to your present schedule, but have difficulty achieving it? If yes, please explain what kind of different sleep/wake schedule you would like (I would like to fall asleep earlier, sleep for six hours, and wake up earlier.)

160. Are there any other daytime symptoms or complaints which you feel may be related to sleep? If yes, please explain briefly.

161. Is there any other complaint, sensation, or problem that bothers you during the day, whether or not it may be associated with sleep? If yes, please explain.

162. Does anyone in your family have sleep problems? If yes, please explain.

- _____ Husband or Wife
- _____ Son or Daughter
- _____ Brother or Sister
- _____ Father or Mother
- _____ Other family member

163. Does anyone in your family have psychiatric problems? If yes, please explain

- _____ Husband or Wife
- _____ Son or Daughter
- _____ Brother or Sister
- _____ Father or Mother
- _____ Other family member

164. **Yes No** Have any of your family or relatives been hyperactive as children?

165. **Yes No** Do you feel that you are living under unusual "pressure" or "stress" at this time?

166. List anything else (not yet covered) which especially interferes with your sleep.

167. List things that make daytime or nighttime symptoms and complaints worse.

168. List things that make daytime or nighttime symptoms and complaints better.

CPAP is the usual first step in the treatment of sleep apnea. Some patients have a choice in deciding who will provide their equipment. Do you have a choice in who provides durable medical equipment? YES or NO

If yes, please provide the name and telephone number of the company you want to provide this equipment.

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

Signature _____ Date _____

Continued description of sleep complaint from page 1 if necessary:

BECK INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Pick out the *one* statement in each group which best describes the way you have been feeling the PAST WEEK (including TODAY). Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all of the statements in each group before making your choice.

- | | |
|--|--|
| <p>1. 0 I do not feel sad
1 I feel sad
2 I am sad all the time & I can't snap out of it
3 I am so sad or unhappy that I can't stand it</p> <p>2. 0 I am not particularly discouraged about the future
1 I feel discouraged about the future
2 I feel I have nothing to look forward to
3 I feel that the future is hopeless & that things cannot improve</p> <p>3. 0 I don't feel like a failure
1 I feel I have failed more than the average person
2 As I look back on my life, all I can see are a lot of failures
3 I feel I am a complete failure as a person</p> <p>4. 0 I get as much satisfaction out of things as I used to
1 I don't enjoy things the way I used to
2 I don't get real satisfaction out of anything anymore
3 I am dissatisfied or bored with everything</p> <p>5. 0 I don't feel particularly guilty
1 I feel guilty a good part of the time
2 I feel quite guilty most of the time
3 I feel guilty all of the time</p> <p>6. 0 I don't feel I am being punished
1 I feel I may be punished
2 I expect to be punished
3 I feel I am being punished</p> <p>7. 0 I don't feel disappointed in myself
1 I am disappointed in myself
2 I am disgusted in myself
3 I hate myself</p> <p>8. 0 I don't feel I am any worse than anybody else
1 I am critical of myself for my weaknesses or mistakes
2 I blame myself all the time for my faults
3 I blame myself for everything bad that happens</p> <p>9. 0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself, but would not carry them out
2 I would like to kill myself
3 I would kill myself if I had the chance</p> <p>10. 0 I don't cry any more than usual
1 I cry more now than I used to
2 I cry all of the time now
3 I used to be able to cry, but now I can't even though I want to</p> <p>11. 0 I am no more irritated now than I ever am
1 I get annoyed or irritated more easily than I used to
2 I feel irritated all of the time now
3 I don't get irritated at all by the things that used to irritate me</p> | <p>12. 0 I have not lost interest in other people
1 I am less interested in other people than I used to be
2 I have lost most of my interest in other people
3 I have lost all of my interest in other people</p> <p>13. 0 I make decisions about as well as I ever could
1 I put off making decisions more than I used to
2 I have greater difficulty in making decisions than before
3 I can't make decisions at all anymore</p> <p>14. 0 I don't feel I look any worse than I used to
1 I am worried that I am looking old or unattractive
2 I feel that there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly</p> <p>15. 0 I can work about as well as before
1 It takes an extra effort to get started at doing something
2 I have to push myself very hard to do anything
3 I can't do any work at all</p> <p>16. 0 I can sleep as well as usual
1 I don't sleep as well as I used to
2 I wake up 1-2 hrs earlier than usual and find it hard to get back to sleep
3 I wake up several hrs earlier</p> <p>17. 0 I don't get more tired than usual
1 I get tired more easily than I used to
2 I get tired from doing almost anything
3 I am too tired to do anything</p> <p>18. 0 My appetite is no worse than usual
1 My appetite is not as good as it used to be
2 My appetite is much worse now
3 I have no appetite at all anymore</p> <p>19. 0 I haven't lost much weight, if any, lately
1 I have lost more than 5 pounds
2 I have lost more than 10 pounds
3 I have lost more than 15 pounds
(I am trying to lose weight by eating less YES NO)</p> <p>20. 0 I am no more worried about my health than usual
1 I am worried about physical problems such as aches & pains, upset stomach or constipation
2 I am very worried about physical problems & its hard to think about much else
3 I am so worried about physical problems that I cannot think about anything else</p> <p>21. 0 I have not noticed a recent change in my interest in sex
1 I am less interested in sex than I used to be
2 I am much less interested in sex now
3 I have lost interest in sex completely</p> |
|--|--|

If you drink alcohol, please answer the following by circling YES or NO

1. Have you ever felt you ought to cut down on your drinking? YES NO
2. Have people annoyed you by criticizing your drinking? YES NO
3. Have you ever felt bad or guilty about your drinking? YES NO
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (eye-opener) YES NO

PATIENT'S NAME: _____

DATE: ___/___/___

SCORE: _____

Sleep Diary

Sleep Consultants Inc.

New Patient Paperwork-FWSW.wpd 6/11/02

Name: _____

	Date _____ Sunday	Date _____ Monday	Date _____ Tuesday	Date _____ Wednesday	Date _____ Thursday	Date _____ Friday	Date _____ Saturday
What time did you go to bed last night?							
How long did it take you to fall asleep last night in minutes?							
How many times did you wake up? At what time(s)? For how							
What time did you wake up this morning? What time did you get							
How did you feel this morning?							
Did you take any naps today? At what time(s)? For how long?							
Did you drink any coffee, tea or cola drinks? How much? At							
Did you drink any alcohol today? How much? At what times?							

Begin completing the diary on the day that you receive it. After completing one side turn it over and continue on the opposite side.

OVER

Sleep Diary

Sleep Consultants Inc.

New Patient Paperwork-FWSW.wpd 6/11/02

Name: _____

	Date _____ Sunday	Date _____ Monday	Date _____ Tuesday	Date _____ Wednesday	Date _____ Thursday	Date _____ Friday	Date _____ Saturday
What time did you go to bed last night?							
How long did it take you to fall asleep last night in minutes?							
How many times did you wake up? At what time(s)? For how							
What time did you wake up this morning? What time did you get							
How did you feel this morning?							
Did you take any naps today? At what time(s)? For how long?							
Did you drink any coffee, tea or cola drinks? How much? At							
Did you drink any alcohol today? How much? At what times?							

SLEEP CONSULTANTS, Inc.
1521 Cooper Street
Fort Worth, Texas 76104
(817) 332-7433

ASSESSMENT OF PATIENT'S BEHAVIOR BY BED PARTNER

Please answer the following questions about your bed partner's behavior over the past *six months* by circling the word that reflects your opinion.

- | | | | | | |
|---|-------|--------|-----------|-------|--------|
| 1. Snores loudly | never | rarely | sometimes | often | always |
| 2. Keeps you awake by loudly snoring | never | rarely | sometimes | often | always |
| 3. Snores loudly in all positions | never | rarely | sometimes | often | always |
| 4. Snoring results in you sleeping separately | never | rarely | sometimes | often | always |
| 5. Breathing pauses and/or snorts are heard | never | rarely | sometimes | often | always |
| 6. Body movements (e.g. legs, arms, body jerks, etc.) | never | rarely | sometimes | often | always |
| 7. Grinding teeth | never | rarely | sometimes | often | always |
| 8. Acting out dreams | never | rarely | sometimes | often | always |
| 9. Sleep onset within 5 minutes or less | never | rarely | sometimes | often | always |
| 10. Poor concentration and/or short term memory | never | rarely | sometimes | often | always |
| 11. Increased irritability and quick temper | never | rarely | sometimes | often | always |

Please estimate the likelihood of your bed partner falling asleep in the following common situations.

0 = never 1 = slight 2 = moderate 3 = high N/A = no chance to observe or form an opinion

- 12. _____ Sitting and reading.
- 13. _____ Watching television.
- 14. _____ Sitting inactive in a public place (e.g. a theater or meeting).
- 15. _____ As a passenger in a car for an hour without a break.
- 16. _____ Lying down to rest in the afternoon when circumstances permit.
- 17. _____ Sitting and talking to someone.
- 18. _____ Sitting quietly after a lunch without alcohol.
- 19. _____ In a car while stopped for a few minutes in traffic.

_____ Total of 12-19

Patient's Name: _____

Date: _____

Name of Person Completing Questionnaire: _____

Relationship: _____

Appointment of Authorized Representative

1. Identifying Information

Patient's name _____

Member's name _____

Member's address _____

Member's plan identification # _____

Provider's plan identification # _____

Service not paid / not authorized by plan _____

Date(s) of service _____

2. **Appointment.** I, _____, appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as my authorized representative in requesting an appeal from _____ regarding its denial of services / denial of payment.

3. **Directed payment.** I agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to my authorized representative, and direct the plan to do so in that event.

4. **Member's signature** _____ **Date** _____

5. **Witness's signature** _____ **Date** _____

Texas Pulmonary & Critical Care Consultants, P.A.
Sleep Consultants, Inc.
Acknowledgment of Review of
Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority