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	
☐	☐	☐	☐	Sitting and reading
☐	☐	☐	☐	Watching TV
☐	☐	☐	☐	Sitting, inactivity in a public place (example, 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

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

Never	Rarely	Frequently	Always	
☐	☐	☐	☐	I snore loudly
☐	☐	☐	☐	I awaken gasping or choking for breath
☐	☐	☐	☐	I awaken in the morning unrefreshed
☐	☐	☐	☐	I have problems falling asleep or staying asleep (insomnia)
☐	☐	☐	☐	My sleep is very restless
☐	☐	☐	☐	My sleep is disturbed by unusual behaviors (for example: nightmares, sleep walking, dream enactments, tongue biting, bedwetting…etc.)
☐	☐	☐	☐	I fall asleep while driving
☐	☐	☐	☐	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.

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

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

Never	Rarely	Sometimes	Usually	Always	
☐	☐	☐	☐	☐	When falling asleep, I feel paralyzed (unable to move)
☐	☐	☐	☐	☐	I feel unable to move (paralyzed) after a nap
☐	☐	☐	☐	☐	I have dream-like images (hallucinations) when I awaken in the morning even though I know I am not asleep
☐	☐	☐	☐	☐	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
☐	☐	☐	☐	☐	I am often unable to move (paralyzed) when I am waking up in the morning
☐	☐	☐	☐	☐	I get “weak knees” when I laugh
☐	☐	☐	☐	☐	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?
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐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:**

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

Females				
Menstrual flow: Regular / Irregular / Heavy		Days of flow:	Days between menses:	
1st day of last cycle:	Number of pregnancies:	Number of live births:	Number of abortions:	Number of Miscarriages:
Pain after sex: ☐Yes ☐No	Birth control: ☐Yes ☐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 _____ ("Patient"), who resides at _____ 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