Branson Pulmonology & Sleep
875 East State Highway 76, Suite A
Branson, MO 65616
Phone: 417-334-5864 Fax: 417-334-4978
Web Site: www.mosleep.com

PATIENT INFORMATION

Name: ____ Birth Date: ___________________
Last First Initial
Mailing Address: ____
Street City State Zip
Physical Address: ____
Street City State Zip

Home Phone: ________________ Work Phone: ________________ Cell Phone: __________________

SSN: ____________________ □Male □Female □Single □Married □Divorced □Widowed □Separated
□ Caucasian □ African American □ Hispanic □ Other__________ Preferred language □ English □ Spanish □ other

Employer: ____________________________ Occupation: ________________________________

Email Address: __________________________________ May we contact you via email? Yes No

Emergency Contact: ___________________________ Relationship:__________________

Phone: __________________ Alternate Phone: __________________

INSURANCE INFORMATION

Primary Insurance:____________________ Insured's Name:______________________________
Last First Initial
Relationship to Patient:_____________________ SSN#:____________________ Birth Date:_________

Secondary Insurance:____________________ Insured's Name: ______________________________
Last First Initial
Relationship to Patient:_____________________ SSN#:____________________ Birth Date:_________

MEDICAL INFORMATION

Primary Doctor:___________________________ Referring Doctor:____________________________

Other Doctors Treating You: ____

Preferred Pharmacy Name:_________________________ Phone Number:________________________

When confirming appointments, which number would you like for us to call? □ Home □ Cell □ other ____________

HOW DID YOU HEAR ABOUT US?

□ Radio (Station) _____________ □ Health Fair (Location) _____________

□ Friend (Name) _____________ □ Physician (Name) ________________

□ Internet __________________ □ Other _____________________________

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Authorization for Release of Information and Payment of Benefits

I hereby assign and authorize payment to Branson Pulmonology and Sleep, LLC. of all medical and/or surgical benefits, including major medical benefits, to which I am entitled to under any insurance policy or policies, under any self-insurance program, or under any other benefit plan.

I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges incurred by me or anyone on my behalf and I hereby accept such responsibility, including, but not limited to, payment of these fees and charges not directly reimbursed to Branson Pulmonology and Sleep, LLC., by any insurance policy, self-insurance program, or other benefit plan.

This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have the right to receive a copy of this authorization.

Medicare Beneficiary Agreement

I request that payment of Medicare benefits be made to Branson Pulmonology and Sleep, LLC. for services rendered. I understand that I will be notified by Branson Pulmonology and Sleep, LLC. if Medicare is likely to deny payment for services and I will be responsible for payment. Concerning products purchased from a DME, Medicare requires a Face-to-Face visit anytime the following occurs: initial rental/purchase, change in order for accessory, supply, drug, etc., on a regular basis (even if no change in order), when an item is replaced, a change in supplier, or when required by state law. Medicare patients may be required to follow-up at least once every six months.

____
Patient Name

______________________________________   ______________________
Person providing the authorization   Date

____
Relationship to patient if not patient

Patient unable to sign due to ____

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Financial Policy

- Our office will file your claims to your insurance carrier(s) as a *courtesy* to you. Insurance policies are contracts between you, (the subscriber), and the company. The doctor can in no way alter the policy nor guarantee your payments. Each company pays different rates for similar services. Some insurance plans may seem identical but have riders that alter the fee schedule.

  Patients who carry any form of medical, dental or surgical insurance should know that all services furnished are charged directly to the patient, who is personally responsible for payment.

  We will prepare all necessary forms and file them with your insurance company. If payment is not received within four months, the fees are due and payable by you.

- Our practice is committed to providing the best treatment for our patients and we charge what is usual, customary, and reasonable for the geographic areas we cover.

- Concerning *payment arrangements,* if you are a self -pay account, arrangements must be made prior to your appointment or testing date. We require that fifty (50) percent of the charges be paid prior to the service being performed. We accept cash, check, VISA, MasterCard, and Discover for all payments.

- If your account must be turned over to an outside collection agency, a collection agency fee equal to thirty-three (33) percent of your account balance will be added on to the existing balance.

X____ ____________________
Signature of Patient or Responsible Party Date

**** PLEASE BRING THIS SIGNED COPY OF OUR FINANCIAL POLICY WITH YOU TO YOUR APPOINTMENT****

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Authorization for Release of Health Information

Patient Name: ____Phone Number: _________________

Address: ____

Social Security Number: ________-________-________ Date of Birth: ________/________/________

Release TO: Name: ____

Address: ____

City & State: ______________________________ Zip: _______________

Phone #: ____

Release FROM: Facility: ____

Address: ____

City & State: ______________________________ Zip: _______________

Information to be released:

I, the undersigned, authorize and request Branson Pulmonology and Sleep Medicine to:

❑ Release and obtain information from all sources necessary to manage my healthcare.

Drug and/or Alcohol Abuse, and/or Psychiatric and/or HIV/AIDS Records Release

I understand if my medical or billing record contains information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release.

Check One: ❑ Yes ❑ No

I understand if my medical or billing record contains information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I agree to its release.

Check One: ❑ Yes ❑ No

Term Limit and Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke the authorization by submitting a notice in writing to Branson Pulmonology and Sleep Medicine at the above address. Unless revoked, this authorization will expire on the following date or event _________________, or 3 (three) years from the date of signature.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The health care facility, its employees, and/or my physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Personal Representative Who May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I authorize Branson Pulmonology and Sleep Medicine and employees to use and disclose the protected health information specified above.

Signature: ____ Date: ____________________

Authority to sign if not patient ______________________ Signature of Witness: __________________________

08/2003 Reflects HIPAA Rule (Section 164.508) which is effective April 14th, 2003/August 2005

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Health Questionnaire

Please complete the following questionnaire, fill in the blanks and placing a check in appropriate areas.

Patient Name: ____________________________ Occupation: __________________________________
Usual Work Hours/Days: ___________________ If retired, previous occupation: ___________________

My Main Complaint(s):

- ❑ Shortness of breath — for how many months/years? ________________________
- ❑ Spot on lung — how long? CT or X-ray date. ________________________
- ❑ Coughing up blood — for how many days? ________________________
- ❑ Persistent cough — for how many months/years? ________________________
- ❑ COPD/asthma/emphysema — When was this diagnosed? ________________________
- ❑ Trouble sleeping at night — for how many months/years? ________________________
- ❑ Being sleepy all day — for how many months/years? ________________________
- ❑ Snoring — For how many months/years? ________________________
- ❑ Unwanted behaviors during sleep, please explain: ______________________________________

Please explain your condition in your own words ____
____
____

Vital Statistics:

What is your: Height: ____feet ____inches Weight: _____pounds Neck size: ______inches
What was your weight one year ago? _____pounds Five years ago? _____pounds

Past Medical History:

- ❑ Hypertension (High Blood Pressure)
- ❑ Congestive Heart Failure
- ❑ Diabetes
- ❑ Cardiac Arrhythmia's
- ❑ COPD/asthma/lung problems
- ❑ Reflux
- ❑ Fibromyalgia
- ❑ TIA "Light Stroke"/stroke
- ❑ Seizures/Blackouts
- ❑ Neuromuscular disease
- ❑ Depression or severe anxiety
- ❑ Pulmonary Hypertension
- ❑ Cancer
- ❑ Thyroid problems

List other medical problems and dates

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

List surgeries and dates

_____________________________________ _____________________________________
_____________________________________ _____________________________________

Vaccinations

Last Flu Vaccine:______________________ Last Pneumococcal Vaccine:______________

Are you on oxygen ❑ Yes ❑ No If yes, how many liters per minute: _____ Frequency:❑ With activity❑ At bedtime

Are you on **CPAP / BIPAP**? ❑ Yes ❑ No
If yes, Current setting: **CPAP**: Pressure __________ **BIPAP**: Pressure __________
Home medical equipment supplier: ____

Past Sleep Evaluation and Treatment:

- ❑ I have had a previous sleep disorder evaluation
- ❑ I have had a previous overnight sleep study
- ❑ I have had a daytime nap study
- ❑ I have been prescribed a CPAP or BiPAP machine for home use
- ❑ I have had surgical treatment for a sleep disorder
- ❑ I have previously been prescribed medication for a sleep disorder

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Family History:
Has an immediate blood relative had any of the following?

Yes	No		Relation	Yes	No		Relation
❑	❑	Cancer	______	❑	❑	Stroke	______
❑	❑	Diabetes	______	❑	❑	Anxiety/Depression	______
❑	❑	Hypertension	______	❑	❑	Sleep apnea	______
❑	❑	Heart disease	______	❑	❑	Narcolepsy	______
❑	❑	Thyroid disease	______	❑	❑	other: ______	______

Habits:
Have you ever used tobacco? ❑ Yes ❑ No **Quit Date:** ______

If yes: Type: / Amount per day: / For how many years:

❑ Cigarettes ______pack(s) ______years
❑ Cigars ______cigars ______years
❑ Tobacco ______pipes or chew ______years

Have you ever used alcohol? ❑ Yes ❑ No **Quit Date:** ______

Have you ever used illegal substances? ❑ Yes ❑ No **Quit Date:** ______
If yes: Type: ______

Drug Allergies: ______

Current Medications:

Medication	Dosage / Strength	Number Of Pills / How Many Times A Day
EXAMPLE: Lisinopril	*40 MG*	*1 Tablet twice a day*

Inhalers or Nebulizers (Name And Strength)	How Many Times A Day

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General
- ❑ Fever
- ❑ Chills
- ❑ Sweats
- ❑ Decreased appetite
- ❑ Weakness/fatigue
- ❑ Joint pain
- ❑ Muscle pain

Heart/Circulation
- ❑ Irregular heart beats/palpitations
- ❑ Heart murmur
- ❑ Rheumatic fever
- ❑ Ankle swelling
- ❑ Chest pain, tightness, pressure

Kidney/Bladder
- ❑ Burning with urination

History of Wheezing
- ❑ More in the morning
- ❑ More at night
- ❑ Frequently throughout the day
- ❑ During or after activity
- ❑ I wheeze with a common cold
- ❑ I wheeze with sinus problems
- ❑ I have seasonal wheezing (please check)
  ❑Spring ❑Summer ❑Fall ❑Winter ❑All year
- ❑ My wheezing worsens when I drink alcohol
- ❑ My wheezing worsens when eating
- ❑ My wheezing worsens when I take aspirin
- ❑ I have noticed other triggers for my wheezing
  ____

Nervous System
- ❑ Depression/frequent unhappiness
- ❑ Shakiness
- ❑ Dizziness
- ❑ Epilepsy/seizures
- ❑ Frequent headaches

Blood
- ❑ Anemia
- ❑ Swollen glands
- ❑ Jaundice or Hepatitis

Ear, Nose and Throat
- ❑ Inhaled allergies
- ❑ Frequent sore throat
- ❑ frequent nasal congestion
- ❑ Sinus problems
- ❑ Post nasal drip
- ❑ Hoarseness
- ❑ Nasal polyps

Stomach/Bowels
- ❑ Heartburn
- ❑ Abdominal pain/discomfort
- ❑ Difficulty swallowing

Home and Work Exposure
- ❑ Pets at home
  if checked, please list pet types: ____________________
- ❑ Birds at home
- ❑ Reguarly exposed to animals or birds at work
- ❑ Mold problems at home or work
- ❑ Exposed to asbestos
- ❑ Other: ____________________________

COPD Assessment Test (CAT)
For each item below, place a mark in the box that best describes you **currently**.
Be sure to only select one response for each questions.

			Score
I never cough	0 1 2 3 4 5	I cough all the time	
I have no phlegm (mucus) in my chest at all	0 1 2 3 4 5	My chest is completely full of phlegm (mucus)	
My chest does not feel tight at all	0 1 2 3 4 5	My chest feels very tight	
When I walk up a hill or one flight of stairs I am not breathless	0 1 2 3 4 5	When I walk up a hill or one flight of stairs I am very breathless	
I am not limited doing any activities at home	0 1 2 3 4 5	I am very limited doing activities at home	
I am confident leaving my home despite my lung condition	0 1 2 3 4 5	I am not al all confident leaving my home because of my lung condition	
I sleep soundly	0 1 2 3 4 5	I don’t sleep soundly because of my lung condition	
I have lots of energy	0 1 2 3 4 5	I have no energy at all	

Total Score ☐

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Modified MRC Questionnaire for Assessing the Severity of Breathlessness	
Please tick in the box that applies to you (one box only)	
mMRC Grade 0 I only get breathless with strenuous exercise	❑
mMRC Grade 1 I get short of breath when hurrying on the level or walking up a slight hill	❑
mMRC Grade 2 I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level.	❑
mMRC Grade 3 I stop for breath after walking about 100 meters or after a few minutes on the level.	❑
mMRC Grade 4 I am too breathless to leave the house or I am breathless when dressing or undressing.	❑

Sleep Habits:

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I talk on the phone/pay bills/work before bed
- ❑ I experience a creeping-crawling or tingling Sensation in my legs when I try to fall asleep
- ❑ I often wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning and I am still tired but unable to return to sleep
- ❑ I have trouble falling asleep
- ❑ I wake up in the morning with headaches
- ❑ I cannot sleep on my back
- ❑ I sleep in to make up for “lost sleep”
- ❑ My sleep pattern varies from weekday to weekend
- ❑ I exercise before bed
- ❑ Other______________________________________

____

Breathing:

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking or gasping for air or feeling smothered
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been told that I snore
- ❑ I have a dry mouth when I wake up
- ❑ I have been awakened by my own snoring

Restlessness:

- ❑ I have uncomfortable feelings in my legs and/or arms when I lie down at night
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I kick or jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep
- ❑ I have the following at night (check all that apply) ❑ Panic attacks ❑ nightmares ❑ headaches ❑ acid reflux
- ❑ I wake up to environmental issues such as (check all that apply)
  ❑ Sounds ❑light/darkness ❑ temperature ❑ partner sounds/movements ❑ location ❑ bed problems

Daytime Sleepiness:

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had “blackouts” or periods when I am unable to remember what just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the results of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up
- ❑ I drink caffeinated beverages during the day: ______ cups/bottles/cans per day
- ❑ I take stimulants to stay awake (amphetamines, methylphenidate, appetite suppressors (diet pills), OTC decongestants (phenylephine, pseudophedrine), cocaine and ecstasy

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Social History:
- ❑ Sleep alone
- ❑ Share a bed with someone
- ❑ Allow children to sleep in bed
- ❑ Share a bedroom, but have separate beds
- ❑ Share a dwelling, but have separate bedrooms

Employment Status:
- ❑ Employed ❑ Unemployed ❑ Retired ❑ Student
- ❑ my job requires driving a vehicle
- ❑ I work with dangerous equipment or substances
- ❑ I am a shift worker on rotating shifts
- ❑ I am a permanent or long-term, third-shift worker

Previous Occupation: ___________________________

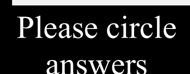
Sleep Schedule:

	Work Days or Weekdays	Off Days or Weekends
Typical bedtime:	am/pm	am/pm
Typical amount of time it takes to fall asleep:		
Typical number of awakenings per night:		
List any activities that you normally do during nighttime awakening(s); i.e., restroom, eat, watch TV, use computer:		
Typical amount of time to fall back asleep after an awakening:		
Typical wake up time for the day:	am/pm	am/pm
Desired wake up time:	am/pm	am/pm
How do you usually awaken; i.e., alarm clock:		
How do you perceive your sleep quality to be? (circle one)	Excellent, Fair, Average, Poor Other: ________________	Excellent, Fair, Average, Poor Other: ________________
Total amount of sleep per night:		
Number of naps per day:		

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. Choose the most appropriate number for each situation in the chart.

Situation	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	My score
Sitting and reading	0	1	2	3	
Watching television	0	1	2	3	
Sitting inactive in a public place—for example, a theater or meeting	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
				Total score:	



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Do you have insomnia ❑ Yes ❑ No (**If no go to the next page).** The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score.

For each question, please *CIRCLE* the number that best describes your answer.

Please rate the *CURRENT (i.e. LAST 2 WEEKS) SEVERITY* of your insomnia problem(s).

Insomnia problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) = ________ your total score

Total score categories:

0–7 = No clinically significant insomnia

8–14 = Sub threshold insomnia

15–21 = Clinical insomnia (moderate severity)

22–28 = Clinical insomnia (severe)

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Are your legs keeping you up at night? ❑ Yes ❑ No (IF NO, YOU ARE FINISHED)

Do you sometimes have an urge to move your legs, often associated with uncomfortable leg sensations? ❑ Yes ❑ No
Do you get relief, at least temporarily, from the urge or leg sensations when you move? ❑ Yes ❑ No
Do your leg symptoms begin or get worse when you are resting or inactive? ❑ Yes ❑ No
Do your leg symptoms get worse in the evening or at night? ❑ Yes ❑ No
Does anyone in your family complain of any of the symptoms described above? ❑ Yes ❑ No

How would you describe your leg symptoms? (Please check all that apply)

❑ Creeping ❑ Crawling ❑ Tingling ❑ Aching ❑ Burning ❑ Pulling

❑ Painful ❑ Itching ❑ Other: ______________________________

Please fill out the table below. This will help your physician diagnose the severity of a condition known as restless leg syndrome.

	Very Severe (4)	Severe (3)	Moderate (2)	Mild (1)	None (0)
1. Overall, how would you rate the discomfort in your legs or arms?					
2. Overall, how would you rate the need to move around during the night?					
3. Overall, how much relief of arm or leg discomfort do you get from moving around?					
4. Overall, how severe is your sleep disturbance from your restless legs?					
5. How severe is your tiredness or sleepiness from constant moving around at night?					
6. Overall, how severe is your restless leg problem as a whole?					
7. How often do you get the mentioned symptoms? Very severe means 7 days a week, severe is 4-5 days a week, moderate is 2-3 days a week, mild is I day a week.					
8. When you have these symptoms how severe are they on an average day? Very severe means 8 hrs, severe 3-8 hrs, moderate 1-3 hrs, mild less than 1 hr.					
9. Overall, how severe is the impact of your symptoms on your ability to carry out your daily affairs, for example, carrying out a satisfactory family, home, social, school, or work life?					
10. How severe is your mood disturbance from your symptoms, i.e. angry, depressed, sad, anxious, or irritable?					

Score analysis: None = 0
Mild = 1-10
Moderate = 11-20 Severe = 21-30 Very severe = 31-40

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Bed Partner Questionnaire

To be completed by the patient's bed partner or someone who has watched the person sleep, without the influence of the patient. Please complete and have the patient bring with them to their appointment.

Patient's Name: ___________________________________ Date: ___________________
Observer's Name: ___________________________________ Relationship to Patient: _________________________

I have observed this person's sleep: ❑ Once or Twice ❑ Often ❑ Almost Every Night

Please mark the severity of the following behaviors that you have observed this person doing ***while asleep.*** **IF NO, PLEASE LEAVE BLANK.**

	NEVER	SOME NIGHTS	EVERY NIGHT
Loud snoring	❑	❑	❑
Loud snorts	❑	❑	❑
Pause in breathing	❑	❑	❑
Twitching or kicking of legs	❑	❑	❑
Sleep talking	❑	❑	❑
Bed-wetting	❑	❑	❑
Awakening with pain	❑	❑	❑
Getting out of bed not awake	❑	❑	❑
Becoming very rigid/shaking	❑	❑	❑
Apparently sleeping even if He/she behaves otherwise	❑	❑	❑
Choking	❑	❑	❑
gasping for air	❑	❑	❑
Twitching/flinging of arms	❑	❑	❑
Grinding teeth	❑	❑	❑
Sitting up in bed not awake	❑	❑	❑
Head rocking/banging	❑	❑	❑
Biting tongue	❑	❑	❑
Crying out	❑	❑	❑
Sleep walking	❑	❑	❑
other ________________	❑	❑	❑

How long have you been aware of the sleep behavior(s) that you checked above? ____

If this person snores, what makes it worse? ❑ Sleeping on his/her back ❑ sleeping on his/her side ❑ Alcohol ❑ Fatigue

How often does the snoring require you and your partner to sleep separately? ❑ Rarely ❑ Sometimes ❑ Often

Mark any positions your bed partner sleeps in: ❑ Back ❑ Side ❑ Stomach

	Never	Occasionally	Often	Unknown
Does your bed partner take naps during the day?	❑	❑	❑	❑
Does your partner stop breathing in his/her sleep?	❑	❑	❑	❑
Does your bed partner fall asleep when driving?	❑	❑	❑	❑
Does he/she fall asleep without warning?	❑	❑	❑	❑
Does your bed partner mumble, talk, or yell during sleep?	❑	❑	❑	❑
Does your bed partner awaken during the night?	❑	❑	❑	❑

If they awaken, how long does it take them to get back to sleep? Hours ______ Minutes ______ ❑ Unknown
Do you know why he/she awakens? ❑ Yes ❑ No If yes, why? ____

Please estimate how many hours of sleep your bed partner gets:

Sleep Schedule	Hours each night	How long does it take to fall asleep?	How long is your partner awake during the night?
Work Days:			
Days Off:			

Does this person drink alcohol? ❑ Yes ❑ No
If yes, this person usually drinks: (check as many as you believe appropriate) ❑ Beer ❑ Wine ❑ Shots of liquor
Please estimate the **per week** use of:
_______ 12 oz. bottle/can/tap **beer** _______ 6-8 oz. glass of **wine** _______ 1-10 oz. **liquor**

Do you consider this person's drinking a problem? ❑ Yes ❑ No ❑ Uncertain

Do you believe this person and yourself share the same understanding about his/her sleep problem, sleeping pill usage, and alcohol/drug usage?
❑ Yes ❑ No Please explain:
____
____
____