MARGARET MIKE, MD
NEW PATIENT INTAKE SHEET

Patient Name: _____ Date of Birth: _____

What city would you be traveling from? _____Which office do you want to schedule? Bedford or Plano

Contact Phone #s_____ email address _____

Address_____City_____ Zip Code_____

Insurance Company_____

How did you hear about Dr. Mike? _____

Who is your primary care physician? _____ PCP phone _____

Have you ever had a Sleep Study done? Yes or No***If Yes must obtain copy before appointment***

When?_____ Where?_____ Physician _____

Do you have a CPAP? Yes or No currently using? _____ If "yes:" who is your DME company?_____

What are your symptoms? (Circle all that applies)

1. Snoring
2. Apnea/stop breathing in sleep
3. Sleepiness during the day
4. Insomnia/trouble falling/staying asleep at night
5. Restless leg syndrome
6. Sleep walk/acting out dreams
7. Narcolepsy
8. Screening for sleep apnea or DOT compliance letter
9. Other/ recent hospitalizations_____
10. On CPAP/Bi-level, need supplies/ unit replaced

How would you like to be contacted to schedule your appointment? Call __ Email __

What are the concerns, reasons, problems that you or your spouse have about your sleep (too much, too little, too active) and/or tiredness/sleepiness during the day? Something else? Perhaps you have been evaluated before for this problem- has it gotten better, worse, or changed? What are your goals for your appointment? Please put the most important one first. Tell me more. Please help me help you.

_____
_____
_____
_____
_____
_____
_____
_____
_____

What treatments have you tried or been prescribed? Did it help? Side effects? Have you been evaluated for this /these problems before? When and where? What are you using/doing currently for this problem?

_____
_____
_____
_____
_____
_____

Office Use only: MRN: Appt date/time Pri 1 2 3

Sleep History

Do you now, or did you in the past, describe yourself as ☐ morning person ☐ evening person ☐ other _____

Usual bedtime on workdays: _____ am/pm Hour of arising on work days : _____ am/pm

Usual bedtime on days off: _____ am/pm Hour of arising on days off: _____ am/pm

Usual amount of sleep on workdays: _____ Usual amount of sleep on days off: _____

Time it takes to fall asleep: _____ How much sleep per night do you think you need?_____

Do you have awakenings during sleep? ☐ Yes ☐ No Number _____ usual length_____

specific causes_____

Do you wake up to urinate during the night? ☐ Yes ☐ No How often? _____

Do you ☐ have heartburn or reflux ☐bed partner waking you

Briefly describe: _____

If you have trouble falling asleep:

Are you sleepy but cannot fall asleep? ☐ Yes ☐ No

Are you wide awake because your body clock isn't ready to sleep yet? ☐ Yes ☐ No

During the time it takes you to fall asleep, do you:

Have thoughts racing through your mind? ☐ Yes ☐ No

Worry about things? ☐ Yes ☐ No

Worry about getting a good night sleep? ☐ Yes ☐ No

Notice that parts of your body startle or jerk? ☐ Yes ☐ No

Experience creeping, crawling, or aching feeling in your legs and/or ability to keep your legs still? ☐ Yes ☐ No

Do your legs twitch or jerk? ☐ Yes ☐ No

Experience any pain or physical discomfort? ☐ Yes ☐ No

Do you currently:

Sleep with a bed partner? ☐ Yes ☐ No

Talk, yell, or scream out in your sleep? ☐ Yes ☐ No Walk in your sleep? ☐ Yes ☐ No

Punch kick or act out your dreams? ☐ Yes ☐ No

Do you consider yourself a restless sleeper? ☐ Yes ☐ No

Are your bed covers a mess in the morning? ☐ Yes ☐ No

Grind your teeth in your sleep? ☐ Yes ☐ No

How much time do you spend in bed after waking up in the morning? _____

During the first 30 minutes after waking up, do you usually feel: ☐ very groggy, ☐somewhat groggy, ☐slightly drowsy but awake, ☐alert?

Is this different from what is used to be? ☐ Yes ☐ No

Since the beginning of your sleep problem have you slept away from home? ☐ Yes ☐ No

Is your sleep usually different? Describe._____

Do you snore? ☐ Yes ☐ No If yes:

When did you first begin to snore? _____(years ago)

Has there been a recent change in your snoring? ☐ Yes ☐ No

Do you snore most of the night? ☐ Yes ☐ No

Do you snore almost every night? ☐ Yes ☐ No

Does your snoring disturb others? ☐ Yes ☐ No Describe _____

My usual sleeping position is ☐ back, ☐ side, ☐ stomach.

Does your sleeping position affect your snoring/breathing? ☐ Yes ☐ No
Do you sleep on ☐a conventional mattress, ☐air matress, ☐ other _____
Have you awakened yourself with the sound of your own snores? ☐ Yes ☐ No
Have you awakened feeling short of breath while you were sleeping? ☐ Yes ☐ No
Do you breathe through your mouth while you are sleeping? ☐ Yes ☐ No
Do you wake up with a dry mouth? ☐ Yes ☐ No
Do you wake up with a headache? ☐ Yes ☐ No
Do allergies affect your snoring? ☐ Yes ☐ No

Are you sleepy during the day? ☐ Yes ☐ No
When did daytime sleepiness begin? _____(Months/years ago)
What time of the day do you nap or "drag"? _____
Are you sleeping during the day that your work or other activities are affected? ☐ Yes ☐ No
Do you get sleepy while inactive (working at a computer, meetings, watching TV, reading etc.)? ☐ Yes ☐ No
Have you sometimes falling asleep at inappropriate times such as while driving, eating, or during conversation? ☐ Yes ☐ No
Do you feel tired and exhausted during the day? ☐ Yes ☐ No
When do you function best ☐morning ☐ afternoon ☐ midday ☐ early evening

Do you take naps? ☐ Yes ☐ No If yes:
Do you take planed naps (deliberately decide to sleep for a short time)? ☐ Yes ☐ No
If yes, how many per week? _____How many times per day? _____ usual length of nap? _____
Do you have spontaneous naps (unintentional, head nods) (in the middle of watching TV, reading, riding in a bus or car etc.)? ☐ Yes ☐ No
If yes how many days per week _____how many times per day _____usual length of nap?_____
Are naps refreshing? ☐ Yes ☐ No
Are naps followed by grogginess? ☐ Yes ☐ No
Do you dream during naps? ☐ Yes ☐ No
Did naps affect nighttime sleep? ☐ Yes ☐ No

Have you ever done something but not realize until later that you had done it? ☐ Yes ☐ No
Have you ever experienced sudden weakness in your legs, face, etc, while awake (which are triggered by strong emotional situations such as laughter, anger, or surprise)? ☐ Yes ☐ No
Have you ever felt paralyzed or unable to move your whole body except your eyes when waking up from sleep or while falling asleep? ☐ Yes ☐ No
Have you ever had hallucinations or dreamlike images that you can see or hear before you fall asleep? ☐ Yes ☐ No

Medical history and review of systems

Current weight _____ current height _____
weight six months ago _____
weight one year ago _____
weight five years ago _____
weight 10 years ago _____
weight 20 years ago _____

Do you get or are you treated for:
☐sinusitis ☐seasonal/chronic allergies ☐shortness of breath ☐asthma ☐chronic cough ☐bronchitis ☐COPD ☐emphysema ☐chest pain ☐ diabetes ☐high blood pressure ☐palpitations ☐heart disease ☐kidney disease ☐gallbladder disease☐ heartburn/ reflux ☐ prostate disease ☐impotence ☐menstrual problems ☐menopause ☐joint

pain or stiffness ☐muscle aches or cramps ☐back pain ☐thyroid disease☐ anemia☐ loss of consciousness ☐head injury ☐seizures or convulsions ☐severe headaches ☐ chronic fatigue syndrome ☐ fibromyalgia ☐depression ☐ high cholesterol/triglycerides ☐ anxiety disorder ☐low hormone
Have you ever broken your nose or other facial bones? ☐ Yes ☐ No
Do you have difficulty breathing through your nose? ☐ Yes ☐ No
Do you have chronic allergies or seasonal? _____

Psychiatric

Have you ever been treated with medication for depression? ☐ Yes ☐ No
Have you ever been hospitalized for psychiatric or psychological problems? ☐ Yes ☐ No
Have you ever had periods where you have especially high levels of energy which last for a few days at a time? ☐ Yes ☐ No
Do you have bipolar disorder? ☐ yes ☐ no
Do you often experience periods of anxiety? ☐ Yes ☐ No
List any other illnesses or symptoms not covered above

_____
_____

Medications

List any food drink medications a recreational drugs taken within two hours of going to sleep

_____
_____
_____
_____

Allergies
Are you allergic to ☐penicillin ☐sulfa ☐aspirin ☐foods ☐dust/pollen ☐codeine ☐morphine ☐latex
☐other_____

Personal History

Do you

☐smoke cigarettes	packs per day _____	How many years? _____
☐smoke cigars or pipe	number per day _____	How many years? _____
☐drink beer or wine	How much and when _____	
☐drink liquor	How much and when _____	
☐drink coffee (caffeinated)	How much and when _____	
☐drink tea (caffeinated)	How much and when _____	
☐drink colas (caffeinated)	How much and when _____	
☐drink other sodas (caffeinated)	How much and when _____	

☐recreational drugs (marijuana, cocaine, speed, etc.)?
Any recent change in intake of above (cigarettes alcohol, etc) ☐ Yes ☐ No
If yes, describe _____
Have you smoked cigarettes, cigars, pipes, or chewing tobacco in the past? ☐ Yes ☐ No
If yes amounts note in number of years _____
When did you quit? _____

Did you have any problems in school? ☐ Yes ☐ No
If yes, describe (focusing, sleepiness, etc) _____
Highest grade or degree completed _____
Vocational/ college, list major _____

Did you serve in the military? ☐ Yes ☐ No Dates of service _____
Are you retired ☐ Yes ☐ No Disabled? ☐ Yes ☐ No
List current and recent occupations, and dates

1. _____
2. _____
3. _____

Does your work require travel? ☐ Yes ☐ No
Do you enjoy your work? ☐ Yes ☐ No if no explain _____
Have/does your sleep related issues or sleepiness impact your functioning at work? ☐ Yes ☐ No
Have you ever been fired or quit work because of the sleep disorder or medical problem? ☐ Yes ☐ No
If yes describe _____
Marital Status: ☐ single ☐ married ☐widowed ☐separated ☐divorced
Date of marriage(s) _____
If more than one give dates durations and it ended in divorce or death

1._____
2._____
3._____

Who is living with you now? Spouse or children or pets etc.

_____

Your children: name, age, health, from which marriage, if deceased cause of death

1. _____
2. _____
3. _____
4. _____

Medications

Do you take over the counter medications/aids for:
Sleep_____
Allergies_____
Heartburn _____
Other _____

List your **present medications**:
Name: _____ strength_____ amount _____reason_____ how long_____
Name: _____ strength_____ amount _____reason_____ how long_____
Name: _____ strength_____ amount _____reason_____ how long_____
Name: _____ strength_____ amount _____reason_____ how long_____
Name: _____ strength_____ amount _____reason_____ how long_____

List **previous** medications taken in the past five years for sleep/alertness/anxiety-depression :
Name: _____ strength_____ amount _____reason_____ how long_____
Name: _____ strength_____ amount _____reason_____ how long_____
Name: _____ strength_____ amount _____reason_____ how long_____
Name: _____ strength_____ amount _____reason_____ how long_____

Childhood:
Was your birth complicated? ☐ Yes ☐ No
Did you consider yourself a normal, healthy child? ☐ Yes ☐ No
Operations as a child: _____
Head injuries/Seizures as a child: _____
Serious illness/injury as a child: _____

Surgery/Surgical History

Have you had a tonsillectomy ☐ Yes ☐ No how old were you? _____
Have you had nasal/sinus/septal surgery ☐ Yes ☐ No how old for you? _____
Have you had soft palate, shortened/pillar implants/UPPP ☐ Yes ☐ No how old for you? _____
Have you had any other ENT procedures ☐ Yes ☐ No how old for you? _____
Have you had weight loss procedure (surgery/revisions) ☐ Yes ☐ No

Type_____ Weight _____Year_____
Type_____ Weight _____Year_____
Type_____ Weight _____Year_____

Adulthood:

Operations?
Procedure _____ when? _____
Procedure _____ when? _____
Procedure _____ when? _____
Procedure _____ when? _____
Procedure _____ when? _____
Other hospitalizations? Give date and reason
_____
_____

Family history

	Age	health	If deceased, age and cause of death
Mother	_____		_____
Father	_____		_____
Brother	_____		_____
Brother	_____		_____
Brother	_____		_____
Sister	_____		_____
Sister	_____		_____
Sister	_____		_____

Diseases in your immediate family (do not include yourself) check yes

☐trouble getting to you are staying asleep	☐Mother ☐Father ☐sibling
☐sleepiness during the day	☐Mother ☐Father ☐sibling
☐restless or jerking legs at night	☐Mother ☐Father ☐sibling
☐loud snoring	☐Mother ☐Father ☐sibling
☐trouble breathing at night/ apnea	☐Mother ☐Father ☐sibling
☐ emotional or psychiatric problems	☐Mother ☐Father ☐sibling
☐suicides or suicide attempts	☐Mother ☐Father ☐sibling
☐drug or alcohol problems	☐Mother ☐Father ☐sibling
☐stroke	☐Mother ☐Father ☐sibling
☐cancer, tumors	☐Mother ☐Father ☐sibling
☐diabetes	☐Mother ☐Father ☐sibling
☐high blood pressure	☐Mother ☐Father ☐sibling
☐heart problems	☐Mother ☐Father ☐sibling
☐seriously overweight	☐Mother ☐Father ☐sibling
☐allergies	☐Mother ☐Father ☐sibling
☐thyroid gland disease	☐Mother ☐Father ☐sibling

Questions For Current/Past PAP Patients **CPAP SUPPLIER_____**

1. When were you first diagnosed with Obstructive Sleep Apnea? _____
2. Weight at the time? _____ When did you start CPAP/Bilevel? _____
3. When was your last titration with nasal CPAP/Bilevel, and what was your weight?
   Last Time_____ Weight at the time_____
4. What is your current CPAP/Bilevel pressure? _____ Not Sure____
5. Has your weight changed since you were last titrated? _____lbs. Up/Down
6. When using the CPAP/Bilevel:

	With CPAP/Bilevel	Without CPAP/Bilevel
1. Do you snore?	☐Yes ☐No	☐Yes ☐No
2. Have gasping/choking awakenings?	☐Yes ☐No	☐Yes ☐No
3. Unexplained awakenings?	☐Yes ☐No	☐Yes ☐No
4. Trips to the bathroom at night? How many? _____	☐Yes ☐No	☐Yes ☐No

7. When using the CPAP/Bilevel do you experience the following:

1. Do you "drag" midday?	☐Yes ☐No	☐Yes ☐No
2. Difficulty Concentrating?	☐Yes ☐No	☐Yes ☐No
3. Decreased Energy?	☐Yes ☐No	☐Yes ☐No
4. Trouble with Memory?	☐Yes ☐No	☐Yes ☐No
5. Trouble staying awake if passive? (reading/watching tv)	☐Yes ☐No	☐Yes ☐No

8. When using The CPAP/Bilevel:
   1. Do you experience nasal dryness? ☐Yes ☐No
   2. Congestion? ☐Yes ☐No
   3. Trouble exhaling? ☐Yes ☐No
   4. Air swallowing, burping, bloating next morning? ☐Yes ☐No
9. Are you having problems with your mask/pillows?(Discomfort/Leaks/Pressure) Please describe:_____
   _____
10. **per night** do you use your CPAP/Bilevel? _____hours
11. How many **hours per week** do you use your CPAP/Bilevel? _____hours
12. Other problems, symptoms, or comments that might be useful for us to know?
    _____
    _____