HAYWARD EAST BAY SLEEP CENTER, AASM ACCREDITED

27001 Calaroga Ave. Suite #1, Hayward, CA 94545-4345 Phone: (510)-670-0246 Fax: (510)-670-2968

REGISTRATION / PLEASE PRINT

First Name:	M.I.:	Last Name:	☐ M ☐ F
Date of Birth: - -	Soc. Security # - -	Driver's Lic. #	
Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Other			
Email:	Preferred Contact ☐ Cell ☐ Home ☐ Work		
Cell Phone:	Home Phone:		
Address:	City:	State & Zip:	
Employer:	Occupation:		

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Not specified Preferred language: ☐ English ☐ Spanish ☐ Other
Race: ☐ Caucasian ☐ African ☐ Asian ☐ Native American ☐ Other

Spouse Name:		Phone Number:
Emergency Contact:	Relationship:	Phone Number:

INSURANCE: Please present your current insurance card(s) to our staff.

1. Primary Insurance:	ID#	Group#
Name of Insured:	SS#	DOB:
2. Secondary Insurance:	ID#	Group#
Name of Insured:	SS#	DOB:

Referred by: Dr.	Primary Care Physician: Dr.

Signature on file: I request that payment of authorized medical benefits be made directly to Stanislaus Sleep Center for any services furnished to me by its physician or provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its agencies any medical information necessary to determine these benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of other physicians who may consult on my case. I also understand that I am responsible for copayments, deductibles, and non-covered services at the time of service and rebilling/collection fees may incur on past due accounts. I have received and read or have had the opportunity to read the "No-Show/Cancellation" policy. You give consent that we may contact your emergency contact regarding appointments. I agree to communication via text message or email. I have received and read or have had the opportunity to read the HIPPA notice of privacy practices NOTICE TO CONSUMERS: Medical doctors and Polysomnographic technologists, technicians and trainees are licensed and regulated by the Medical Board of California (800) 633-2322, www.mbc.ca.gov

Signature:	Date:
*IF PATIENT IS A MINOR - Guardians Name:	Relationship:

MEDICATION LIST

NAME: _____

Medication Name	Dose	Frequency

Allergic to: _____

EAST BAY HAYWARD SLEEP MEDICAL CENTER AASM ACCREDITED

Kirit B. Patel, MD, FCCP, FAASM

27001 Calaroga Ave. Suite #1
Hayward, CA 94545
PH: 510-670-0246

DATE: _____

NAME: _____ ( ) Male ( ) Female AGE: _____

THE EPWORTH SLEEPINESS 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 things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never dose
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing
Sitting and watching tv	_____
Watching TV	_____
Sitting inactive in a public place (e.g., a theater or a 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 lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____
Total score:	_____

Thank you for your cooperation.

EAST BAY SLEEP MEDICAL CENTER SLEEP HISTORY QUESTIONARE

Name: _____ DOB: _____ Date: _____

Y= YES N= NO DK= DONT KNOW N/A= Not applicable			
Have you ever had a sleep study before?	Y	N	DK
Do you snore?	Y	N	DK
Do you usually take naps or feel sleepy during the day?	Y	N	DK
Have you gained weight in the last 5 years? Yes / No How much? _____ Lbs.			
Have you been told you stop breathing while you sleep?	Y	N	DK
Do you grind your teeth?	Y	N	DK
Do you have burning / itching / pain in your legs at night?	Y	N	DK
Do you kick your legs while asleep?	Y	N	DK
Please indicate if any of the following behaviors occurred during your sleep. (check all that apply) ☐ ***Body jerking*** ☐ ***Excessive sweating*** ☐ ***Sleep talking*** ☐ ***Sleepwalking*** ☐ ***Rocking movement*** ☐ ***Awakened by air hunger*** ☐ ***Awakened with heart palpitations*** ☐ ***Frequent nightmares*** ☐ ***Shouting/screaming/swearing*** ☐ ***Bedwetting***			
Bedtime on weekdays? and wake up Bedtime on weekends? and wake up			
Do you have difficulty falling asleep? Y N DK			
How long does it take you to fall asleep at night? A Guess is O. K			
Do you have frequent awakenings during sleep? Y N DK how often?			
Do you have a burning feeling in your chest with fluid (acid) coming up from your throat? Y N DK			
Have you ever been awake but briefly unable to move or speak?	Y	N	DK
Have you ever felt sudden weakness after laughing or being surprised?	Y	N	DK
Have you ever sensed you were dreaming while drowsy?	Y	N	DK
Do you take Over the counter (OTC) Medication to help you sleep?	Y	N	DK
What kind of work do you do or used to do (if retired) What shift do you work?			
How many caffeinated beverages do you drink daily? Coffee Soda Tea			
Do you use recreational drugs? If so, which ones and how often?			
How many alcoholic beverages do you drink on average? Liquor Beer Wine How often?			
Do you smoke? Cigarettes Other how much?			
Do you use ☐ OXYGEN ☐ CPAP ☐ NEBULIZER			
Do you have chronic pain or see a pain specialist?	Y	N	DK
How many miles a week do you drive? Miles per week.			

Name: _____

Past Medical History

☐ Allergic Rhinitis	☐ High Blood Pressure	☐ Migraine headache
☐ Deviated Nasal Septum	☐ Atrial Fibrillation / Cardiac Arrythmias	☐ Difficulty Concentrating
☐ Enlarged tonsils	☐ Congestive Heart failure	☐ Depression
☐ Diabetes	☐ Coronary Artery Disease	☐ Anxiety
☐ High Cholesterol	☐ Pulmonary hypertension	☐ Bipolar Disorder
☐ Hyperthyroidism	☐ COPD / Emphysema	☐ ADHD
☐ Anemia	☐ Stroke / TIA	☐ Seizure Disorder
☐ Chronic Back / Neck pain	☐ Fibromyalgia	☐ Parkinsons Disease
☐ Hepatitis C	☐ Liver Cirrhosis	☐ Rheumatoid Arthritis

Past Surgical History:

☐ Tonsillectomy (T&A)	☐ Open heart Surgery	☐ Neck surgery
☐ Deviated nasal septum surgery	☐ Heart Valve surgery	☐ Back surgery
☐ Sinus surgery	☐ Pacemaker/AICD implantation	☐ Gallbladder surgery
☐ Sleep apnea surgery / UPPP	☐ Angioplasty / Stent placement	☐ Gastric Bypass surgery
☐ Turbinate reduction surgery.	☐ Other (Please specify):	

Family History (check all that apply):

	Sleep apnea	Narcolepsy	Insomnia	Restless leg syndrome	Heart disease	High blood pressure	Stroke	Diabetes	Other
Mother									
Father									
Sister									
Brother									
Grandparents									
Children									