Arizona Grand Medical Center

3777 Crossings Drive Prescott Az, 86305 Phone (928)771-9693

7900 E Florentine Prescott Valley Az, 86314 Phone (928)772-8041

Patient Information

Home Phone: _____ Cell Phone: _____

Last Name: _____ First Name: _____MI_____

Mailing Address: _____APT _____City/State/Zip_____

Sex: Male Female Birthdate: _____ Age _____ Soc. Sec. # _____ -_____ -_____

Language: _____ Race/Ethnicity: _____ Email: _____

Employer: _____Work Phone: _____ Occupation: _____

Referring/PCP Physician

Primary Care Physician _____ Phone: _____

Referring Physician: _____ Phone: _____

Emergency Contact Information

Name: _____ Relationship: _____ Telephone #:_____

Living Will: _____ I do have one _____ I do **not** have one at this time

Authorization to Release Information & Assignment of Benefits

I hereby authorize any insurance company to pay the proceeds or any benefits due me directly to Arizona Grand Medical Center, PLLC. I further acknowledge and understand that I am responsible for all services rendered to me or any member of my family. Although I have requested the doctor bill my insurance, it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

I consent to receive calls from Arizona Grand Medical Center for my protected healthcare and other services at the phone number(s) above, include my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automatic dialing system

Signature: _____ Date: _____

Health Insurance Portability and Accountability Act of 1996 (HIPPA)

I have received a copy of the privacy Rules from the provider and authorize the list of person(s) who may receive my protected health information. I may revoke this at any time by giving written notification to the provider. I further authorize Arizona Grand Medical Center to receive medical records & medications, paper or electronic.

Name of Authorized Person: _____ Relationship: _____

May we leave a message regarding: TEST RESULTS Yes ( ) No ( ) APPOINTMENTS Yes ( ) No

Signature: _____ Date: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:
Your help is greatly appreciated

Name:_____ DOB_____ Date:_____

Occupation: (Former & Current)_____

Do you smoke_____ if Yes what_____ How many years_____

How much_____ when did you stop_____ what did you do to quit_____

Have you been diagnosed to have any of the following?

Asthma, allergic rhinitis, sinusitis, bronchitis, COPD, emphysema, lung fibrosis, pneumonia, tuberculosis, valley fever, lung cancer, long nodule, any other cancer. Deep venous thrombosis, pulmonary embolism, pulmonary hypertension, sleep apnea, insomnia, narcolepsy, restless leg syndrome, pleural effusion, congestive heart failure, gastro esophageal reflux disease, stroke, Parkinson's disease, anemia.

Diseases that you have been diagnosed with: When

_____ _____
_____ _____
_____ _____

Family History:
Mother:_____
Father:_____
Siblings:_____

Have you experienced any of the following? (Circle when appropriate)
Shortness of breath How Long _____ always or episodic, on exertion, at rest, at night
Coughing How Long _____ always or episodic, on exertion, at night
Sputum How Long _____ amount_____ color_____blood_____
Chest pain How Long _____ Where_____with breathing- Yes or No
Sleep problems Snoring, Choking, Stops breathing, Leg or body movements, Leg cramps. Sleepy during the day time, other _____
Vaccination Flu- When_____ Pneumonia- When _____
Medications: (please list inhalers, oxygen, nebulizers, CPAP/BIPAP and all drugs)
_____
_____
_____

Did you have the following tests? Where When

Blood Test_____
CT scan of the chest_____
Chest X-ray_____
Echocardiogram_____
Pulmonary function tests_____
Sleep Study_____
Bronchoscopy_____

Thank You for your help

Emergency Contact Phone Number:_____

Ez SLEEP LAB

Name:_____ today's date:_____

Birth date __/__/____ Sex: Male Female Height:_____ Weight: _____ Neck Size _____

Referring Doctor:_____ Primary Care Doctor:_____

Other Physicians you would like report sent to:

Usual Medications	Dose	Did you take today?		If "yes" what time
		Y	N	
		Y	N	
		Y	N	
		Y	N	
		Y	N	
		Y	N	
		Y	N	

Have you had any of the following today (If "yes" please list what time)

Caffeine:_____ Alcohol:_____

Tobacco:_____ Naps:_____

Medical History

General:	Weight gain Depression	Tobacco Use anxiety	Alcohol Use
Ears, Nose, and Throat: (UPPP)	Deviated septum	Sinus surgery	Sleep apnea surgery
Sleep disorders: movement	Sleep apnea	Sleep talking/walking	periodic limb
Pulmonary:	Asthma	COPD/Emphysema	Lung cancer
Cardiac:	Hypertension Pacemaker	Congestive heart failure Coronary artery disease (i.e. heart attack, angioplasty)	Atrial fibrillation
Gastro-intestinal:	Acid Reflux	Hiatal hernia	Ulcer disease
Endocrine:	Thyroid disease	Diabetes	
Neurologic:	Seizure disorder	Stroke	
Hematologic:	Anemia		
Other:			

Past Surgeries:_____

Are you currently on:
Oxygen if yes, how much? _____ How long? _____
CPAP if yes, what pressure? _____ How long? _____
BiPAP if yes, what pressure? _____ How long? _____

How do you feel using CPAP?

Worse about the same better much better

Have you had a previous sleep test yes no

If yes, when?_____ if yes, where?_____ if yes, what type of test? _____

Circle Y or N

1. Y N Do you experience daytime sleepiness?
2. Y N Do you take daytime naps?
3. Y N Have you ever fallen asleep while driving or at a stop sign?
4. Y N Have you been told that you snore?
5. Y N Have you been told you hold your breath when you sleep?
6. Y N Have you ever snored or gasped yourself awake?
7. Y N Do you experience morning headaches?
8. Y N Do you experience hoarseness or throat irritation?
9. Y N Do you experience itchy or crawly sensation in your legs at bedtime?
10. Y N Have you been told that you kick at night?
11. Y N When angry or happy, have you ever lost muscle strength?
12. Y N Have you been unable to move upon waking up?
13. Y N Have you experienced hallucinations upon sleeping or waking?
14. Y N Do you have difficulties initiating sleep?
15. Y N Do you feel depressed?
16. Y N Do you awaken earlier then you would like to in the morning?
17. Y N Do your thoughts prevent you from falling asleep at night?
18. Y N Do you drink caffeine in the evenings?
19. Y N Do you use tobacco in the evenings?
20. Y N Do you use illicit drugs?
21. Y N Do you use alcohol in the evenings?
22. Y N Do you use medication to help you sleep?
23. Y N do you use medication to help you stay asleep? (if yes include in medication list)

What is your usual bed time? _____ (Weekend: _____)
What is your usual wake time? _____ (Weekend :_____)
How many hours of sleep do you usually get? _____ (Weekend: _____)
Are you a shift worker Yes No
If yes how often do you change shifts? _____
Current shift hours: From:_____ To: _____ Since _____(date)
Why do you think that you being tested? _____
Describe your problem:

a. How long have you had it?
b. What have you done about it?
c. How has it affected your quality of life?

KEY

0= would NEVER doze
1= SLIGHT chance of dozing
2= MODERATE chance of dozing
3= HIGH chance of dozing

SITUATION	**CHANCE OF DOZING** (use key above)			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. theater, meeting)	0	1	2	3
As a passenger in a car, for a hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3