HISTORY & PHYSICAL

Anesthesia & Sleep Medicine Services of Florida

Neurologic Health & Restorative Sleep

Sleep Disorder Center
1485 37th St. Suite 111, Vero Beach, FL 32960
Phone (772) 226-6855
Fax (772) 226-6854
www.flsleepmedicine.com

Phillip A. Nye, MD, FASA
Diplomate of the American Board of Anesthesiology
& Sleep Medicine Specialist

Name:_____ DOB _____ Date: _____

CHIEF COMPLAINT

_____

_____

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MEDICAL HISTORY

☐ Headache/Migraine _____	☐ Murmur _____	☐ Genitourinary Disease _____
☐ Headache/Tension _____	☐ Hypertension_____	☐ Venereal Disease_____
☐ Epilepsy/Seizures _____	☐ COPD _____	☐ Arthritis _____
☐ Cerebro Vascular_____	☐ Pneumonia _____	☐ Cancer _____
☐ Other Neuromuscular _____	☐ Asthma_____	☐ Tuberculosis _____
☐ Head Injury_____	☐ Peptic Ulcer Disease _____	☐ HIV_____
☐ Spinal Cord Injury _____	☐ Colonic Polyps_____	☐ E+OH Abuse _____
☐ Cervical Spine Disease _____	☐ Anemia_____	☐ Drug Use_____
☐ Lumbar Spine Disease_____	☐ Diabetes_____	☐ Exposures _____
☐ CNS Malignancy_____	☐ Peripheral Vascular Disease _____	☐ Mumps_____
☐ Depression_____	☐ Thyroid Disease_____	☐ Measles _____
☐ Coronary Artery Disease _____	☐ Menstrual/Sexual Dysfunction _____	☐ Polio_____
☐ MI _____	☐ Other Endocrine_____	☐ Rheumatic Fever _____
☐ Arrhythmias _____	☐ Liver Disease/Hepatitis _____	☐ Allergy/Hay Fever _____
☐ Congestive Heart Failure _____	☐ Renal Disease_____	☐ Other _____

Name:_____ DOB _____ Page #:_____

DRUG ALLERGIES

_____

_____

_____

PRIOR SURGERIES / HOSPITALIZATIONS

Reason: _____

_____

Pregnant now? ☐ YES ☐ NO

REVIEW OF SYSTEMS - GENERAL

☐ Fatigue	☐ Cardiac	☐ Genitourinary
☐ Weight Loss	☐ Respiratory	☐ Musculoskeletal
☐ Fevers	☐ Peripheral Vascular	☐ Dermatologic
☐ Depression	☐ Gastrointestinal	☐ Hematologic
☐ Ear / Nose / Throat	☐ Other	☐ Other

REVIEW OF SYSTEMS - NEUROLOGIC

☐ Headache	☐ Blurred Vision	☐ Weakness - Arms
☐ Dizziness	☐ Diplopia	☐ Weakness - Legs
☐ Syncope	☐ Amaurosis	☐ Numbness - Arms
☐ Confusion	☐ Other Visual Changes	☐ Numbness - Legs
☐ Concentration	☐ Difficulty Chewing	☐ Paresthesias
☐ Memory	☐ Facial Numbness / Tingling	☐ Stiffness
☐ Lethargy	☐ Drooling	☐ Clumsiness
☐ Personality Change	☐ Difficulty Tasting	☐ Pain
☐ Hallucinations	☐ Tinnitus	☐ Poor Balance
☐ Speech Difficulty	☐ Vertigo	☐ Poor Coordination
☐ Spells	☐ Decreased Hearing R / L	☐ Trouble Walking
☐ Nausea	☐ Dysphagia	☐ Incontinence - Bladder
☐ Vomiting	☐ Hoarseness	☐ Incontinence - Bowel
☐ Trouble with Smell	☐ Choking	☐ Other

Name:_____ DOB _____ Page #:_____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disorder	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
CNS Tumors	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐
Neuromuscular	☐	☐	☐	☐	☐	☐
Other_____	☐	☐	☐	☐	☐	☐

ADDITIONAL REMARKS

_____

_____

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FINANCIAL POLICY PAGE ONE:

Thank ypu for choosing Anesthesia ans Sleep Medicine Services of Florida.We are committed to providing you the best possible care we can provide. Prompt payment of your account allows us to practice medicine and it allows us to continue providing for you.

All patients must complete our Patient Registration form and sign all policies before seeing the doctor. We also ask that you present your insurance card and a picture ID at each visit and notify us as soon as possible of any changes in your insurance coverage, address and/or telephone numbers. We would like to keep your patient information as current as possible.

- **CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE**
- **WE ACCEPT CASH / CREDIT CARDS /OR PERSONAL CHECKS (*NOTE: $40.00 FEE IS CHARGED FOR RETURNED CHECKS.)**

IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN THE PROPER INSURANCE REFERRALS FOR ALL VISITS

- **INSURANCE CLAIMS ARE FILED AS A COURTESY TO OUR PATIENTS**

FILLING OUT FORMS:

The charge for filling out forms brought in by patients are (example: employment, disability, life insurance, DMV, etc.)

$10.00 - for one (1) page form
$25.00 - for up to three (3) pages
$40.00 - for four (4) or more pages

The charges for filling out forms is the patient's responsibility and fees are collected before the patient can pick up the forms.

Participation of Insurance:

We participate with most major insurance providers. Each insurance plan has rules and guidelines that must be followed by patients and physicians. It is the patient's responsibility to familiarized with the benefits and rules of the health plan, as stated in the insurance contract between patient and their insurance provider.

Non-Insurance Participation:

If our practice does not participate with your insurance plan, you will be responsible for payment of the visit(s). As a courtesy we will file your insurance claim and have the payment sent directly to you.

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FINANCIAL POLICY PAGE TWO:

INSURANCE REFERRALS:
Certain health insurance plans (HMO) require that you obtain a referral from your Primary Care Physician (PCP) before visiting a Specialist's office. It is the patient's responsibility to acquire this referral and keep track of the number of visits allowed and the start and end date of this referral. Alternative payment arrangements or rescheduling of your appointment may be necessary if proper authorization or referral is not obtained.

PRESCRIPTION REFILLS:
All refills require at least 7 days advance notice to be approved by your Doctor and sent into your pharmacy. Do not wait until you run out of your medication to call in for a refill.

WORKERS COMPENSATION:
We require approval/authorization by your employer and/or your worker's compensation carrier and your Employer's first report of injury prior to your initial visit. If our claim is denied, you will be responsible for payment in full for all visits.

PERSONAL INJURY:
If you are involved in a personal injury lawsuit or claim, we will bill your medical insurance carrier. In the absence of medical insurance, you will be responsible for payment of services on day of service(s). Tidewater Neurologists, Inc. does not participate in litigation cases.

SELF-PAY:
Payment in full is expected at time of service.

Thank you for understanding our financial policy. Please let us know should you have any questions or concerns.

(Please sign both places below:)

FINANCIAL AGREEMENT

I have read, understand and accept the above financial policy. In the event of non-payment by my insurance carrier for whatever reason, I understand I am responsible for the payment of the balance owed inclusive of any costs of collections, including collection agency fees and attorney fees of 33 1/3 percent of the amount past due and any court costs incurred to collect any amount that is past due.

Patient Signature _____ **Date** _____

FINANCIAL POLICY PAGE THREE:

ASSIGNMENT OF BENEFITS
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Anesthesia and Sleep Medicine Services of Florida to release any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits directly to Anesthesia and Sleep Medicine Services of Florida, Inc.

Patient Signature _____ Date _____

This financial agreement is in effect as long as the patient is under the care and treatment of Anesthesia and Sleep Medicine Services of Florida, Inc

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INSURANCE INFORMATION

Primary Insurance Co:_____

Subscriber Name: _____ SS# _____ DOB: _____

Sponsor Name: _____ SS# _____ DOB: _____

Secondary Insurance Co: _____

Subscriber Name: _____ SS# _____ DOB: _____

Sponsor Name: _____ SS# _____ DOB: _____

****PLEASE PRESENT INSURANCE CARDS AND PERSONAL ID WITH THIS REGISTRATION FORM****

Patient Name:_____ Date:_____

MEDICAL INFORMATION

Primary Care Physician: _____ Office #: _____

Address of PCP:_____

Referring Physician: _____ Office #: _____

Preferred Pharmacy: _____ Phone #:_____

Address/Location of Pharmacy:_____

Current List of Medications / Dose / And How Medication Is Taken

_____

_____

_____

_____

_____

Anesthesia & Sleep Medicine Services of Florida

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGES

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the Patient's signature in acknowledgement of this ***Notice of Privacy Practices,*** but was unable to do so as documented below:

Date:_____Initial:_____Reason:_____.

****This HIPPA Privacy Form will be in effect as long as you are a patient in this practice.**

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& Sleep Medicine
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PATIENT NO SHOW/ CANCELLATION POLICY

Any Patient that fails to show up for a scheduled office appointment without calling the office to cancel the appointment or reschedule the appointment 24 hours in advance, or as soon as possible in an extreme emergency situation will be charted a $25.00 fee, billed directly to the patient after the "second" no show appointment. This charge will be used to help cover the expenses incurred in preparing the patients chart for the office visit. **Your insurance company will not be responsible for this charge.**

We make every effort to make an appointment reminder call to our patients the day prior to the appointment, ***however***, there is no guarantee that we can reach all patients, so please keep up with your re-appointment cards. If we are able to reach our patients cancellations will be acceptable at that time.

The goal of our Physicians and Staff is to provide the most efficient care possible to meet the needs of ALL our patients. In order to do this we need to manage our Physicians time as wisely and productively as possible.

We ask the help of all patients in this endeavor and thank you in advance for your help and cooperation.

I have read and understand the Patient No Show / Cancellation Policy.

Patient Signature _____ Date _____

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PATIENT REGISTRATION

Date:_____ Account #_____

Name:_____ SS# _____ Age:_____
Please write name EXACTLY as it appears on your insurance card.

DOB:_____ Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ W ☐ D

Race: _____
(American Indian / Asian / Black / Hispanic / Latino / Native Hawaiian / White / Unreported or Refused to Give)

Ethnicity: _____
(Hispanic / Latino - Non-Hispanic/Latino - Unreported or Refused to Give)

Preferred Language: _____
(English / American Sign / Arabic / French / German / Hindi / Urdu / Japanese / Mandarin / Portuguese / Russian / Spanish)

Address: _____

City: _____ State:_____ Zip Code: _____

Home #: _____ Cell #: _____

Email: _____

Responsible Person for this Visit:_____
Please list name of SUBSCRIBER on your insurance card.

Relationship to Patient: _____

Patient or Guardians Employer: _____

Business Address: _____ Business Phone: _____

Emergency Contact
Person: _____ Phone #: _____

Do you have a living will? ☐ Yes ☐ No

Anesthesia & Sleep Medicine Services of Florida

PRESCRIPTION MEDICATION POLICY

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REFILLS:

- Patients are to call the office to request refills (when at least one week supply is left in the bottle). **Refills WILL NOT be called in the same day as the request.** _____ Patient Initial
- Refills will take 5 to 7 days for the office to process. **NO EXCEPTIONS.** _____ Patient Initial
- Any medication **SAMPLES** will be given to patients by the Doctor ONLY at the time of appointment.
- Any medication changes will be made at Patient's office visit ONLY. (i.e.: New medication WILL NOT be started from phone messages
- Refills will not be called in for any patient who has not been seen in over **ONE YEAR.** _____ Patient Initial
- Refills will not be called in for **Controlled medications / pain medications** if patient has not been seen for more then **SIX MONTHS.**
- Patients taking controlled medications will be subject to random drug screenings at the patient's expense.

NARCOTIC / PAIN MEDICATIONS:

- Prescriptions for Narcotic medication are used for acute problems only. If long term use is necessary patients will be referred back to the Primary Care Physician or to a pain management specialist.

PRESCRIPTIONS MISUSE, ALTERATION OR FORGERY:

- Alteration of a prescription or use of a medication against medical advise WILL NOT be tolerated. It will result in termination of your care and prosecution as directed by state and federal law.

I have read and understand the Prescription Medication Policy.

_____ _____

Patient Signature Date

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SLEEP DISORDER SCREENING QUESTIONNAIRE

NAME (LAST, FIRST, MI)			SSN	
ADDRESS (STREET OR BOX NO.)				
CITY		STATE	ZIP	
TELEPHONE (HOME)	TELEPHONE (WORK)	DATE OF BIRTH	AGE	SEX (CIRCLE ONE) M F
OCCUPATION	WORKING HOURS FROM _____ TO _____			
REFERRING PHYSICIAN				
REFERRING PHYSICIAN'S ADDRESS				

Height _____ Weight _____ Neck Size _____ Blood Pressure _____ Pulse _____

Any recent weight increase? ☐ Yes ☐ No How much _____ Over what time period _____

Any recent weight loss? ☐ Yes ☐ No How much _____ Over what time period _____

Reason for Sleep Study: ☐ Sleepiness ☐ Snoring ☐ Disturbed Sleep

SNORING:

1. How many years have you been told you snore? _____
2. Does your snoring disturb your bed partner? ☐ Yes ☐ No
3. Has your snoring become progressively worse? ☐ Yes ☐ No Over what period of time? _____
4. Have you been told you snore when sleeping? (*Circle all that apply*)
   On your back On your side On your stomach In a sitting position
5. On a scale of 1 to 5 (1 is minimal and 5 very loud), how loud is your snoring? _____
6. Which pattern best describes your snoring? (*Circle one*)
   a. Snoring is present almost continuously.
   b. Snoring is noted only occasionally and is not continuous.
   c. I snore loudly, then snoring and breathing stops, and then I snore loudly again.
7. Have you ever awakened from sleep because you are snoring? ☐ Yes ☐ No

NAME: _____

EXCESSIVE DAYTIME SLEEPINESS: (*Epworth Sleepiness Scale*)

1. Do you usually feel tired during the day? ☐ Yes ☐ No
2. 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

   1 = slight chance of dozing

   2 = moderate chance of dozing

   3 = high chance of dozing

SITUATION:	**CHANCE OF DOZING**
a. Sitting and reading	_____
b. Watching TV	_____
c. Sitting, inactive in a public place (e.g., a theater)	_____
d. As a passenger in a car for an hour without a break	_____
e. Lying down to rest in the afternoon when time permits	_____
f. Sitting and talking to someone	_____
g. Sitting quietly after a lunch without alcohol	_____
h. In a car, while stopped for a few minutes in traffic	_____

3. How many naps do you take per day? _____ Length _____

   Do you feel refreshed after a nap? ☐ Yes ☐ No
4. Do you experience drowsiness or a tendency to fall asleep while driving? ☐ Yes ☐ No
5. Have you been in a car accident due to falling asleep at the wheel? ☐ Yes ☐ No ☐ Near miss
6. Please describe an incident when you fell asleep during the day when you were not expected to fall asleep.

   _____

   _____

APNEA:

1. Have you ever been observed to stop breathing during sleep? ☐ Yes ☐ No
2. Do you wake up with dry mouth? ☐ Yes ☐ No
3. How many times do you awake to go to the bathroom? _____
4. Have you ever awakened choking or gasping for breath? ☐ Yes ☐ No
5. Upon awakening, do you feel refreshed and rested? ☐ Yes ☐ No

NARCOLEPSY: *(Sleepiness with dreaming and spells of weakness)*

1. Do you have sudden attacks of sleepiness? ☐ Yes ☐ No
2. Have you recently noticed increased irritability or trouble thinking? ☐ Yes ☐ No
3. Has daytime sleepiness affected your job performance of your employment? ☐ Yes ☐ No
4. Do you have cataplexy? ☐ Yes ☐ No
   (*Cataplexy is a brief (seconds or minutes) episode of muscle weakness; e.g., jaw drop, arm or leg weakness and/or paralysis. When the attack is over, the patient is completely normal. Laughter, anger, athletic activity, excitement are the usual factors that initiate an attack of cataplexy.*)
5. Do you have episodes of arm or leg paralysis (sleep paralysis) during sleep? ☐ Yes ☐ No
6. Do you hear or see something in the beginning or last part of sleep that is not real? (hallucinations) ☐ Yes ☐ No

NAME: _____

LEG PROBLEMS: *(Restless legs and compulsive leg moving at night)*

1. Do you have leg cramps at night? ☐ Yes ☐ No
2. Have you ever been told that your arms or legs move a lot at night? ☐ Yes ☐ No
3. Do you experience "creepy crawling" and/or aching feeling in your legs which make your want to move them? ☐ Yes ☐ No
4. Do you jerk your arms or legs during sleep? ☐ Yes ☐ No

SLEEP STATUS AND HABITS:

1. What do you usually do the hour before bed? _____
2. Do you often read in bed? ☐ Yes ☐ No
3. Do you often watch TV in bed? ☐ Yes ☐ No
4. Do you eat in bed? ☐ Yes ☐ No
5. During the night, do you often look at the clock? ☐ Yes ☐ No
6. On average, how long does it take you to fall asleep at night? _____ Min. _____ Hrs.
7. Do you have difficulty falling and/or staying asleep? ☐ Yes ☐ No
8. What time do you usually go to bed during the week? _____ Week-ends? _____
9. What time do you usually wake up during the week? _____ Week-ends? _____
10. How many times do you usually awaken during the night? ☐ 0-1 ☐ 2-3 ☐ more than 3
11. How many times do you usually awaken to urinate? ☐ 0-1 ☐ 2-3 ☐ more than 3
12. How long does it take to return to sleep? _____
13. Upon awakening, do you feel ☐ tired ☐ rested/refreshed ☐ other?
14. How many hours do you sleep at night? _____

MEDICAL HISTORY:

1. Do you have difficulty breathing through the nose? ☐ Yes ☐ No
2. Do you wear dentures? ☐ Yes ☐ No
3. Have you had any of the following:
   a. Tonsillectomy and/or adenoidectomy? ☐ Yes ☐ No When: _____
   b. Nasal or sinus surgery? ☐ Yes ☐ No When: _____
   c. Vocal cord surgery (polyp, nodules, etc.)? ☐ Yes ☐ No When: _____
   d. Any neck operations? ☐ Yes ☐ No When: _____
4. Have you been treated for sleep apnea? ☐ Yes ☐ No
   When: _____ Where: _____
   How: ☐ Tracheostomy ☐ UPP ☐ CPAP ☐ Drugs
   Did treatment improve: ☐ Sleepiness ☐ Snoring ☐ Tiredness ☐ Quality of sleep
5. Do you have any of the following:
   a. High blood pressure ☐ Yes ☐ No
   b. Heart disease ☐ Yes ☐ No
   c. Morning headaches ☐ Yes ☐ No
   d. Memory loss ☐ Yes ☐ No
   e. Sexual problems ☐ Yes ☐ No
   f. Lung disease ☐ Yes ☐ No
   g. Thyroid disease ☐ Yes ☐ No
   h. Allergy ☐ Yes ☐ No
   i. Swelling of your legs ☐ Yes ☐ No
   j. Urinary or kidney problems ☐ Yes ☐ No
   k. Stroke ☐ Yes ☐ No
   l. Diabetes ☐ Yes ☐ No
   m. Epilepsy ☐ Yes ☐ No
   n. Elevated cholesterol ☐ Yes ☐ No
   o. Any other neurologic disorder ☐ Yes ☐ No _____
   p. Any psychiatric disorder ☐ Yes ☐ No _____
   q. Any other problems ☐ Yes ☐ No _____

NAME: _____

6. Medications:

_____

_____

_____

_____

_____

_____

_____

Allergies to Any Medications: _____

_____

_____

7. General health: _____
8. Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____ or cigarettes per day? _____
9. Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much per day?_____
10. Does alcohol affect your sleep? ☐ Yes ☐ No

    If yes, please describe: _____

    _____
11. How many caffeinated drinks do you have in a day? Coffee _____ Tea _____ Soda _____
12. Do you use prescription or non-prescription sleeping pills? ☐ Yes ☐ No

FAMILY HISTORY:

1. Anybody in your family snore? ☐ Yes ☐ No
2. Anybody in your family is very sleepy? ☐ Yes ☐ No
3. Anybody in your family diagnosed with sleep disorder? ☐ Yes ☐ No If yes, what? _____

ANY FURTHER COMMENTS REGARDING YOUR CONDITION NOT COVERED IN THIS FORM?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Can we use the medical information provided in this form for publications or teaching *(without identifying the patient)*?

☐ Yes ☐ No

NAME:_____ AGE:_____ SEX:_____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement that best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. (0) I do not feel sad.
   (1) I feel sad.
   (2) I am sad all the time and I can't snap out of it.
   (3) I am so sad or unhappy that I can't stand it.

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 and that things cannot improve.

3. (0) I do not 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 is a lot of failures.
   (3) I feel I am a complete failure as a person.

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.

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.

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.

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.

8. (0) I don't feel I am worse than anybody else.
   (1) I am critical of myself all the time for my faults.
   (2) I blame myself all the time for my faults.
   (3) I blame myself for everything bad that happens.

NAME: _____

9. (0) I don't have any thoughts of killing myself.
   (1) I have thoughts of killing myself, but I would not carry them out.
   (2) I would like to kill myself.
   (3) I would kill myself if I had a chance.

10. (0) I don't cry anymore than usual.
    (1) I cry more now than I used to.
    (2) I cry all the time now.
    (3) I used to be able to cry, but now I can't cry even though I want to.

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 the time now.
    (3) I don't get irritated at all by the things that used to irritate me.

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.

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.

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.

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.

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 hours earlier than usual and it is hard to go back to sleep.
    (3) I wake up several hours earlier than I used to and cannot get back to sleep.

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.

NAME: _____

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.

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 purposely trying to lose weight by eating less. ☐ Yes ☐ No

20. (0) I am no more worried about my health than usual.
    (1) I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
    (2) I am very worried about physical problems and its hard to think of much else.
    (3) I am so worried about my physical problems that I cannot think about anything else.

21. (0) I have not noticed any 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.

TOTAL SCORE _____

Anesthesia & Sleep Medicine Services of Florida

Neurologic Health & Restorative Sleep

Sleep Disorder Center
1485 37th St. Suite 111
Vero Beach, FL. 32960
(772) 226-6855
Fax: (772) 226-6854
www.flsleepmedicine.com

Phillip A. Nye, MD, FASA
Diplomate of the American Board of Anesthesiology
& Sleep Medicine Specialist

REFERRAL FORM:

❖ **SLEEP DISORDER CONSULTATION**

Date:_____ Referring Doctor: _____

Office Phone: _____ Office Fax: _____

Patient Name:_____

Address: _____

City: _____ State:_____ Zip Code: _____

Home #: _____ Cell #: _____

DOB:_____ Sex: M / F SSN: _____

is this patient willing to see NP or PA YES NO Email: _____

**To help us serve your patient, please fax the following information with this referral form:*

- COPY OF INSURANCE CARDS
- INSURANCE REFERRAL OR AUTHORIZATION
- MEDICAL RECORDS

THANK YOU FOR YOUR REFERRAL.

Please fax to: (772) 226-6854
Attn: Dr. Phillip Nye, Anesthesia and Sleep Medicine Services of Florida