South Valley Sleep Center
18740 Ventura Blvd ste 205,
Tarzana, CA 91356

PATIENT DEMOGRAPHICS

Patient Last Name * _____

Patient First Name * _____

Social Security Number _____

Patient DOB * _____

Patient Address * _____

City * _____

State, Zip * _____

Patient Home Number * _____

Patient Cell Number * _____

Email Address: * _____

Emergency Contact * _____

Relationship * _____

Emergency Phone * _____

Primary Insurance _____

Insurance Member ID * _____

Referring Physician _____

• I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

• I authorize the release to my DME provider or referring/consulting/primary care physician of any information that may be needed.

• I authorize the facility named above to obtain a photograph for my medical records.

• I hereby authorize all payments of insurance benefits to go directly to this even if it is made payable to me. I understand that any allowed charges not fully paid by my insurance will be my responsibility and will be billed accordingly.

• I authorize the sleep center staff to perform necessary service I may need.

• I acknowledge that I have been given the option to read "Notice of Privacy Practices".

• I hereby authorize and request the release of my medical records to and from this facility

PATIENT SIGNATURE : _____

DATE _____

South Valley Sleep Center
18740 Ventura Blvd ste 205,
Tarzana, CA 91356

MODIFIED EPWORTH SLEEPINESS SCALE

Please complete the following information in your estimation of the chances of dozing in the following situations. (Even if none of these things have occurred recently, try to work out how they would have affected you.)

Sitting and reading	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing
Watching TV	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing
Sitting, inactive in a public place (e.g., a theater)	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing
As a passenger in a car for an hour without a break	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing
Lying down to rest in the afternoon when circumstances permit	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing
Sitting and talking to someone	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing
Sitting quietly after lunch without alcohol	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing
In a car, while stopped for a few minutes in traffic	☐ 0-would never doze	☐ 1 - slight chance of dozing
	☐ 2 - moderate chance of dozing	☐ 3 - high chance of dozing

PLEASE ADD ALL OF THE NUMBERS NEXT TO YOUR ANSWERS ABOVE AND CHOOSE FROM THE TOTAL BELOW	☐ 1	☐ 2
	☐ 3	☐ 4
	☐ 5	☐ 6
	☐ 7	☐ 8
	☐ 9	☐ 10
	☐ 11	☐ 12
	☐ 13	☐ 14
	☐ 15	☐ 16
	☐ 17	☐ 18
	☐ 19	☐ 20
	☐ 21	☐ 22
	☐ 23	☐ 24

South Valley Sleep Center
18740 Ventura Blvd ste 205,
Tarzana, CA 91356

SLEEP AND MEDICAL HISTORY

General Sleep:

Please rate how often you or others have noted that you:

Snore	☐ Never ☐ Frequently	☐ Occasionally
Snore loudly enough that others complain	☐ Never ☐ Frequently	☐ Occasionally
Awaken from sleep feeling short of breath, gasping, or choking	☐ Never ☐ Frequently	☐ Occasionally
Hold your breath or stop breathing while asleep	☐ Never ☐ Frequently	☐ Occasionally
Experience other breathing problems at night	☐ Never ☐ Frequently	☐ Occasionally
Have headaches upon waking that improve in less than 2 hours	☐ Never ☐ Frequently	☐ Occasionally
Sweat excessively at night	☐ Never ☐ Frequently	☐ Occasionally
Have dry mouth upon waking	☐ Never ☐ Frequently	☐ Occasionally
Experience heart pounding or beating irregularly during the night	☐ Never ☐ Frequently	☐ Occasionally
Feel sleepy or tired during the day	☐ Never ☐ Frequently	☐ Occasionally
Awaken feeling unrested or unrefreshed	☐ Never ☐ Frequently	☐ Occasionally
Get sleepy while driving	☐ Never ☐ Frequently	☐ Occasionally
Have had a wreck due to sleepiness	☐ Never ☐ Frequently	☐ Occasionally
Have trouble at work or school because of sleepiness	☐ Never ☐ Frequently	☐ Occasionally
Become irritable or “crabby”	☐ Never	☐ Occasionally

	☐ Frequently	
Experience decrease in memory or concentration abilities	☐ Never ☐ Frequently	☐ Occasionally
Fall asleep involuntarily or suddenly or in awkward situations	☐ Never ☐ Frequently	☐ Occasionally
Experience sudden weakness, buckling of knees or facial heaviness when laughing, scared, angry or crying	☐ Never ☐ Frequently	☐ Occasionally
Feel totally unable to move (paralyzed) when first waking or falling asleep	☐ Never ☐ Frequently	☐ Occasionally
Have nightmares or night terrors	☐ Never ☐ Frequently	☐ Occasionally
Walk in your sleep	☐ Never ☐ Frequently	☐ Occasionally

Do you have other medical condition(s)?	☐ Yes	☐ No
If yes, what condition(s):	_____	
Do you take medications?	☐ Yes	☐ No
If yes, please list:	_____	
Do you have a heart condition(s)?	☐ Yes	☐ No
If yes please list them:	_____	
Have you have any surgery?	☐ Yes	☐ No
If yes please list them:	_____	
Have you lost or gained weight in the past 6 month?	☐ Yes	☐ No
If yes, Please describe:	_____	
Have you ever had a sleep study before?	☐ Yes	☐ No
If yes, Where? When?	_____	
Have you ever used CPAP/BiPAP before?	☐ Yes	☐ No
If yes, What pressure:	_____	
Are you on supplemental Oxygen?	☐ Yes	☐ No
If yes, How many LPM?	_____	