Mountain Heart™
Sleep Facility

# Sleep Study Information Packet

Patient Name:

_____

Thank you for scheduling your sleep study with us. At Mountain Heart we truly care about our patients and we want you to feel comfortable with your scheduled testing. In order to maximize your knowledge of care and understanding, we have scheduled the following appointments for you:

Your Sleep Study is scheduled for:

Date:_____at _____

Your follow up appointment to review the results of the study is scheduled for:
Date:_____at _____

**Please allow 10-14 business days for this sleep study to be read by our sleep doctor and faxed to your referring physician.**

## Sleep Study Instructions

1. Please be here at your scheduled appointment time. **Please note that we are not able to accommodate patients earlier than the designated appointment time. Please do not plan to arrive prior to your scheduled appointment.**
2. Keep a regular sleep routine the night before your test. It is important to stay awake at least 12 hours before your test is scheduled to start. **DO NOT NAP.**
3. Bring a current list of all your medications. **IF YOU TAKE ANY MEDICATIONS AT NIGHT OR IN THE AM, PLEASE BRING THEM WITH YOU. NO MEDICATIONS WILL BE PROVIDED BY THE STAFF. Let your Sleep Technician know if you will be taking a sleep aid upon your arrival, they will instruct you further.**
4. **Do not use any alcohol or caffeine after 2:00 p.m.** on the day of your test, unless instructed todo so by your physician.
5. **Refrain from using any hair gels or spray.** We recommend bringing a scarf or hat to wear when leaving.
6. **No creams or lotions on your face or legs.**
7. **No make-up or foundation.**
8. **Minimize jewelry**, especially necklaces or earrings.
9. **Remove nail polish,** at least off one finger.
10. Most patients are ready to leave between 5:00 a.m. and 6:00 a.m. **Please arrange for pick-up at this time if you did not drive yourself.**
11. Bring pajamas or something comfortable to sleep in. Sleeping **nude or in underwear is not acceptable.**
12. Males are asked to be **clean-shaven** (where you normally shave) upon arrival for testing.
13. This is not an invasive procedure. You may drive yourself; no medications will be administered to you at the lab.
14. Pillows and blankets will be provided.
15. Alcohol, smoking, and vaping are not permitted inside the building.

## Sleep Study Information Packet

**Sleep Study Check List**

_____Eat Dinner
_____Shower/Shave
_____Hair is Washed & Clean
_____Paperwork Signed & Completed?
_____Medications Packed
_____CPAP Mask Packed (if applicable)
_____Dental Device packed (if applicable)
_____Pajamas Packed
_____Toiletries
_____Slippers or flip-flops
_____Snacks Packed (if needed)

**What You Can Expect:**

When you arrive for your sleep study, please enter through the WEST entrance of the building, the technician will greet you and then take you to your room. You will be asked to change into your nightclothes and complete any necessary paperwork. You will have a chance to use the restroom & prepare for bed. Once you are ready for bed the sleep tech will begin to place small sensors on your head/face/legs with tape and cream. The sensors are then plugged into a machine that will monitor your sleep. During the night if you need to use the restroom you will call the sleep tech to assist in disconnecting you from the monitors. There will be a camera in your room to monitor your body movements. The technician will be outside your room the entire night. You will leave at approximately between 5:30 A.M. and 6:00 A.M. the following morning. Please arrange for a pick-up at this time if you did not drive yourself.

**What A Sleep Study Shows:**

The Sleep study monitors all stages of sleep. To do this, the following are recorded:

- Eye Movements
- Heart Rate, Brain Waves, Muscle Activity
- Level of oxygen in your blood
- Breathing and snoring
- Sudden leg or body movements

If you have breathing problems, a CPAP (Continuous Positive Airway Pressure) machine may be used. CPAP is a device that can help you breathe and improve your sleep. It may be used during the second half of your study or on another night.

**Can my family member stay with me during my sleep study?**

- NO. Only if a special need has been determined and requested by your physician may a family member stay with you during your sleep study or if prior approval was obtained through the sleep lab.
- Pediatric patients, under 18 years of age, must have a parent/caregiver present at all times.
- Having a guest in the room with you during your sleep study is disruptive and may result in faulty and/or incomplete data

Our building is locked at night. A doorbell is located to the right of the door. Push the red button and a technician will let you in (allow for a few minutes for him/her to get to answer.)

**In case of Emergency, you can be contacted during your sleep study by a family member at 928-226-6406**

Mountain Heart™
Advanced Technologies. Hands On Care.

# WELCOME TO MOUNTAIN HEART

Dear New Patient,

Welcome to Mountain Heart Cardiovascular Care Center and Accredited Sleep Facility. It is our pleasure to serve you. Our goal is to provide you with exceptional customer service in a safe healthcare environment that emphasizes the importance of being proactive about your health. We strive to meet all of your heart care needs and provide you with the highest quality care at the lowest price point possible.

Please take a moment to complete the attached patient information and at your convenience, review our complete office policies and learn about additional services we offer online at www.mountainheartcares.com. If there is anything we can do to improve your experience at any point, please do not hesitate to let us know.

In our efforts to maintain cost efficient care and stay on-time during clinic, we need your help. The following policies help us to ensure an on-time visit, and avoid any financial surprises:

1) **CANCELLATION POLICY:** All patients are required to provide 48 hour cancellation notice. This policy allows us to fill any vacant appointments with a patient that needs to be seen urgently. Multiple cancellations without notice may be cause for termination from the practice.
2) **ZERO TOLERANCE NO SHOW POLICY:** Mountain Heart does not permit missed appointments without notification to the practice. No show appointments cause a burden on the practice and limit our provider's ability to see urgent patients. After three no-show appointments within a 12 month period, patient accounts will be reviewed and may result in dismissal from the practice.
3) **CO-PAYS/DEDUCTIBLES:** For the benefit of our patients we accept all insurances. We recomend that you check with your insurance company to verify that our providers are on the contracted provider list. As part of our contract with insurance companies we are legally required to collect co-pays and deductibles from you at the time of service. We ask that you be prepared to pay your co-pay and deductible at the time of the visit. We will accept cash, check, money order or credit card.

Please arrive 15 minutes before your appointment to allow time for registration. If you are late for your appointment we may need to reschedule.

We appreciate your help in maintaining our low costs and look forward to participating in your healthcare needs. Again, welcome to Mountain Heart.

Sincerely,

Your Mountain Heart Care Team
Dr. Kent Winkler, MD, FACC, FSCAI
Medical Director

Mountain Heart™

2000 S. Thompson St., Flagstaff, AZ 86001, Ph (928) 226-6400

# HIPAA NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

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**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students licensing, fundraising and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

**Other Permitted and Required Uses and Disclosures** will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS:** The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health Information (fees may apply)** - Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** - This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in fun. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications** - You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternative i.e. electronically.

**You have the right to request an amendment to your protected health Information** - If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures** - You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

**Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

Mountain Heart™
Sleep Facility

## Patient Bill of Rights and Responsibilities

**You the patient have the right** to have all of your questions answered prior to the test being done.

**You the patient have the right** to assistance in completing the forms provided by the sleep program, this may include having a technologist sit with you and discuss the forms, read them to you, and or write your responses for you.

**You the patient have the right** to have a family member accompany you to the sleep study and stay with you until it is time for the study to begin.

**You the patient have the right** to feel safe when sleeping in the facility.

**You the patient have the right** to voice any concerns you have regarding the services, the facility or the staff.

**You the patient have the right** to participate in decisions made regarding your care.

**You the patient have the right** to personal privacy while in the facility and to know that any information gathered in the process will be kept private .

## Responsibilities

**You the patient have a responsibility** to provide accurate and complete information regarding your present medical/sleep history, past history, hospitalizations, medications and other matters related to your health.

**You the patient have a responsibility** to voice any concerns that you have about the care provided to you.

**You the patient have a responsibility** to ask any and all questions that you might have about the sleep study and follow-up process.

**You the patient have a responsibility** to follow the treatment plan prescribed; and, if you are unable, or unwilling, you must notify us or your physician.

**You the patient have a responsibility** to accept consequences when you do not complete the sleep study or follow prescribed treatment.

**You the patient have a responsibility** to be respectful of the staff and your surroundings while in the facility.

**You the patient have a responsibility** to meet financial obligations that result from this service.

Mountain Heart™
2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

## PATIENT INFORMATION

Last Name First Name M.I.

Mailing Address City State Zip

Date of Birth Sex M F Soc. Sec. # Marital Status S M W D

Hm Ph # Wk Ph # Cell Ph. #

Primary Language Race Ethnicity

This data may be used by healthcare providers and government agencies for benchmarking and other quality improvement measures. Responses are voluntary.

Patient Email Address

(We do not sell or advertise personal information) How do you prefer to be contacted for reminders? ❑ Phone ❑ Postal Mail ❑ E-mail

Spouse or Partner's Name Phone

Employers Name Phone

Referring Physician Name Phone

Primary Care Physician Name Phone

Pharmacy Name & Location Phone

How did you hear about us? ❑ Physician ❑ Hospital/ER ❑ Internet ❑ Newspaper ❑ Friend ❑ Television ❑ Dentist ❑ Other_____

## INSURANCE INFORMATION (Copy of Insurance Card(s) will be made)

### *Primary Insurance Info*

Insurance Company CoPay Amount

Member/Subscriber ID# Group #

Policy Holder Relationship to Patient Date of Birth

### *Secondary Insurance Info*

Insurance Company CoPay Amount

Member/Subscriber ID# Group #

Policy Holder Relationship to Patient Date of Birth

## EMERGENCY CONTACT INFORMATION

Name Phone # Relationship to Patient

***To Protect the privacy of all Mountain Heart Patients, I will not electronically record, photograph or duplicate patient health information or identity.***

## MEDICAL AUTHORIZATION AND RELEASE OF INFORMATION
## OFFICE VISIT COPAYS AND DEDUCTIBLES ARE DUE AT CHECK-IN

**As a courtesy to our patients, Mountain Heart will submit a claim to your insurance for you. However, this does not guarantee full coverage or non-covered services. I understand and agree that any non-covered charges incurred by me are solely my responsibility.**

I hereby authorize Mountain Heart to furnish the insured's insurance company all information which said insurance company may request concerning my present illness or injury. I hereby assign to the doctors all money to which I am entitled for medical and/or surgical expenses relative to the service performed. It is understood that any money received from the above-named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to said doctors for all charges. This authorization shall continue and be in full force and effect until revoked in writing by me. I understand that deductible and copays are due at the time of service and I am ultimately responsible for payment of all charges for services rendered and any incurred collection costs (40%) by any outside agency. **We accept VISA, MASTERCARD, AMEX and DISCOVER.**

Patient Signature Date

Guardian Signature (proof of guardianship will be obtained) Date

Mountain Heart™
2000 S. Thompson St., Flagstaff, AZ 86001, Ph (928) 226-6400

# ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Mountain Heart's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

| | |
|---|---|
| Patient Name (Type or Print) | Name/Relationship if signed by other than patient |
| Signature | Date |

Kent D. Winkler, MD, FACC, FSCAI
Medical Director

Mountain Heart™
Advanced Technologies. Hands On Care.

2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

# AUTHORIZATION FOR INFORMATION RELEASE

Patients/Legal Guardians:

By signing this form, you are giving our office staff permission to discuss (either by phone or in person) personal medical information with persons whom you have given permission to know your private medical history.

| Name | Relationship |
|---|---|
| Name | Relationship |
| Name | Relationship |

# ADVANCE DIRECTIVE ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____

Please check one of the following Statements:

- ❑ Five Wishes
- ❑ I Have Executed an Advance Directive
- ❑ A Living Will
- ❑ Designation of a Health Care Surrogate
- ❑ Durable Power of Attorney
- ❑ I Have Not executed an Advanced Directive, a Living Will, Durable Power of Attorney, Designation of a Health Care Surrogate.

Name of Designee:

Address: _____

_____

Relationship: _____

Telephone: _____

**(Please bring in a copy of any of the above documents for our records.)**

Patient Signature: _____ Date: _____

Mountain Heart™
A Northern Arizona Healthcare partner

# Medical Records Release Authorization

2000 S. Thompson St., Flagstaff, AZ 86001 Main (928) 226-6400 Fax (928) 226-6410

Patient Name_____Maiden Name_____SS#_____

Date of Birth_____Home Phone_____Cell/Work_____

Address_____City/State/Zip_____

Email Address:_____

**A) I hereby authorize records FROM:**

Name _____

Address _____

City/State/Zip_____

Phone #_____ Fax#_____

**B) To be released TO:**

Name Mountain Heart

Address 2000 S. Thompson St.

City/State/Zip Flagstaff, AZ 86001

Phone # 928-226-6400 Fax# 928-226-6410

**C) For the purpose of:**

___Litigation
___Insurance
___Self/Personal Copy
___Transfer or Continuity of Care
___Disabiltiy
___Work Comp
___Other

Date Range_____ to_____

- ❑ Physician Office Notes
- ❑ Immunizations
- ❑ Operative/Procedure Reports
- ❑ Other_____
- ❑ Cardiology/EKG Reports
- ❑ Lab/Path Reports
- ❑ Radiology/XRay/MRI Reports
- ❑ Minimum Necessary

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order assure treatment. I understand that any disclosure of information carries with it the potential for an authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

**I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.**

_____ _____****Subject to Fees**

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

This authorization will expire one year from the above date unless I specify an expiration date:_____

(Expiration date of authorization)

Mountain Heart
2000 S Thompson Street
Flagstaff, AZ 86001
Phone: 928 226-6400
Fax: 928 226-6410

# SLEEP MEDICINE HISTORY FORM

Name:_____ DOB:_____ Age:_____ Sex: M/F

Weight: _____ lbs Height:_____ ft _____in

Primary Care Provider: _____ Collar size (inches): _____

**Please circle the appropriate response**

## SLEEP ROUTINE:

1. What TIME do you GO TO BED? _____
2. How long does it take for you to fall asleep? _____
   What occurs during that time?_____
3. Do you frequently wake up in the middle of the night? YES/NO
   a. If YES, how many times? _____
   b. What is the reason for waking up during the night? _____
   c. How long does it take you to return to sleep? _____
4. What TIME do you WAKE UP in the morning? _____
5. Do you feel REFRESHED UPON WAKING UP? YES/NO
6. Do you take any
   a. Scheduled/Planned Naps YES/NO When_____ How Long_____
   b. Unscheduled/Unplanned Naps? YES/NO ___ When driving
      ___ When inactive
      ___ In conversations
   c. IF YES, Do you feel refreshed after the nap? YES/NO
7. Any change in sleep schedule on your DAYS OFF? _____
8. Have you recently had any change in your WEIGHT in the PAST 3 YEARS? GAINED/LOST How much? _____

9. Has anyone told you that you SNORE? YES/NO
   a. If YES, How LOUD? MILD/ MODERATE/ LOUD/ VERY LOUD
   Has anyone seen you STOP BREATHING or have pauses in breathing when you sleep? YES/NO
10. Do you wake-up from sleep with a CHOKING/GAGGING sensation? YES/NO
11. Has anyone told you that you MAKE SNORTING/GASPING noises in sleep? YES/NO
12. Do you wake up with a DRY MOUTH? YES/NO
13. Do you wake up with a HEADACHE? YES/NO
14. Do you DROOL on the pillow? YES/NO
15. Do you feel TIRED during the day? NO/ Mild/ Moderate/ Severe

# SLEEP MEDICINE HISTORY FORM

16. Do you have UNCOMFORTABLE SENSATIONS in your legs before bedtime? YES/NO
17. If YES, please describe them? _____
18. Do you have any of the following during sleep?
    a. SLEEPWALKING YES/NO
    b. SLEEP TALKING YES/NO
    c. FREQUENT NIGHTMARES YES/NO
    d. ACTING OUT DREAMS YES/NO

## SLEEP HYGIENE:

1. Do you do any of these activities in your bed/bedroom?
    a. WATCH TV YES/NO
    b. EAT YES/NO
    c. READ YES/NO
2. Do you drink coffee/caffeinated beverages? Never/Occasional/Moderate
3. SMOKING Never/Former/Current
4. Do you drink ALCOHOL? Never/Occasional/Moderate
5. Do you use illicit drugs? YES/NO Type_____

## MISCELLANEOUS:

1. When FALLING ASLEEP or WAKING UP
    a. Do you ever SEE or HEAR things? YES/NO
    If YES, DESCRIBE _____
    b. Do you ever FEEL PARALYZED? YES/NO
2. Do you ever feel SUDDEN MUSCLE WEAKNESS when you are laughing or surprised? YES/NO

## DRUG ALLERGIES: Check box if no known allergies to any medications ❑.

a. Drug name _____ - What Reaction?_____
b. Drug name _____ - What Reaction?_____
c. Drug name _____ - What Reaction?_____

## FAMILY HISTORY:

1. Does anyone in your family have sleep apnea, insomnia, restless legs, or narcolepsy? YES/NO _____
    a. If YES, who? _____

# SLEEP MEDICINE HISTORY FORM

**CURRENT MEDICATIONS:** Please list all of your current medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Have you ever had a SLEEP STUDY before?** NO/YES where?_____

**PAST MEDICAL HISTORY**

❏ Hypertension (high blood pressure)
❏ Heart attack
❏ Cardiac arrhythmias
❏ Atrial fibrilation
❏ Lung problems / COPD / Asthma
❏ Parkinson's disease
❏ Arthritis
❏ Depression / anxiety / bipolar
❏ Nasal allergies / nasal congestion
❏ Congestive heart failure
❏ Stroke / TIA
❏ Pulmonary hypertension
❏ Anemia / iron deficiency
❏ Seizures
❏ Autoimmune disease
❏ End stage kidney disease / dialysis
❏ Thyroid disease
❏ Diabetes
❏ Heartbum / reflux
❏ Fibromyalgia
❏ Menopause
❏ Cancer
❏ Broken nose
❏ Head injury
❏ Chronic Pain (reason)_____
Other:_____

**SURGERIES:**

Please list all your surgeries

_____

_____

_____

**REVIEW OF SYSTEMS:** Check the symptoms you frequently experience:

Const: ❏ Fever ❏ Feeling poorly ❏ Feeling tired ❏ Chills

ENT: ❏ Ear pain ❏ Frequent nosebleeds ❏ Sore throat ❏ Hearing loss ❏ Nasal discharge ❏ Hoarseness lasting more than 2 weeks ❏ Nasal congestion

Heart: ❏ Passing out ❏ Chest pain, tightness or pressure ❏ Palpitations ❏ Swelling of feet/ ankles

Resp: ❏ Shortness of breath ❏ Frequent cough for more than 2 weeks ❏ Wheezing

GI: ❏ Abdominal pain ❏ Difficulty swallowing/ food "sticking" ❏ Frequent heartburn/ indigestion ❏ Constipation ❏ Diarrhea ❏ Nausea ❏ Vomitting

MSK: ❏ Joint pain ❏ Joint swelling ❏ Joint stiffness ❏ Limb pain ❏ Limb swelling ❏ Muscle pain ❏ Back pain

Neuro: ❏ Frequent headaches ❏ Seizures ❏ Numbness/tingling ❏ Weakness ❏ Ringing in ear(s)

Behav: ❏ Anxiety ❏ Change in personality ❏ Sleep disturbance ❏ Depression

Hema: ❏ Swollen glands ❏ Easy bleeding ❏ Easy bruising

GU: ❏ Frequent need to urinate at night ❏ Incontinence ❏Sexual dysfunction/loss of libido

Mountain Heart™
Sleep Facility

Phone: 928 226-6400
Fax: 928 226-6410

2000 S Thompson St
Flagstaff, AZ 86001

# EPWORTH SLEEPINESS SCALE FORM

NAME_____ DOB_____ DATE_____

The test is a list of eight situations in which you rate your tendency to become Sleepy

Instructions: Be as truthful as possible.
Write down the number corresponding to your choice in the right hand column. Total your score below.

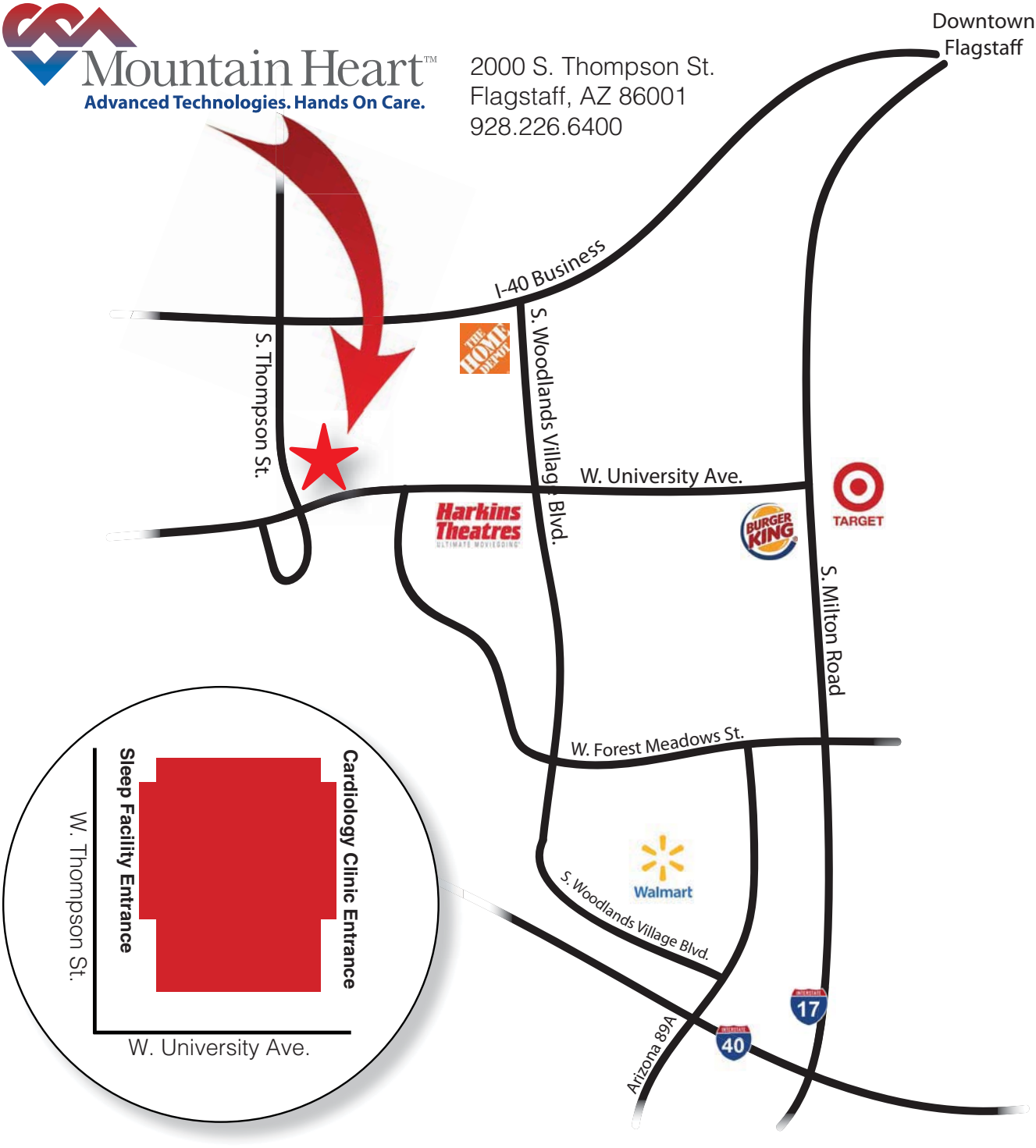
**No chance of dozing =0**
**Slight chance of dozing =1**
**Moderate chance of dozing =2**
**High chance of dozing =3**

| SITUATION | SCORE |
|---|---|
| Sitting and reading | |
| Watching TV | |
| Sitting inactive in a public place (e.g., a theater or a meeting) | |
| 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 a lunch without alcohol | |
| In a car, while stopped for a few minutes in traffic | |

Total Score = _____

Mountain Heart™
Advanced Technologies. Hands On Care.

2000 S. Thompson St.
Flagstaff, AZ 86001
928.226.6400




**From Page and the North:**
take 89 South into Flagstaff, continue onto the Business Loop 40 (you will see signs for I-40 W/US-66, W/Los Angeles). Turn left onto S Woodlands Village Blvd, at the light, turn right onto W University Ave, 3 blocks up, turn right into the parking lot at Mountain Heart.

**From Winslow and East:**
take I-40 West to I-17/89A North, keep right at the fork, continue on S Milton Rd. At W University Ave. take a left (there will be a Burger King where you will be turning), follow W University straight through the stop sign and traffic signal, 3 blocks up, turn right into the parking lot at Mountain Heart.

**From Williams and West:**
take I-40 East to I-17/89A (exit 195) North, bear left on the off ramp, continue on S Milton Rd. At W University Ave. take a left (there will be a Burger King where you will be turning), follow W University straight through the stop sign and traffic signal, 3 blocks up, turn right into the parking lot at Mountain Heart.