DATE: _____ / _____ / _____

PATIENT NAME: _____

BIRTHDATE: _____ / _____ / _____

Michael F Sedrak A Medical Corporation

License#: A82582, TaxID#: 20-8149126, NPI#: 1750464111

10336 Wilshire Blvd #602 Los Angeles, CA 90024

Ph#: (310)728-0494, Fax#: (559)553-8874

BED PARTNER QUESTIONNAIRE

Please ask someone who has watched you sleep to complete this form.

Observer's Name: _____ Relationship to patient: _____ Date: _____

I have observed this person's sleep: ☐ once or twice ☐ often ☐ almost every night

Check any of the following behaviors that you have observed this person doing while asleep. **Circle** those that you consider severe problems for this person.

light snoring
loud snoring
loud snorts
pause in breathing (how long? _____seconds
choking
gasping for air
twitching, moving or kicking of legs
twitching or flinging of arms
grinding teeth
sleep talking
sitting up in bed not awake
getting out of bed not awake
head rocking or banging
awakening with pain
becoming very rigid and/or shaking
biting tongue
crying out
apparently sleeping even if he/she behaves otherwise

If snores, what makes it worse? sleeping on back sleeping on side
alcohol fatigue

Does snoring sometimes require you or your partner to sleep separately? **Y** ☐ **N** ☐

Does this person drink alcohol or use street drugs? **Y** ☐ **N** ☐

Modified Epworth Sleepiness Scale

As an observer, please complete the following information in your estimation of the chances of his/her dozing in the following situations. (Even if none of these things have occurred recently, try to work out how they would have affected him/her.) Use the scale below to choose the most appropriate number for each situation.

0 - would never doze **1** - slight chance of dozing **2** - moderate chance of dozing 3 - high chance of dozing

	0	**1**	**2**	**3**
Sitting and reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting, inactive in a public place (e.g., a theater)	☐	☐	☐	☐
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	☐	☐	☐	☐

DATE: _____ / _____ / _____

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HIPAA 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.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation's (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and disclosures of protected health information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnosis or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In additions, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

DATE: _____ / _____ / _____

PATIENT NAME: _____
BIRTHDATE: _____ / _____ / _____

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You have the right to inspect and copy your protected health information.
Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable, anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information.
This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filling a complaint.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Observer's Name: _____ Relationship to patient: _____ Date:_____

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Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

PATIENT SIGNATURE : _____

Date _____

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PATIENT DEMOGRAPHICS

All information will be confidential. In order to serve you properly, we request the following information:

Patient name (last, first): _____ Male ☐ Female ☐

How did you hear about us? ☐ Physician ☐ Referred by:

☐ Website/Internet ☐ Yellow Pages ☐ Television/Radio ☐ Magazine/Newspaper

☐ Insurance Co. ☐ Patient/Friend ☐ Other:

DOB: _____ SSN: _____

Email address: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Alt phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency contact name (last, first): _____

EC Phone: _____ EC Relationship: _____

- I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize the release to my DME provider or referring/consulting/primary care physician of any information that may be needed.
- I authorize SVSC to obtain a photograph for my medical records.
- I hereby authorize all payments of insurance benefits to go directly to SVSC or practitioner even if it is made payable to me. I understand that any allowed charges not fully paid by my insurance will be my responsibility and will be billed accordingly.
- I authorize the sleep center staff to perform necessary service I may need.
- I acknowledge that I have been given the option to read the SVCS “Notice of Privacy Practices”.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

DATE: _____ / _____ / _____

PATIENT NAME: _____
BIRTHDATE: _____ / _____ / _____

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RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY MEDICAL RECORDS TO:

Michael F Sedrak A Medical Corporation
10336 Wilshire Blvd #602 Los Angeles, CA 90024
Ph#: (310)728-0494, Fax#: (559)553-8874

I HEREBY AUTHORIZE AND REQUEST RELEASE OF MY MEDICAL RECORDS FROM:

Michael F Sedrak A Medical Corporation
10336 Wilshire Blvd #602 Los Angeles, CA 90024
Ph#: (310)728-0494, Fax#: (559)553-8874

TO/FROM _____

_____

_____

THE LATEST HISTORY AND PHYSICAL IN YOUR POSSESSION CONCERNING MY ILLNESS.

NAME _____ SS# _____

DOB _____

ADDRESS _____

_____

_____

SIGNATURE _____ DATE _____

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SLEEP AND MEDICAL HISTORY

Today's Date: _____

Name: _____ Age: _____ Primary MD: _____

DOB: _____ Height: _____ Weight:_____ Referring MD: _____

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions **as thoroughly as you can**.

All answers should refer to a typical night (or day) of sleep.
If you are already using CPAP, answer according to when you are wearing the mask.

Annotate your main problem(s):

☐ Act out dreams ☐ Hard to fall asleep ☐ Hold breath when sleeping ☐ Snore ☐ Too tired
☐ Gasp or Choke ☐ Hard to stay asleep ☐ Legs kick/move ☐ Too sleepy ☐ Usually feel un-rested
☐ Other: _____

General Sleep:

1. For how long have you had this problem?
☐ Only within the last month ☐ 1-6 months ☐ 6 months – 2 years ☐ > 2 years

2. Rate the severity of your problem.
☐ Mild ☐ Moderate ☐ Severe ☐ the problem is only for others

3. Is it getting worse?
☐ No ☐ Yes ☐ Do not know

5. Does your sleep problem negative impact ….your work performance? ☐ No ☐ Yes
….your sex life? ☐ No ☐ Yes
….your quality of life? ☐ No ☐ Yes
….your social activity? ☐ No ☐ Yes

6. Do any other members of your family have significant sleep problems? ☐ No ☐ Yes
If yes, please explain: _____

7. Do you use any medication or other substance to help you sleep? ☐ No ☐ Yes
If yes, please list name, dose, frequency, length of usage: _____

8. Have you ever discussed these sleep problems with another doctor?
☐ No ☐ Yes… Dr. Name: _____ Diagnosis: _____

List **present** sleep treatment: _____ Date started: _____

List **prior** sleep treatment: _____ Dates: _____

DATE: _____ / _____ / _____

PATIENT NAME: _____

BIRTHDATE: _____ / _____ / _____

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SLEEP AND MEDICAL HISTORY

N = Never **O** = Occasionally **F** = Frequently

Please rate how often you or others have noted that you:	**N**	**O**	**F**
Snore	☐	☐	☐
Snore loudly enough that others complain	☐	☐	☐
Awaken from sleep feeling short of breath, gasping, or choking	☐	☐	☐
Hold your breath or stop breathing while asleep	☐	☐	☐
Experience other breathing problems at night	☐	☐	☐
Have headaches upon waking that improve in less than 2 hours	☐	☐	☐
Have dry mouth upon waking	☐	☐	☐
Sweat excessively at night	☐	☐	☐
Experience heart pounding or beating irregularly during the night	☐	☐	☐
Feel sleepy or tired during the day	☐	☐	☐
Awaken feeling unrested or unrefreshed	☐	☐	☐
Get sleepy while driving	☐	☐	☐
Have had a wreck due to sleepiness	☐	☐	☐
Have trouble at work or school because of sleepiness	☐	☐	☐
Become irritable or “crabby”	☐	☐	☐
Experience decrease in memory or concentration abilities	☐	☐	☐
Fall asleep involuntarily or suddenly or in awkward situations	☐	☐	☐
Experience sudden weakness, buckling of knees or facial heaviness when laughing, scared, angry or crying	☐	☐	☐
Feel totally unable to move (paralyzed) when first waking or falling asleep	☐	☐	☐
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep (similar to hallucinations)	☐	☐	☐
Find yourself doing complex tasks of which you were totally unaware (such as driving/navigating without conscious awareness)	☐	☐	☐
Have nightmares or night terrors	☐	☐	☐
Act out your dreams	☐	☐	☐
Walk in your sleep	☐	☐	☐
Do anything else considered “unusual” while asleep	☐	☐	☐
Recurrently or rhythmically move, twitch or jerk your legs **while asleep**	☐	☐	☐
Feel restlessness, agitation or discomfort in your legs **at or before bedtime**	☐	☐	☐

If so.....

Do you feel an overwhelming urge to move your legs?	**Y** ☐	**N** ☐
Does it happen only in the evening?	**Y** ☐	**N** ☐
Does it happen only when relaxed?	**Y** ☐	**N** ☐
Does it get better if you move about or walk?	**Y** ☐	**N** ☐
Does it disturb sleep or sleep onset?	**Y** ☐	**N** ☐

How often do you experience this? _____ days per **week** or **month** (*circle one*)

DATE: _____ / _____ / _____

PATIENT NAME: _____

BIRTHDATE: _____ / _____ / _____

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SLEEP AND MEDICAL HISTORY

Sleep Hygiene:

1. Do you often have anxiety (worry about things) around bedtime? **Y** ☐ **N** ☐
2. Do you often feel sad or depressed? **Y** ☐ **N** ☐
3. Do you sleep better away from home than in your own bed? **Y** ☐ **N** ☐
4. Do you have thoughts racing through your mind while trying to go to sleep? **Y** ☐ **N** ☐
5. Do you get anxious or upset when you are unsuccessful with falling asleep? **Y** ☐ **N** ☐
6. Do you usually take coffee, tea, or chocolate within 2 hours before you go to bed? **Y** ☐ **N** ☐
7. Do you do physical exercise within 2 hours before bedtime? **Y** ☐ **N** ☐
8. Do you watch TV or read in bed before falling asleep? **Y** ☐ **N** ☐
9. Do you ever sleep, nap, or rest during the awake portion of your day? **Y** ☐ **N** ☐

   If yes… how often? _____ # per day _____ total per week

   …on average, how long is your nap? ☐ less than 1 hr ☐ 1 hr or more

   …after a nap do you still remain tired? **Y** ☐ **N** ☐
10. Check any condition that routinely applies to you:

    ☐ sleep with someone else in your bed ☐ sleep with a pet in your room ☐ sleep by yourself

    ☐ provide assistance to someone during the night (child, invalid, bed partner, animal)
11. Check any factors that disturb your sleep:

    ☐ heat ☐ cold ☐ light ☐ noise ☐ bed partner ☐ other: _____

Sleep Habits:

12. You feel your best during ☐ Morning ☐ Afternoon ☐ Evening
13. Estimate your total actual **sleep per night**? (do not include time awake in bed)
14. What time do you **usually go to bed**? **on WORKDAYS**?_____ **on NON-WORKDAYS**? _____
15. What time do you **usually rise from bed**? **on WORKDAYS**?_____ **on NON-WORKDAYS**? _____
16. How long does it **usually** take you to **fall asleep**?_____
17. How many hours of sleep do you feel you **need** in order to feel your very best?_____
18. In a perfect world, what would be your choice for an **ideal hour** to go to bed?_____To awaken?_____
19. In your opinion, what usually **prevents** you from quickly falling to sleep?_____
20. How many times do you **typically wake up** at night?_____Cause?_____
21. If you wake up, **on the average**, how long do you **stay awake**?_____
22. If you do awaken during the night, in which part(s) of your sleep period is it predominantly?

    ☐ soon after falling asleep ☐ middle of the night ☐ near end of sleeping period

Current Medications:

Please list **all medicines **prescribed** by your doctor **and their dosages****

_____ _____

_____ _____

DATE: _____ / _____ / _____
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MEDICAL HISTORY

Past Medical History:

Please check any condition that a doctor has diagnosed you with

Cardiac/Heart: (C)	Digestive: (D)	Endocrine/Other: (E)	Lung/Pulmonary: (L)	Neurology: (N)	Psychology: (P)
☐ Anemia	☐ Acid Reflux (GERD)	☐ Chronic Fatigue Syn	☐ Asthma	☐ Headache	☐ Depression
☐ Angina	☐ Hiatal Hernia	☐ Fibromyalgia	☐ Bronchitis	☐ Infection of Brain/Spinal Cord	☐ Anxiety
☐ CHF (Heart Failure)	☐ Other Digestive Probs	☐ Thyroid Disease	☐ COPD	☐ Injury of Brain/Spinal Cord	
☐ Heart Attack		☐ Cancer	☐ Emphysema	☐ Seizure/Epilepsy	
☐ Other Heart Problem			☐ Other Lung Prob.	☐ Other Brain/Nerve Disorders	

☐ Other: _____

Medication Allergies:

Are you allergic to any medications? (Please list)

_____ _____ _____

Past Surgical History:

Please list any operations and approximate date of surgery (head or neck only)

Date	Type of Surgery	Date	Type of Surgery
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

Has anyone in your blood-related family ever been afflicted with:

☐ Act out dreams	☐ Excessive Sleepiness	☐ Narcolepsy	☐ Sleep Walking
☐ Depression	☐ Heart Attack	☐ Restless Legs	☐ Stroke
☐ Diabetes	☐ Hypertension	☐ Sleep Apnea	☐ Suicide

Social History:

Marital Status: ☐ S ☐ M ☐ D ☐ W **Occupation:** _____

Please check all that apply:

Alcohol ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Alcoholic

Tobacco ☐ None ☐ Yes-type _____ How much _____

Recreational Drugs ☐ None ☐ Yes-type _____ Frequency _____

Other:

Personal assessment of current health: ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Weight gain in the past 12 months: ☐ None amt:_____lbs

Weight loss in the past 12 months: ☐ None amt:_____lbs

Most you have ever weighed (non-pregnant): _____lbs In what year? _____

DOCTOR ONLY
Today:
_____ lbs

DATE: _____ / _____ / _____

PATIENT NAME: _____
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REVIEW OF SYSTEMS

Do you presently, or have you in the recent past, suffered from any of the listed items? (check all that apply)

Constitutional

- ☐ Night Sweats
- ☐ Loss of Appetite
- ☐ Fatigue
- ☐ Weight Loss

Ear, Nose, Throat and Allergy

- ☐ Trouble Breathing Through Nose
- ☐ Night Time Congestion
- ☐ Trouble Swallowing
- ☐ Hoarse Voice
- ☐ Frequent Nosebleed
- ☐ Swollen Glands
- ☐ Frequent Infections
- ☐ Frequent Hives
- ☐ Frequent Colds
- ☐ Nasal/Seasonal Allergies

Heart

- ☐ Chest Pain While Awake
- ☐ Chest Pain While Asleep
- ☐ Very Rapid Heart Beat
- ☐ Irregular Heartbeat
- ☐ Leg Swelling
- ☐ Pains in Legs When Walking

Lungs

- ☐ Chronic Cough
- ☐ Pain with Breathing
- ☐ Short of Breath with Mild Exertion
- ☐ Trouble Breathing Laying Flat

Genital/Urinary

- ☐ Trouble with Erection
- ☐ Testicular Pain or Swelling

Musculoskeletal

- ☐ Joint Pain or Swelling
- ☐ Back Pain (Chronic)
- ☐ Muscle Pain or Weakness
- ☐ Leg Cramps

Endocrine

- ☐ Cold Intolerance
- ☐ Excessive Thirst
- ☐ Sexual Dysfunction

Psychiatric

- ☐ Hallucinations
- ☐ Nightmares
- ☐ Feel Depressed
- ☐ Feel Nervous or Tense
- ☐ Suicidal Thoughts

Nervous System

- ☐ Frequent Headaches
- ☐ Loss of Strength in Specific Body Area
- ☐ Loss of Feeling in Specific Body Area
- ☐ Fainting Spells
- ☐ Trouble with Balance
- ☐ Trouble with Coordination
- ☐ Dizziness
- ☐ Trouble Walking

DATE: _____ / _____ / _____

PATIENT NAME: _____

BIRTHDATE: _____ / _____ / _____

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EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 doze
1 - slight chance of dozing
2 - moderate chance of dozing
3 - high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_____
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 traffic	_____
	Total: _____

DATE: _____ / _____ / _____

PATIENT NAME: _____
BIRTHDATE: _____ / _____ / _____

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POST SLEEP QUESTIONNAIRE

Patient Name _____

Date of Study _____

How comfortable were you about the study?
☐ Comfortable ☐ Ok
☐ Not Comfortable ☐ Very Uncomfortable

If you were on CPAP, how comfortable were you?
☐ Comfortable ☐ OK
☐ Not Comfortable ☐ Very Uncomfortable

Did you fall asleep easily after light were out?
☐ Yes ☐ No

Did you fall asleep easily after CPAP was started?
☐ Yes ☐ No

How long did it take you to fall asleep after light out? _____

How long did it take you to fall asleep after CPAP was started? _____

How does it compare to your usual sleep?
☐ More sleep ☐ Same sleep
☐ Less sleep

Do you remember waking up last night?
☐ Yes ☐ No

IF yes, how many times? _____

Do you have any physical complaints?
☐ Yes ☐ No

IF yes, please explain _____

How do you feel right now?
☐ Very tired ☐ Awake but not alert
☐ Rested ☐ Wide awake and alert

If you remember your dream from last night, briefly describe it. _____

How were you treated by your technician? _____

_____

_____

_____