Dear Patient,

Please complete the enclosed paperwork in which you provide information regarding your sleep problem, and bring it with you to your appointment with Dr. Baten scheduled for:

Date: ________________________________

Time: ________________________________

If you have any questions regarding this information please call the office at 505-983-8182.

Thank You.
PATIENT INFORMATION

Last Name: ___________________________ First Name: ___________________________

Address: _______________________________________________________________

City: ___________________________ State: ___________________________ Zip: ___________

Home Phone: ___________________________ Cell: ___________________________ Work: ___________________________

Date of Birth: ___________________________ Social Security #: ___________________________

Gender (please circle)  M or   F  Marital Status (please circle)  M  S  D  W

Referring Physician: ___________________________ Primary Physician: ___________________________

EMERGENCY CONTACT

 RESPONSIBLE PARTY

Name: ___________________________ Name: ___________________________

Phone: ___________________________ SS# ___________________________ DOB: ___________________________

Relationship to Patient: ___________________________ Phone: ___________________________

EMPLOYMENT INFORMATION

Employer Name: ___________________________ Fulltime or Part-time (please circle)

Address: ___________________________________________ Phone: ___________________________

INSURANCE INFORMATION

COPAY DUE AT THE TIME OF SERVICE. NO EXCEPTIONS. PLEASE give INSURANCE CARD TO FRONT DESK TO MAKE COPY. NO THIRD PARTY INSURANCE ACCEPTED

Is this a worker's compensation claim? YES or NO (please circle)

Is this an accident claim? YES or NO (please circle) IF YES, Please provide info below:

Insurance Name: ___________________________________________

Billing Address: ___________________________________________

Adjustors Name: ___________________________ Phone: ___________________________

Claim# ___________________________ Date of Injury: ___________

Do you have an Attorney for this claim? YES or NO (please circle)

Attorney Name: ___________________________ Phone: ___________________________

Insurance is filed by our office for all professional services when appropriate, should your insurance company refuse payment, patient is responsible for all unpaid charges!

Signature: ___________________________ Date: ___________________________
RELEASE OF PROTECTED HEALTH INFORMATION

Signing this authorization is not a condition of treatment

Patient's Name: __________________________ DOB: ___________________ SS# _____________

It is the policy of Neurological Associates to share Protected Health Information as follows:

- **Primary Care Physicians** are provided with medical records generated by our office and the results of tests ordered by our office.
- **Testing Facilities** (x-ray, lab, etc) are provided with your Name, DOB, SSN, insurance info and Diagnosis.
- **Pharmacies** are provided with your Name, DOB and Prescription Info.
- **Insurance Companies** for the purpose of payment.

___ Check here if you agree with releases info to the above entities
___ Check here and cross out any policy you disagree with
___ Check here if info is to be released to no one

I also understand I may authorize (i.e., a spouse, friend or medical representative) to verbally communicate with Neurological Associates regarding Protected Health Info for purpose of medical treatment: (This does not include obtaining copies of records)

Name: _______________________________ Relationship: _______________________________

I understand that I can revoke this authorization at any time by giving written notice to the Privacy Officer in our office. The revocation is not effective for information previously disclosed in reliance on the authorization in effect at the time.

I understand that information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I have a right to:

* Inspect or copy the Protected Health Info to be disclosed
* Refuse to sign this authorization

Signature: ___________________________ DOB: ___________________ Date: ___________________

If signed by a personal representative of patient:

Name (print): _______________________________ Relationship: ___________________ 
Signature: _______________________________ Date: ___________________
PRESCRIPTION POLICY

ALL NEW AND ESTABLISHED PATIENTS

Signing this acknowledgement means you understand our prescription policy.

Medications are prescribed in specific quantities for a specific time period (i.e., 30 for 30 days). No medications will be refilled before the appropriate time.

All regular medications will require 24 hour notice prior to being filled. All narcotics will be closely monitored and will require 48 hour notice prior to refilling with a written prescription.

All medication refills will be taken Monday thru Thursday. No refill requests will be processed on Friday, or on the weekend.

No medication will be prescribed for patients who have not been seen on a regular basis.

If you miss a scheduled appointment and run out of medicine, we will refill your prescription until your next appointment. If you fail to come to your next appointment, your prescription will not be refilled.

If you run out of medicine before your scheduled appointment, please ask your pharmacist to fax our office Monday thru Thursday to request a refill, until your next scheduled appointment with Dr. Baten.

Our telephone hours are 8:30 a.m. to 4:00 p.m. Please call between these hours.

Print Name: ____________________________________________

Signature: ____________________________________________ Date: _____________________
BED PARTNER QUESTIONNAIRE

Patient Name: ________________________________ Date: __________________

Check any of the following behaviors that you have observed the patient doing while asleep.

____ loud snoring
____ light snoring
____ twitching of legs or feet during sleep
____ pause in breathing
____ grinding teeth
____ sleep talking
____ sleepwalking
____ bed wetting
____ sitting up in bed but not awake
____ head rocking or banging
____ kicking with legs during sleep
____ getting out of bed but not awake
____ biting tongue
____ becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

If you have heard loud snoring, do you remember pauses in the snoring or occasional loud "snorts"?

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
SLEEP QUESTIONNAIRE

Name: ___________________________ Sex: ___ Age: ___ Date: ___________

Occupation: ______________________ Usual Work Hours/Days: _______________

Referring Physician: ___________________ Primary Physician: ___________________

Marital status: Single  Married  Divorced  Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas

My Main Sleep Complaint(s) Is:

___ trouble sleeping at night     For how many months/years? ____________

___ being sleepy all day     For how many months/years? ____________

___ snoring     For how many months/years? ____________

___ unwanted behaviors during sleep, explain ____________________________________

___ Other, explain. _____________________________________________________________

Sleep Pattern

<table>
<thead>
<tr>
<th>Work Days (Weekday)</th>
<th>Off Days (Weekends)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical bedtime</td>
<td></td>
</tr>
<tr>
<td>Typical amount of</td>
<td></td>
</tr>
<tr>
<td>time it takes to</td>
<td></td>
</tr>
<tr>
<td>fall asleep</td>
<td></td>
</tr>
<tr>
<td>List any activities</td>
<td></td>
</tr>
<tr>
<td>that you normally</td>
<td></td>
</tr>
<tr>
<td>do during nighttime</td>
<td></td>
</tr>
<tr>
<td>awakening(s) (i.e.</td>
<td></td>
</tr>
<tr>
<td>restroom, eat,</td>
<td></td>
</tr>
<tr>
<td>watch TV)</td>
<td></td>
</tr>
<tr>
<td>Typical amount of</td>
<td></td>
</tr>
<tr>
<td>time to fall back</td>
<td></td>
</tr>
<tr>
<td>asleep after an</td>
<td></td>
</tr>
<tr>
<td>awakening</td>
<td></td>
</tr>
<tr>
<td>Typical wake up</td>
<td></td>
</tr>
<tr>
<td>time</td>
<td></td>
</tr>
<tr>
<td>How do you usually</td>
<td></td>
</tr>
<tr>
<td>awaken? (i.e. alarm</td>
<td></td>
</tr>
</tbody>
</table>
Typical time you get out of bed __________________     __________________
Total amount of sleep per night __________________    __________________
Number of naps per day __________________     __________________

Please check all of the following statements that are true about your sleep

Sleep Habits
___ I usually watch TV or read in bed prior to sleep
___ I frequently travel across 2 or more time zones
___ I drink alcohol prior to bedtime
___ I smoke prior to bedtime or when I awaken during the night
___ I eat a snack at bedtime
___ I eat if I awaken during the night
___ I typically awaken to urinate during sleep
___ I have trouble falling asleep
___ I awaken frequently during the night
___ I am unable to return to sleep easily if I awaken during the night
___ Thoughts start racing through my mind when I try to fall asleep
___ I awaken early in the morning, still tired but unable to return to sleep
___ I have nightmares as an adult
___ I experience a tingling sensation in my legs when I try to fall asleep
___ I sweat a great deal during sleep
___ I cannot sleep on my back

Breathing
___ I have been told that I stop breathing while asleep
___ I awaken at night choking, smothering or gasping for air
___ I have been told that I snore
___ I have been told that I snore only when sleeping on back
___ I have been awakened by my own snoring

Restlessness
___ I am a restless sleeper
___ I kick or jerk my legs and/or arms during sleep
___ I experience restlessness, tingling or crawling in my arms or legs
___ I experience an inability to keep my legs still prior to falling asleep
___ I talk in my sleep as an adult
___ I have sleep walked as an adult
___ I grind my teeth in my sleep

Daytime Sleepiness
___ I take daytime naps
___ I have a tendency to fall asleep during the day
___ I have experienced lapses in time or blackouts
___ I have fallen asleep while driving
___ I have had auto accidents as a result of falling asleep while driving
___ I fall asleep while watching TV
I fall asleep during conversations
I fall asleep in sedentary situations
I performed poorly in school because of sleepiness
I have had injuries as the result of sleepiness
I have experienced sudden muscle weakness in response to emotions such as laughter, anger or surprise
I have experienced an inability to move while falling asleep or when waking up
I have experienced hallucinations or dreamlike images or sounds when falling asleep or waking up
I drink caffeinated beverages during the day _____ cups/bottles/cans per day

Habits
Do you smoke? _____ If yes, what? ____________________________________________________
Amount per day _______ For how many years? _______________________________________
Do you drink Alcohol? ________
If yes: What _______ Frequency _______ Amount per week _______
Beer _______ Daily _______ Weekends _______ Rare _______ cans/week
Wine _______ Daily _______ Weekends _______ Rare _______ glasses /week
Liquor _______ Daily _______ Weekends _______ Rare _______ drinks/week

Social History
Marital Status: S M D W
____ sleep alone
____ share a bed with someone
____ share a bedroom, but have separate beds
____ share a dwelling, but have separate bedrooms

Employment Status
Employed __ Unemployed __ Retired __
____ My job requires driving a vehicle
____ I work with dangerous equipment or substances
____ I am a shift worker on rotating shifts
____ I am permanent or long term third shift worker
____ I am currently a student

Medical History
What is your: Height _______
Weight _______
Neck Size _______
What was your weight one year ago _______
Five years ago _______
Current Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th># Times per day</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Allergies: ____________________________________________________________

Past Sleep Evaluation and Treatment

___ I have had a previous sleep disorder evaluation
___ I have had previous overnight sleep studies
___ I have had daytime nap studies
___ I have been prescribed a CP AP or BIP AP machine for home use
___ I have had surgical treatment for a sleep disorder
___ I have previously been prescribed medication for a sleep disorder
___ I have been previously treated for a sleep disorder

Past Medical History

___ High Blood Pressure
___ Heart Disease
___ Diabetes
___ Stomach or colon problems
___ Lung Problems/ COPD/ Asthma
___ Fibromyalgia
___ TIA
___ Seizures
___ Cancer
___ Hepatitis/ Jaundice
___ Hearing impairment
___ Depression or anxiety
___ Alcoholism
___ Chemical dependency or abuse
___ Reflux
___ Stroke
___ Blackouts
___ Arthritis
___ Thyroid problems

Female

___ Premenstrual Syndrome
___ Menopause

Male

___ Prostate Problems
___ Erectile dysfunction/impotence

List other past medical problems and dates

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

List Surgeries and the year

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

In the PAST 12 MONTHS check any of the following symptoms you have had

___ Frequent Headache
___ Fainting or passing out
___ Frequent Heartburn! Indigestion
___ Abdominal pain
<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Loss of vision</td>
<td>___ Frequent constipation</td>
</tr>
<tr>
<td>___ Hearing loss/ringing in ears</td>
<td>___ Frequent Diarrhea</td>
</tr>
<tr>
<td>___ Hoarseness for more than 2 weeks</td>
<td>___ Rectal bleeding! black stools</td>
</tr>
<tr>
<td>___ Nosebleeds</td>
<td>___ Difficulty urinating/incontinence</td>
</tr>
<tr>
<td>___ Cough for 2-4 weeks or more</td>
<td>___ Blood in urine</td>
</tr>
<tr>
<td>___ Coughing up blood</td>
<td>___ Urinating more than 2X per night</td>
</tr>
<tr>
<td>___ Shortness of breath/wheezing</td>
<td>___ Pain in joints or bones</td>
</tr>
<tr>
<td>___ Swelling in feet or ankles</td>
<td>___ Unusual bruising or bleeding</td>
</tr>
<tr>
<td>___ Chest pain, pressure, or heaviness</td>
<td>___ Convulsions</td>
</tr>
<tr>
<td>___ Irregular heartbeat</td>
<td>___ Change in wart/mole/skin growth</td>
</tr>
<tr>
<td>___ Difficulty swallowing</td>
<td>___ Weight loss of more than 10 lbs</td>
</tr>
</tbody>
</table>

**Family History**

Has an immediate blood relative had any of the following?

<table>
<thead>
<tr>
<th>Relation</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Stroke</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Depression</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Sleep Apnea</td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>Narcolepsy</td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
</tr>
</tbody>
</table>

*Using the answer key below, please circle the number that best applies to your life over the past 6 months*

**Answer Key** 1- Never 2-Rarely 3-Sometimes 4-Usually 5-Always

<table>
<thead>
<tr>
<th>Symptom</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have trouble getting to sleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I wake up often during the night</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>At bedtime, thoughts race through my mind</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>At bedtime, I feel sad and depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>When falling asleep, I feel unable to move</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>When falling asleep, I have &quot;restless legs&quot;</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I awake suddenly gasping for breath</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>At night my heart pounds, beats rapidly, or beats irregularly (palpitations)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I sweat a great deal at night</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My sleep is disturbed by restless legs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have a lot of nightmares</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel unable to move (paralyzed) after a nap</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have dream like images when I awaken in the morning even though I know I am not asleep</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have slept for several days at a time, or at least</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have been overwhelmingly sleepy for that long</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
I have been unable to sleep at all for several days
I feel that I have insomnia
I am very sleepy during the day and I struggle to stay awake
In the past 6 months, I have fallen asleep accidentally in some of these situations; eating a meal, talking on the phone, talking to someone, riding in a bus or car, watching TV, at a theatre, reading a book, at a lecture
I got bad grades in school because I was too sleepy
I now have trouble doing my job because of sleepiness or fatigue
I often have to let someone else drive the car because I am too sleepy to do it
I see dream-like images either just before or just after a daytime nap, yet I am sure I am awake when they happen
I am often unable to move (paralyzed) when I am waking up in the morning
Sometimes I realize I have driven my car to the wrong place, and I can't remember how I did it
I get "weak knees" when I laugh
I get sudden muscular weakness when laughing, angry, or in situations of strong emotions
I have high blood pressure
My desire or interest in sex is less than what it used to be
I am unhappy about loving relationships in my life
I have considered or attempted suicide
Someone in my family has been hospitalized for a psychiatric illness or "nervous breakdown"
I smoke tobacco within two hours of bedtime
I have problems with my nose blocking up when I am trying to sleep
My snoring or my breathing problem is much worse if I sleep on my back
My snoring or my breathing problems are much worse if I fall asleep right after drinking alcohol
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 doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>____</td>
</tr>
<tr>
<td>Watching TV</td>
<td>____</td>
</tr>
<tr>
<td>Sitting inactive in a public place (e.g. a theater or meeting)</td>
<td>____</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>____</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon</td>
<td>____</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>____</td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td>____</td>
</tr>
<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td>____</td>
</tr>
</tbody>
</table>
### SLEEP DIARY

**Patient's Name:** _________________________________ Please Print

**INSTRUCTIONS:** Complete these logs as instructed using the directions provided below. Complete the logs in the morning and the evening. Do not complete the logs during the night. Write additional comments on the back. Bring these logs with you for your appointment or mail them to your physician.

1. Leave the times you are awake BLANK
2. SHADE, crosshatch or color the times you sleep
3. ARROW DOWN whenever you lie down to sleep
4. ARROW UPWARD when you awaken (include naps)
5. "M" - meals, "S" - snacks, and "D" - drinks with alcohol
6. Include notes below each week or on the back

**EXAMPLE:**

<table>
<thead>
<tr>
<th>DATE</th>
<th>6am</th>
<th>8am</th>
<th>10am</th>
<th>Noon</th>
<th>2pm</th>
<th>4pm</th>
<th>6pm</th>
<th>8pm</th>
<th>10pm</th>
<th>MN</th>
<th>2am</th>
<th>4am</th>
<th>6am</th>
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**1st Week**

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<tr>
<th>DATE</th>
<th>6am</th>
<th>8am</th>
<th>10am</th>
<th>Noon</th>
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<th>4pm</th>
<th>6pm</th>
<th>8pm</th>
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**2nd Week**

<table>
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<tr>
<th>DATE</th>
<th>6am</th>
<th>8am</th>
<th>10am</th>
<th>Noon</th>
<th>2pm</th>
<th>4pm</th>
<th>6pm</th>
<th>8pm</th>
<th>10pm</th>
<th>MN</th>
<th>2am</th>
<th>4am</th>
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