Patient Information Change Form

Patient Name: _____ **Patient DOB: _____ /_____ /_____**

Please update any information below that has changed since your last visit, or

☐ Check here if no changes to any of the information below

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Insurance

Carrier: _____ Group: _____

Plan ID: _____

Policy Holder Name (if not self):_____ Relationship: _____

Policy Holder Date of Birth: _____/ _____/_____

Medications

☐ Check here for no medication(s) taken

_____ _____ _____

Allergies

☐ Check here for no allergies

_____ _____ _____

Neuro Diagnostic Sleep Centers

Appointment Date
_____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Symptoms	X	Sleep Habits	Time
Loud snoring		At what time do you usually get in the bed?	
Breathing or snoring stops in my sleep		How long does it take you to fall asleep after you have turned out the lights?	
Awaken gasping for breath		How often do you awaken each night?	
Become sleepy during the day		Total time I spend awake in bed?	
Difficulty falling asleep		I usually wake up from sleep at?	
Difficulty remaining asleep		What time do you get out of bed from sleep?	
Awaken too early		Indicate total length of naps daily?	
My mind races with many thoughts when I try to fall asleep		If you do rotating shift work, or have other work schedule changes and need more space to describe?	
I often worry whether or not I will be able to fall asleep		**Epworth Sleepiness Scale**	
Fatigue			
Awaken with a dry mouth			
Vivid or lifelike visions (people in room, etc.) as you fall asleep or wake up		How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation. 0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing	
Irritability/ Depression			
Memory impairment or Inability to concentrate		**Situation**	**Score**
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep		Sitting and reading	
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep		Watching TV	
Pain which delays, prevents, or awakens me from sleep		Sitting, inactive, in a public place(e.g., a theater or a meeting)	
Inability to move as you are trying to go to sleep or wake up		As a passenger in a car for an hour without a break	
Morning headaches		Lying down to rest in the afternoon	
Sudden weakness or feel your body go limp when you are angry or excited		Sitting and talking with someone	
Irresistible urge to move legs or arms		Sitting quietly after a lunch without alcohol	
Creeping or crawling sensation in your legs before falling asleep		In a car, while stopped for a few minutes in traffic	
Legs or arms jerking during sleep			
Frequent urination disrupting sleep		**Total***	
Sleep talking or Sleep walking		*Greater than 10 indicates sleepiness	

Neuro Diagnostic Sleep Centers

Appointment Date

_____/_____/_____

Review of Symptoms

Please Check ALL That Apply

CARDIAC	Chest Pain		Murmur(s)		Palpitation(s)	
CONSTITUTIONAL	Fatigue		Fever		Sleep Disorders	
	Weight Gain		Weight Loss			
EARS,NOSE,THROAT	Difficulty Swallowing		Hearing Aids		Ringing In Ears	
	Ear Pain		Hearing Loss			
ENDOCRINE	Diabetes		Thyroid			
EYES	Blurred Vision		Double Vision		Eye Pain	
GASTROINTESTINAL	Abdominal Pain		Constipation		Heartburn/Reflux	
	Bowel Incontinence		Diarrhea		Vomiting	
HEMATOLOGIC	Anemia		Easy Bruising			
INFECTIOUS	AIDS / HIV		Scabies		Tuberculosis	
	Hepatitis		Sexually Transmitted Disease(s)			
MUSCULOSKELETAL	Joint Pain		Muscle Pain		Other	
NEUROLOGICAL	Difficulty with Speech		Fainting/Black Out		Numbness	
	Difficulty Using Hands		Headache(s)		Seizures	
	Difficulty Walking		Memory Loss		Tingling	
	Dizziness		Muscle Weakness		Tremors	
PSYCHIATRIC	Anxiety		Bi-Polar Disorder		Depression	
RESPIRATORY	Asthma		Chronic Cough		Shortness of Breathe	
UROLOGIC	Kidney Stones		Painful Urination			
	Prostate Disorder		Urinary Hesitation			

NeuroDiagnostic Sleep Centers

Sleep Consultation Consent

I have been referred to AMDx, LTD (dba, NeuroDiagnostic Laboratories) for a sleep consultation to determine if I am a candidate for sleep therapy. If it is determined that I am an eligible candidate for sleep therapy, related service(s) will be scheduled and rendered at a later date.

I understand that the provider will be asking me a series of questions regarding my current condition in order to complete an evaluation and recommend possible treatment options.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP CONSULTATION.

Patient Name (printed): _____

Patient Signature:_____ Date: ____/____/____

If applicable, please print the name of the patient's representative:_____

Relationship to Patient: _____

Representative Signature: _____