Saint Alphonsus Medical Group

Sleep Medicine

Boise, Caldwell, Meridian, Nampa

Main Phone #: 208-302-3300

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Welcome to our practice! We are looking forward to meeting you on your upcoming visit and collaborating with you to meet your healthcare needs. As an introduction to our office, we want to provide you with some important information to make your visit with us a positive, rewarding experience.

What to Bring to Your Appointment:

● **Completed paperwork (attached). If you do not bring completed paperwork, *your appointment may be rescheduled.* *FOR ALL MYCHART USERS: If you have completed your registration on MyChart, you are still required to complete the questionnaire included in this packet and bring it to your scheduled appointment.***

● Data Chip from your home CPAP machine if you currently use a CPAP device (required at every visit).

● Current medication list that includes dosage and frequency of all your medications.

● Photo ID and insurance card. Please be prepared to pay your copay if applicable.

Confirming Appointments:

You will receive an appointment reminder 2 days before your scheduled appointment. This will be either an automated phone call or text message. ***Appointment confirmation is required***. Please listen to the message, or review the text, and follow the prompts to confirm or cancel if necessary.

Visits:

Your scheduled appointment time is the time you are expected to arrive at the clinic—arrival after your scheduled time may be considered late arrival (see below). Your visit starts with the general check-in process, which includes the completion of paperwork necessary as a new patient to our clinic. Once the check-in is complete, our medical assistants will work with you to collect additional health information. Your assigned provider will then meet with you to complete your visit, ordering tests as necessary. Should a sleep study or other tests be required, we will walk you through the steps of what comes next, so you understand your care plan before you leave our clinic. Please plan at least 90 minutes for your first appointment with us.

Late Arrivals:

Arriving late at your appointment causes delays for both our providers and other patients. We ask that you please arrive at your scheduled time since late arrivals may be asked to reschedule for another day/time.

Appointment Cancellations:

If you cannot keep your appointment, we ask that you provide at least 24-hour notice by calling us directly at 208-302-3300. We understand that access to sleep services is tight, with our providers booked out several months. We ask that for the benefit of others waiting for appointments that you please commit to the time you have reserved with us. We are happy to reschedule appointments when properly notified.

Thank you for choosing Saint Alphonsus Medical Group Sleep Medicine! We will see you soon.
Regards,
SAMG Sleep Medicine Team

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New Patient Adult Sleep Medicine Questionnaire

Epworth Sleepiness Scale				
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the scale below to choose the most appropriate number for each situation. 0 = would **never** doze 1 = **slight** chance 2 = **moderate** chance 3 = **high** chance				
Situation:	**Chance of Dozing**			
	0	**1**	**2**	**3**
Sitting and reading				
Watching TV				
Sitting inactive in a public place (e.g., movie 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 lunch without alcohol				
In a car while stopped for a few minutes in traffic				

In your own words, please describe the main reason for coming to the clinic today:

_____

Have you had a sleep study or sleep evaluation before? If so, specify when and where:

_____

Symptom Checklist

Fatigue/Sleepiness	**Yes**	**No**
I feel tired or fatigued during the day.		
I struggle to stay awake during the day.		
I wake up feeling refreshed.		
I have fallen asleep while driving.		
I have difficulty with memory or concentration		
Sleep-Disordered Breathing		
I snore or have been told I snore.		
I have experienced choking, shortness of breath, or gasping during sleep		
I have been told that others have seen me choking or gasping during sleep		
How much weight have you gained in the last year? _____		
I sometimes wake up with a headache.		
I struggle with nasal congestion.		
I have experienced leg swelling.		
I wake at night to urinate.		
Someone in my family has sleep apnea.		
Movement Disorders		
I have restlessness or discomfort in my legs at night.		
I have a history of sleepwalking, sleep talking, sleep eating, or acting out in my dreams		
I clench or grind my teeth at night.		
I have regular nightmares.		

Sleep Hygiene	Yes	No
My bedtime is _____. My wake time is _____. I sleep_____ hours per night.		
I struggle to fall asleep. If yes, about how long before you fall asleep? _____		
I have or currently use medications to help me sleep. Please list what you have/are taking:		
I wake up multiple times during the night. How many times? _____ If yes, list the reasons that wake you up:		
I nap intentionally or accidentally fall asleep during the day.		
I sleep in my bed at night.		
I watch television or use electronics in bed.		
I sleep with pets.		
I work in my bedroom.		
My bedroom is noisy or uncomfortable.		
Excessive Daytime Sleepiness (EDS)		
I have felt paralyzed while waking up or falling asleep.		
I have felt weakness in my face or knees when laughing or experiencing strong emotion		
I experience dream like hallucinations while falling asleep or waking up.		
I have a history of depression.		
I have a history of severe head trauma		
I have chronic pain. What medications do you use for pain?		

Past Medical History

Mark all that apply:

- o Allergies
- o Anemia
- o Anxiety
- o Asthma
- o Atrial Fibrillation
- o Blood clots
- o Cancer, type: _____
- o COPD
- o CHF
- o Depression
- o Dementia
- o Diabetes
- o GERD
- o Heart attack or heart disease
- o High cholesterol
- o High blood pressure
- o Migraine headaches
- o Narcolepsy
- o Parkinson's disease
- o Renal disease
- o Restless leg syndrome
- o Seizure disorder
- o Sleep Apnea
- o Thyroid disorder
- o Other (*specify*): _____

_____

Social History

Circle one answer per following questions:

1) Do you use chewing tobacco, cigars, or cigarettes? Yes, currently No, I quit _____ (year) Never
2) Do you drink alcohol? Yes, frequency: _____times/week, _____drinks/episode No
3) Do you drink caffeine? Coffee, tea, or soda: _____ drinks/day
4) Marital status: Married Single Divorced Widowed other: _____
5) Are you employed? ___Yes ____No
6) What is your occupation? _____

Name: _____

Date of Birth: _____

Past Surgical History

Mark all that apply*:*

- o Angiography with stent
- o Appendectomy
- o Back surgery
- o CABG
- o Cardiac pacemaker
- o Gastric bypass/sleeve
- o Hernia repair
- o Hip replacement
- o Knee replacement
- o Knee arthroscopy
- o Shoulder arthroscopy
- o Sinus Surgery
- o Septoplasty
- o Thyroidectomy
- o Tonsillectomy
- o Uvuloplasty
- o Other (*specify*):_____

Family History

List health problems for each:

Mother: _____Deceased: yes / no

Father: _____Deceased: yes / no

Siblings: _____

Review of Systems

Please mark yes **ONLY** to those symptoms you have experienced in the **last 2 weeks**.

Pulmonary	**Yes**	**Constitutional**	**Yes**	**Renal**	**Yes**
Shortness of breath at rest		Fever		Blood in urine	
Shortness of breath with exercise		Night Sweats		Frequent urination at night	
Frequent Cough		Chills		Painful urination	
Waking up at night short of breath		Weight loss			
Wheezing				**ENT**	
Blood clots		**Gastrointestinal**		Frequent sore throat	
		Trouble swallowing		Sinus infections	
Hematology/Oncologic		Heartburn		Hay fever	
Anemia		Abdominal pain		Dry Mouth	
Bleeding tendency		Nausea			
		Vomiting		**Musculoskeletal**	
Psychiatric				Muscle weakness	
Depression		**Neurologic**		Joint pain	
Anxiety		Migraines or headaches		Joint swelling	
Poor Sleep		Numbness or tingling			
Snoring		Dizziness		**Cardiac**	
Morning headaches		Imbalance/unsteadiness		Chest pain	
Sleep during the day		Vertigo		Leg swelling	
Panic attacks				Heart racing or thumping	
				Sleeping on 2+ pillows	

Fall Risk: Have you fallen in the last year? ☐ No ☐ Yes Number of falls/past year _____
Do you have problems with walking or balance? ☐ No ☐ Yes

Depression Screening: Over the last 2 weeks, how often have you been bothered by the following:

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless?	☐	☐	☐	☐

Current Medication / Allergy List

In order for us to provide you with the highest quality of care, we ask that you provide us with current medication (including any over the counter and herbal medicines), and allergy list.

Please complete the following:

Medication Name	Strength/Dose	How Often (Directions)

ALLERGIES:

_____

_____

_____

_____

Thank you for your cooperation!

Patient Initials: _____