

EL PASO SLEEP CENTER

West
4305 N. Mesa Suite B
El Paso, TX 79912

Far East
3030 Joe Battle
El Paso, TX 79938

PRE-REGISTRATION INFORMATION

Appt. Time & Date: _____ *Dr.* _____

Last Name: _____ *First Name:* _____ *MI* _____ *Gender M/F*

Date of Birth: ____ / ____ / ____ *Social Security Number:* _____

Guarantor Name (if different from patient): _____

Address: _____ *City:* _____ *State:* _____ *ZIP:* _____

Home #: (____) _____ *Work #:* (____) _____ *Cell #:* (____) _____

Referring Physician: _____ *PCP:* _____

Emergency contact: _____ *Relationship:* _____ *Phone #:* (____) _____

How did you hear about EL PASO SLEEP CENTER? _____

Name: _____

Date: _____

Age: _____

**SLEEP DISORDER CENTER
PEDIATRIC QUESTIONNAIRE**

Please complete this questionnaire and return it to the physician who interviews you and your child at the time of the Initial Evaluation

In answering the questions are as complete as possible. The more information that is given the more complete will be the evaluation of your child's condition.

Use the back of the previous page to complete detailed answers or to add additional information which is relevant.

Circle the most appropriate answers in the questionnaire.

DK means Don't Know **NA** means Not Applicable

The **Sleep Disorder Center** physicians will go over the answers with you. We look forward to being able to evaluate your child's problem and to be able to provide therapeutic advice.

1. Please describe in your own words as briefly as possible your child's main problem?

2. When was the very first time this problem began? Years Ago

3. List any medications that your child is currently taking to help with the sleep problems:

<u>Preparation</u>	<u>Dose</u>	<u>Time</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Describe what your child usually does during the last 30 minutes before bedtime:

5. Does your child do any of the following in bed at night? Read Watch iv Listen to the radio

Read	Yes/No
Watch TV	Yes/No
Listen to the radio	Yes/No

Other: _____

6. Will your child fall asleep alone in bed? Yes/No
7. In order to sleep, does your child often need a special toy or object? Yes/No
If so, describe: _____
8. Does your child often need a bottle in order to go to sleep? Yes/No
9. What type of bed does your child sleep in?
Crib/Single Bed/Double Bed/Other _____
10. Does your child sleep alone? Yes/No
11. Which side of the body does your child sleep on:
Left Side/Right Side/Back /Face Down
12. What time is the bedroom light turned off: _____ pm/am
13. Does a parent or the child turn off the light? Yes/No
14. Is your child bothered by environmental noises at night? Yes/No

15. As an infant, was your child "colicky"?
16. As an infant, did your child require any of the following devices to get to sleep?
Swing/Snuggly/Car Ride/Being Held/Other: _____
17. On average how long does it take your child to fall asleep? _____ Hrs. _____ Mins
18. What is the quickest time it has taken your child to fall asleep in the last 2 weeks? _____ Hrs. _____ Mins
19. What is the longest time it has taken your child to fall asleep? _____ Hrs. _____ Mins
20. What do you think prevents your child from falling asleep?
Fears/Loneliness/Not Sleepy/ Worries/Other: _____

21. Do you get annoyed / angry when your child cannot sleep? Yes/No

22. How often does your child cry him/herself to sleep ____ Times Per Week

23. Do you ever let your child cry in bed in order to get to sleep? Yes/No

If so, how long do you let the child cry: 10 / 20 / 30 minutes / as long as it takes

24. When unable to fall asleep, does your child get out of bed? Yes/No

If so, how long after getting into bed: ____ Hrs. ____ Mins

25. Once out of bed, what does your child do?

26. How long is your child up for? ____ Hrs. ____ Mins

27. When your child returns to bed, how long does it take to fall back to sleep? ____ Hrs. ____ Mins

28. If the child does not get out of bed, how long does it take to fall back to sleep? ____ Hrs. ____ Mins

29. Once having fallen asleep, how long does your child sleep for? ____ Hrs. ____ Mins

30. Does your child awaken during the night? Yes/No

If so, on average how long will your child be awake for? ____ Hrs. ____ Mins

31. How often does your child awaken during the night? _____ Times

32. What time does your child finally awaken in the morning? _____ am

33. What time does your child get out of bed in the morning? _____ am

34. How does your child seem on awakening in the morning?

35. How does a poor nights sleep affect your child the next day?

36. Does your child feel sleepy during the day? Yes/No
37. Does your child nap during the day? Yes/No
 If so, how often and for how long? Time _____ Hrs. _____ Minutes _____
38. What time of day does your child nap? _____ am _____ pm
39. If there are no naps, what time of day does he/she your feel most tired? _____ am _____ pm
40. What time of day does your child seem most alert? _____ am _____ pm
41. As the sleep period approaches, does your child become more alert? _____ am _____ pm
42. Do you think a poor night's sleep affects your child's school performance the next day? Yes/No
43. Has the teacher comment on this? Yes/No
44. Does your child toss and turn in bed? Yes/No
45. Have you ever noticed your child's head rocking from side to side at night? Yes/No
 If so, please describe:

46. How often does this behavior occur? _____ Times
47. What time of night is this activity likely to occur? _____ am/pm
48. Does your child complain of aching legs at bedtime? Yes/No
49. Does your child moves his/her legs around in bed at night? Yes/No/DK
50. Do your child's legs jerk while he/she is asleep at night? Yes/No/DK
51. Does your child have nightmares? Yes/No
 If so, at what age did they begin? _____ Years
 How often do they occur? _____ Times Per Night

52. Does your child ever awaken suddenly with a scream and appear inconsolable?
If so, how often? _____ Yes/No
_____ Times Per Night
53. Does your child sleep walk?
If so, how often? _____ Yes/No
_____ Times Per Night
54. If your child sleep walks, has he ever injured him/herself? _____ Yes/No
55. Does your child ever wet the bed?
If so, how often? _____ Yes/No
_____ Times Per Night
56. Does your child snore at night?
57. Does the snoring occur every night?
If not, how often does it occur? _____ Yes/No
_____ Times Per Night
58. Does your child ever seem to stop breathing while asleep?
If so, for how long? _____ Yes/No
_____ Seconds
59. Has your child ever had a tonsillectomy or adenoidectomy?
If so, please give the date: _____ Yes/No
60. Please state when your child was able to sleep consistently without any problems:
Never/_____ Years/Months Ago
61. What time did your child then go to bed at? _____ pm
How long did it take your child to fall asleep? _____ Minutes
62. Did your child awaken during the night?
If so, how often and for how long (times): _____ Yes/No
_____ Minutes
63. What time did your child awaken in the morning? _____ am
64. At what time would you like your child to fall asleep now? _____ pm
65. How long would you like your child to sleep for? _____ Hours

66. What time would you like your child to awaken in the morning? _____ am

67. For how long do you think normal children of your child's age sleep? _____ Hours

68. Do you consider your child's sleep to be: Mild/Moderate/Severe

69. Please add any other comments about your child's sleep problem that you think are relevant:

70. Please list all people whom you have consulted about your child's sleep problem.
Starting with the first, list the date, name, degree, specialty, investigations, treatment and outcome of all treatments (give details of medications on the next page).

<u>Date</u>	<u>Name</u>	<u>Degree</u>	<u>Specialty</u>	<u>Investigation</u>	<u>Treatment</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

71. Please list all medical illness that your child has been treated for in the past or is now under treatment for.
Give the date, name of illness, treatment and outcome.

72. Operations:

73. List of medications your child has been prescribed to help with the sleep problem.
Give the names, dosage, time they were taken, how long they were taken for, any Beneficial's effects, when they were stopped (start with the first medication taken).

<u>Medication</u>	<u>Dose</u>	<u>Time</u>	<u>Length</u>	<u>Effect</u>	<u>Stopped</u>

74. Please give the following family information:

	<u>Age</u>	<u>Illnesses</u>
<u>Mother:</u>	<hr/>	<hr/>
<u>Father:</u>	<hr/>	<hr/>
<u>Brothers:</u>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
 <u>Sisters:</u>		
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

EL PASO SLEEP CENTER

EPWORTH SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you “Have Not” done some of these recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number of each situation:

0 = No Chance of Dozing
1 = Slight Chance of Dozing
2 = Moderate Chance of Dozing
3 = High Chance of Dozing

Situation	Chance of Dozing
Sitting and Reading	
Watching T.V.	
Sitting inactive in a public place (e.g. movies / theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	



ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of consultations / sleep study benefits to Dr. Gonzalo Díaz / El Paso Sleep Center For services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance. Yo, autorizo el pago por consultas o estudios del sueño a el Dr. Gonzalo Díaz / El Paso Sleep Center de su parte ya sea en persona o bajo su supervisión. Yo entiendo que yo será responsable por la porción que mi aseguranza de salud no tiene cobertura.

AUTHORIZATION TO RELEASE INFORMATION

I, hereby authorize Dr. _____ to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

Yo, autorizo a el Dr. _____ proporcionar información médicas que sean necesarias para mi cuidado de salud o pare procesar reclamos de a seguridad.

MEDICARE / MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Yo, certifico que toda la información que he proporcionado para el pago de mis servicios es verídico. Yo, autorizo proporcionar toda mi documentación médica. Yo autorizo el pago de parte de mi aseguranza para el pago de mi cuidado.

AUTHORIZATION OF PATIENTS RELEASE OF INFORMATION

During the course of your treatment at the El Paso Sleep Center the doctor may prescribe a CPAP unit for your use at home. If the El Paso Sleep Center is not in the network for your particular insurance, the El Paso Sleep Center will forward your information to a medical equipment company to provide you with any medical equipment that may be necessary.

I authorize El Paso Sleep Center to release patient information to a medical equipment company that would be able to further assist me in regards of receiving the CPAP unit or any other medical supplies.

PLEASE PRINT

Patient Name: _____

Date: _____

Parent / Guardian: _____

Date: _____

Signature: _____

Date: _____



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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Law Enforcements

Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government mandated reporting.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Appointment Reminders

Your health information will be used by our staff to send you appointment reminders, leave messages on, voice mail and with family members.

Other Uses and Disclosures that Require our Authorization

Disclosures of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.