

Sleep Screening Questionnaire

Patient Name: _____ Date: _____

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. Please check one box per line.

---CHANCE OF DOZING OFF---

Never	Slight	Moderate	High	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting and reading
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watching TV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting, inactivity in a public place (example, a theater)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a passenger in a car for an hour without a break
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying down to rest in the afternoon when circumstances permit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting and talking to someone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting quietly after lunch without alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In a car, while stopped for a few minutes in traffic

BRIEF SLEEP SYMPTOM CHECKLIST (Please check the boxes that best describes you)

Never	Rarely	Frequently	Always	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I snore loudly
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I awaken gasping or choking for breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I awaken in the morning unrefreshed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I have problems falling asleep or staying asleep (insomnia)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My sleep is very restless
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	My sleep is disturbed by unusual behaviors (for example: nightmares, sleep walking, dream enactments, tongue biting, bedwetting...etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I fall asleep while driving
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I've been told that I stop breathing in my sleep (told by _____)

Sleep Schedule (Please provide the following information)

What time do you go to bed on WEEKDAYS? _____AM or PM Do you nap? [YES] [NO]

What time do you get up on WEEKDAYS? _____AM or PM How often do you nap? _____time per week

What time do you go to bed on WEEKENDS? _____AM or PM How long are the naps? _____minutes

What time do you get up on WEEKENDS? _____AM or PM Do you awaken refreshed? [YES] [NO]

Are you a shift worker? [YES] [NO] If yes, what kind of shift do you work? _____

Sleep Problems Checklist (v04060)

Patient Name: _____ Date: _____

What problem causes you to seek our help and does it affect your life? _____

CHECK the box for each problem you CURRENTLY HAVE.

- | | |
|---|--|
| <input type="checkbox"/> Loud snoring with frequent awakenings | <input type="checkbox"/> Teethgrinding during sleep |
| <input type="checkbox"/> Crawling feelings in legs when trying to sleep | <input type="checkbox"/> Morning headaches |
| <input type="checkbox"/> Leg-kicking during sleep | <input type="checkbox"/> Morning dry mouth |
| <input type="checkbox"/> Leg cramps in sleep | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Trouble falling asleep at night | <input type="checkbox"/> Tongue biting in sleep |
| <input type="checkbox"/> Trouble staying asleep at night | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Racing thought when trying to sleep | <input type="checkbox"/> Acting out dreams |
| <input type="checkbox"/> Increased muscle tension when trying to sleep | <input type="checkbox"/> Uncontrollable daytime sleep attacks |
| <input type="checkbox"/> Fear of being unable to sleep | <input type="checkbox"/> Falling asleep unexpectedly |
| <input type="checkbox"/> Lying in bed worrying when trying to sleep | <input type="checkbox"/> Falling asleep at work |
| <input type="checkbox"/> Waking too early in the morning | <input type="checkbox"/> Falling asleep at school |
| <input type="checkbox"/> Sleep talking | <input type="checkbox"/> I use sleeping pills to help me sleep |
| <input type="checkbox"/> Sweating a lot at night | <input type="checkbox"/> I use alcohol to help me sleep |
| <input type="checkbox"/> Waking up with reflux (and/or heartburn) | <input type="checkbox"/> Pain interfering with sleep |
| <input type="checkbox"/> Waking up to urinate 2 or more times nightly | where is the pain? |
| <input type="checkbox"/> Nightmares | _____ |

For each symptom, please CHECK the boxes that BEST DESCRIBES YOU

Never Rarely Sometimes Usually Always

- | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | When falling asleep, I feel paralyzed (unable to move) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I feel unable to move (paralyzed) after a nap |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I have dream-like images (hallucinations) when I awaken in the morning even though I know I am not asleep |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I see vivid dream-like (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I am often unable to move (paralyzed) when I am waking up in the morning |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I get "weak knees" when I laugh |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I get sudden muscular weakness (or even brief periods of Paralysis, being unable to move) when laughing, angry, or in Situations of strong emotion |

Milepost Medical Adult Medical Questionnaire

Name: _____

Date: _____

Reason for today's visit:						
Past Medical History: Please mark if you or your family members have had any of the following:						
	Self	Father	Mother	Sibling	Child	Other
High Blood Pressure						
Heart Attack/Stent						
Heart Failure						
Arrhythmia						
High Cholesterol						
Diabetes						
Thyroid Problems						
Cancer (Type)						
COPD/Emphysema						
Asthma						
Sleep Apnea						
Stomach Ulcers						
Seizures						
Migraines						
Depression						
Anxiety						
Other Psychiatric Illness						
Alcoholism						
Kidney Problems						
Stroke or TIA						
Allergies/Hayfever						
Arthritis						
Osteoporosis/Fracture						
Anemia						
Other:						

Surgical History: Please mark if you have had any of these surgeries (what YEAR)	
Heart Bypass	
Angioplasty/Stents	
Pacemaker	
Appendix Removal	
Gallbladder Removal	
Tonsil Removal	
Hernia Repair	
Back Surgery	
C-Section	
Tubal Ligation	
Hysterectomy	
Vasectomy	
Breast Augmentation	
Mastectomy	
Breast Lump Removal	
Cataracts	
Joint Surgery (Type)	
Other:	

MEDICATIONS: Please list all prescription, over-the-counter, or supplement medications you are taking.				
Medication	Dosage	Frequency	Reason for Taking	Need refill today?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies to Medication/Food/Other: PLEASE DESCRIBE THE REACTION (rash, nausea, etc)				

**Milepost Medical
Adult Medical Questionnaire**

Name: _____

Are you CURRENTLY having any of the following symptoms?				
Fever		Wheezing		Arm/Leg Weakness
Chills				Joint Pain
Night Sweats		Nausea/Vomiting		Muscle Pain
Weight Loss		Diarrhea		Neck Pain
Weight Gain		Constipation		Back Pain
Fatigue		Abdominal Pain		Numbness/Tingling
Swollen Glands		Trouble Swallowing		Difficulty Walking
		Heartburn		
Vision Problems		Bloody/Black Stools		Fainting Spells
Eye Pain		Hemorrhoids		Headaches
Ringing in Ears		Loss of Appetite		Dizziness
Ear Pain				Seizures
Hearing Problems		Pain with Urination		
Nosebleeds		Blood in Urine		Depression/Anxiety
Sinus Pain/Drainage		Urgency to Urinate		Sleeping Difficulty
Sore Throat		Urinating 2x Per Night		Memory Problems
		Incontinence		Suicidal Thoughts
Chest Pain				Concentration Difficulty
Palpitations		Rashes/Hives		
Irregular Heartbeat		Nail Fungus		Infertility
Leg Swelling		Changing Mole		Vaginal Discharge
Varicose Veins				Breast Pain
Snoring		Excessive Thirst		Breast Lumps
Shortness of Breath		Excessive Hunger		Erectile Dysfunction
Cough		Heat/cold Intolerance		

Year of last test	Prostate (Males)	Colonoscopy	Cardiac Stress Test
	TB Test	Eye Exam	Dental Exam
	Bone Density	Mammogram	Pap Smear
Date of last vaccine	Flu:	Tetanus:	Pneumonia:
			Shingles:

<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	# of children:
Concerns about safety or abuse at home? Yes / No				Occupation:
Alcohol: (amount/type/frequency)	Coffee/Tea/Caffeine: (cups/day)		Smoking: <input type="checkbox"/> No <input type="checkbox"/> Current <input type="checkbox"/> Past/Quit Packs/day _____ # of yrs _____	

Females				
Menstrual flow: Regular / Irregular / Heavy		Days of flow:	Days between menses:	
1 st day of last cycle:	Number of pregnancies:	Number of live births:	Number of abortions:	Number of Miscarriages:
Pain after sex: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth control: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of birth control:	Name of Birth control:	

List any other physicians that you see and their specialty:

**Milepost Medical
Adult Medical Questionnaire**

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Marital Status: _____ Gender: M / F

Insurance Information:

Why do we ask for this? While we do not bill your insurance for our services, it is important that we know what your insurance coverage is to help make sure we refer you to services that are within your network. If you do not have insurance, just leave this section blank.

Insurance Company: _____

Policy Number: _____ Group Number: _____

Pharmacy Info:

Local Pharmacy Name: _____ Phone Number: _____

Location: _____

Mail Order Pharmacy Name: _____

Confidential Communication (Please check one):

I give permission for Milepost Medical to release medical information (or leave a message) to the following person(s):

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

I do not give permission for Milepost Medical to release information to anyone other than to myself.

In case of emergency, please let us know whom we may contact:

Name: _____ Phone #: _____ Relationship: _____

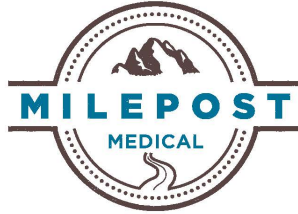
Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

How did you hear about us?

Family/Friend Internet Facebook Flyer Other _____

Physician Referral _____



Dr. Amie Stringfellow
18220 State Highway 249, Suite 335
Houston, Texas 77070

CONSENT TO EMAIL COMMUNICATIONS

I understand that Milepost Medical, P.A., uses electronic mail (email) to communicate with its patients for the limited purposes set forth below. I further acknowledge and understand that email may not be a secure communication and that there may be some level of risk that the information in the email could be read by a third party. I understand these risks and wish to receive communications from Milepost Medical, P.A., by email for the limited purposes described below notwithstanding such risks. I further understand that Milepost Medical, P.A., will not be responsible for any unauthorized access of my protected health information while in transmission to me based on my request for email communications. I also understand that Milepost Medical, P.A., is not responsible for safeguarding my protected health information once it is delivered to me.

I give my consent to Milepost Medical, P.A., to communicate with me by email for the limited purposes of providing appointment scheduling and appointment reminders, communicating about medical issues as initiated by me, and about my account information.

I understand that I will receive no email communications from Milepost Medical, P.A., except for the limited purposes described above unless otherwise required by law.

Please indicate below if Milepost Medical, P.A., has your permission to communicate with you by email for the limited purposes described above.

_____ Yes. You may communicate with me by email for the purposes described above.

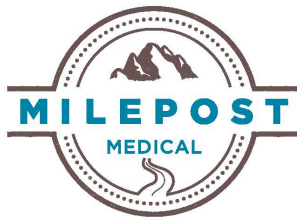
_____ No. Please do not communicate with me by email.

Signature of Patient/Patient Representative

Date

Relationship to Patient

Patient/Patient Representative's Email Address: _____



Dr. Amie Stringfellow ~ 18220 State Highway 249, Suite 335 ~ Houston, Texas 77070

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

To read Milepost Medical's Notice of Privacy Practices in its entirety, please visit our website at www.milepostmedical.com or ask for a copy in our office.

By signing below, you acknowledge that you have received access to the *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

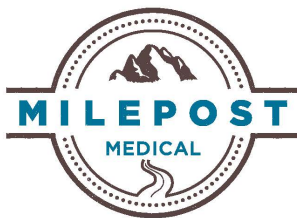
SIGNATURES:

Patient/Legal Representative: _____ **Date:** _____
(Signature)

Patient Name: _____ **Patient Date of Birth:** _____
(Please Print Name)

If Legal Representative, relationship to Patient: _____

Witness: _____ Date: _____



Dr. Amie Stringfellow
18220 State Highway 249, Suite 335
Houston, Texas 77070

MEDICAID PRIVATE PAY AGREEMENT: Patient understands Milepost Medical is accepting Patient as a private pay patient until cancelled in writing by either party, and Patient will be responsible for paying for any services Patient receives. The Physician will not file a claim to Medicaid for services provided to Patient.

MEDICARE PRIVATE PAY AGREEMENT: This agreement is between Dr. Amie Stringfellow ("Physician"), whose principal place of business is 18220 State Highway 249, Suite 335 Houston, Texas 77070 and patient [redacted] ("Patient"), who resides at [redacted]

[redacted] and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on **January 1, 2015** for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act. Physician agrees to provide the following medical services to Patient (the "Services"): Primary Care and Sleep Medicine services

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him. Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.

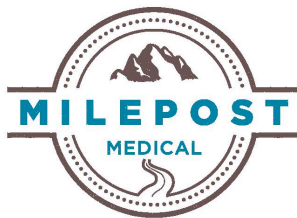
Executed on: _____

Patient Name

Patient Signature

Amie N. Stringfellow, M.D.
Physician Name

Physician Signature



Dr. Amie Stringfellow
18220 State Highway 249, Suite 335
Houston, Texas 77070

Authorization to Transfer Medical Records

Please send information including diagnosis and records of any treatment or examination rendered to _____ ("Patient"), DOB _____.

To: Milepost Medical
18220 State Highway 249, #335
Houston, TX 77070
Phone: 832.912.4820
Fax: 832.463.5065

From: _____

From: Milepost Medical
18220 State Highway 249, #335
Houston, TX 77070
Phone: 832.912.4820
Fax: 832.463.5065

To: _____

Reason for Transfer:

- Moving to a new area
- Transferring care to new physician
- Continuing care
- Continuing Sleep Medicine Care

Comments: _____

I hereby authorize you to release information including the diagnosis and records of any treatment or examination rendered to Patient to Amie Stringfellow, M.D. during the period from _____ to _____. I am aware that the records released may contain information relating to psychiatric or psychological testing, physical testing, physical abuse, or drug and alcohol abuse, and HIV/HTVL/AIDS results.

Patient or Guardian Signature Date

Relationship to patient, if guardian signed

Witness Date