Sleep Disorder Center
of Panama City
502 N. MacArthur Avenue
Panama City, Florida 32401

Dr: Jesus M Ramirez. MD
PULMONARY - CRITICAL CARE
SLEEP-AWAKE MEDICINE

May use Adobe Acrobat to complete this document

DEMOGRAPHICS

Patient Name: _____Sex: _____
Last First MI

Date of Birth: _____ Age: _____ SSN: _____

Address: _____
City State Zip

Marital Status: S ☐ M ☐ D ☐ W ☐ Email: _____

Phone Number: Home- _____ Cell- _____

Communication Preference: _____Pharmacy: _____

Ethnicity: Hispanic/Latino Yes ☐ No ☐ Language fluently spoken: _____

Sexual Orientation: _____or Decline ☐ Race: _____

Gender Identification: _____or Decline ☐

Employment Status: Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐

Occupation: _____ Do you have insurance coverage? _____

Family Physician or Primary Care Physician: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Contact Number: 1) _____ 2)_____

Address: _____
City State Zip

Patient Signature: _____ Date: _____

The Sleep disorder Center of Panama City is Accredited and Certified by :

AMERICAN ACADEMY OF SLEEP MEDICINE

Setting Standards & Promoting Excellence in Sleep Medicine

Health and Sleep History

- My Main Complaint: _____
- Height: _____ Weight: _____
- Please check all that apply:

[ ] Excessive daytime fatigue	[ ] Difficulty falling asleep
[ ] Snoring	[ ] Legs jerk during sleep
[ ] Witnessed apnea (stop breathing in sleep)	[ ] Difficulty staying asleep

- Typical Bedtime: _____ Wake time: _____
- How long it takes to fall asleep: _____ min./hrs.
- Any sleeping medications taken: _____
- Number of times I wake up per night: _____
- On average when I wake up I feel: _____
- Shift worker: [ ] Yes [ ] No
- Please check all of the following statements that apply to your nighttime and sleep habits:

( ) I usually watch T.V. prior to going to sleep at night	
( ) I frequently travel across a time zone for work or daily activities	
( ) I drink alcohol prior to bedtime	
( ) I smoke prior to bedtime or when I wake up during the night	
( ) I eat or snack right before bedtime	
( ) I eat if I wake up during the night	
( ) I typically wake up during the night to use the restroom	
( ) I am unable to fall back asleep if I wake during the night	
( ) Thoughts start racing through my mind when I try to fall asleep	
( ) I wake up from a full night's sleep (approx. 6-8 hours) and do NOT feel rested	
( ) I have nightmares	( ) I kick or jerk my extremities while I sleep
( ) I sweat during sleep	( ) I can NOT sleep on my back
( ) I feel like I'm in a daze	( ) I wake up with a dry mouth
( ) I wake myself up snoring	( ) I am a restless sleeper
( ) I talk in my sleep	( ) I sleep walk
( ) I grind my teeth while I sleep	( ) I have fallen asleep while driving
( ) I experience a creeping, crawling, or tingling feeling in my arms, hands, or legs	
( ) I use CPAP or BIPAP	
( ) I wake up at night gasping for breath or feeling like I am choking	
( ) I have experienced a lapse in time or blackout	
( ) I normally fall asleep while watching T.V.	
( ) I have fallen asleep during a conversation	
( ) I fall asleep if I sit still somewhere for very long	
( ) I have experienced sudden muscle weakness in response to strong emotions	
( ) I have experienced an inability to move upon waking or when trying to fall asleep	
( ) I drink several caffeinated beverages a day	
( ) I feel depressed because I cannot sleep	
( ) I experience dream-like scenes while I'm awake	
( ) I wake up coughing or wheezing	

Epworth Scale

Use the following scale to choose the most appropriate number for each situation based on your usual daily activities. Circle the number that applies to you.

Scale: 0= No chance of dozing 1=Slight chance of dozing 2= Moderate chance of dozing 3= High chance of dozing	Chance of Dozing
Sitting and reading	0 1 2 3
Watching T.V.	0 1 2 3
Sitting inactive in a public place (e.g. theatre or meeting)	0 1 2 3
As a passenger in a car for an hour without stopping	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (with no alcohol)	0 1 2 3
In a car, while stopped a few minutes in traffic	0 1 2 3
Subtotal Epworth Score:	+ + + =
Epworth Score	

Medical and Social History

Please check all that apply and write any additional conditions not listed in the space below:

☐	Heart Disease	☐	Seizures	☐	Heartburn
☐	Hiatal Hernia	☐	Impotence	☐	Bladder problems
☐	Kidney Disease	☐	Headaches	☐	Gout
☐	Vertigo/ Dizziness	☐	Fibromyalgia	☐	Asthma
☐	COPD	☐	HX Pneumonia	☐	HX Bronchitis
☐	Hemophilia	☐	Syncope/Fainting	☐	Meningitis
☐	Stomach Ulcer	☐	Cancer: _____	☐	Prostate Problems
☐	Arthritis	☐	Hypertension	☐	Dementia
☐	Bipolar	☐	Depression	☐	Anxiety
☐	PTSD	☐	Back Pain	☐	Low Blood Pressure
☐	Allergies	☐	Muscle Disease	☐	Heart Attack
☐	MS	☐	ADHD	☐	Renal Failure
☐	Restless Leg Syn.	☐	Diabetes	☐	Hypothyroidism
☐	Anemia	☐	Head Injury	☐	Emphysema
☐	High Cholesterol	☐	Hyperlipidemia	☐	Narcolepsy
☐	Sleep Apnea	☐	Stroke/ TIA	☐	CAD
☐	CHF	☐	Cataracts	☐	Chronic Congestion
☐	Neuropathy	☐	Atrial Fibrillation	☐	Herniated Disc
☐	IBS	☐	Mitral Valve Disorder	☐	Osteoporosis
☐	Visual Impairment	☐	Alcoholism	☐	Narcotic Use
☐	Insomnia	☐	Migraines	☐	Obesity

- Other:_____

_____

Smoker: [ ] No [ ] Yes, Packs per day: _____ Smoked For: _____yrs

Drink Alcohol: [ ] No [ ] Yes, How often: _____

- Surgeries: _____

_____

Family History: Please list any major medical problems	
Father:	
Mother:	
Children:	
Sister/Brother:	
Other:	

****If you have your medications with you or if you brought a written list of your medications you may leave this section blank and give your medications/list to the nurse once you are called back to an exam room****

Medication Name	Dosage and Frequency	Prescribing Doctor

Allergies: _____

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Thank you for choosing the Sleep Disorder Center of Panama City!!

Patient Name: _____ Date: _____

Release of Information

I hereby authorize the SLEEP DISORDER CENTER OF PANAMA CITY to release my information to any medical provider such as physicians, medical equipment companies, or hospitals as well as to any insurance company or responsible party. This information may include diagnosis, records of treatment, and any procedures or services rendered. In addition to the above release, I authorize the SLEEP DISORDER CENTER OF PANAMA CITY to release any information to the following
Name person: _____

Assignment of Benefits

I authorize and request payments of insurance benefits paid directly to SLEEP DISORDER CENTER OF PANAMA CITY. I further authorize a copy of this agreement to be used in place of the original and authorize any holder of information about me to be released to agents when information is needed to determine benefits. I understand that I am fully responsible for all deductibles, coinsurances, and disallowed items. I also understand that if a particular item or service rendered if deemed "not reasonable and necessary" under Medicare standards and the claim is denied then I am fully responsible.

Consent to Treat

I authorize SLEEP DISORDER CENTER OF PANAMA CITY and/or authorized persons employed by them to perform and/or initiate medical evaluation and treatment and authorize or order services on my behalf. I understand that in the event of a medical emergency, my physician will be contacted. If immediate medical care is requires, 911 will be summoned and I will be transported to Bay Medical Sacred Heart. I understand that there have been no guarantees made to the results of the test(s)/ procedure(s).

Consent for Photographs/Video Recording

I consent to be photographed and videotaped for my sleep study. I have been shown the location of the camera and the technician has explained that the camera will be turned on and recording started prior to the study and turned off at the end of my study.

Cancellation Policy

We ask that you call us no later than 24 hours in advance if you need to cancel or change your sleep study. If you fail to comply you will be charged a cancellation fee of $150.

I have read all of the information provided to me by the SLEEP DISORDER CENTER OF PANAMA CITY. By signing this document I agree to and understand all of the information listed above.

_____ _____
Patient Signature Date Witness Signature Date

Patient Name: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of the SLEEP DISORDER CENTER OF PANAMA CITY's Notice of Privacy Practices.

_____ _____
Patient Signature Date Witness Signature Date

_____ _____
Personal Representative Date Personal Representative (print)

****For Office Use Only****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ The patient refused to sign

_____ We were unable to communicate with the patient

_____An emergency situation prevented us from obtaining an acknowledgment

_____ Other: _____

_____ _____

Employee Signature Date