HeMacinto
Sound Sleep Center
343 East Main Street Suite 106 San Jacinto, CA 92583
Tel: (951) 654-5592 Fax: (951) 654-0839
info@hemacintosleep.com

Patient General Health Questionnaire

Patient Name: _____ Date of Birth: _____Sex: M / F

Height: _____ Weight: _____ Weight last year: _____ Waist: _____ Neck Size: _____

Emergency Contact:_____Phone: _____Relation: _____

Check any of the following symptoms you have had in the past 12 months:

Yes	*No*		*Yes*	*No*	
□	□	Frequent headaches	□	□	Frequent heartburn
□	□	Fainting	□	□	Indigestion
□	□	Passing out	□	□	Abdominal pain
□	□	Sudden loss of vision or strength	□	□	Frequent constipation
□	□	Inability to speak	□	□	Frequent diarrhea
□	□	Hearing loss or ringing in ears	□	□	Rectal bleeding
□	□	Black Stools	□	□	Urinary Incontinence
□	□	Hoarseness for more than 2-4 weeks	□	□	Difficulty urinating
□	□	Nosebleeds	□	□	Blood in urine
□	□	Cough for more than 2-4 weeks	□	□	Urinating more than twice a night
□	□	Coughing up blood	□	□	Pain in joints or bones
□	□	Shortness of breath or wheezing	□	□	Unusual bruising or bleeding
□	□	Wheezing	□	□	Swelling in feet or ankles
□	□	Epilepsy	□	□	Seizures
□	□	Chest pain, tightness or pressure	□	□	Change in wart, mole or skin
□	□	Irregular or sudden, fast heartbeat	□	□	Weight loss of more than 5 lbs.
□	□	Difficulty swallowing or food “sticking”		□	Other: _____

Past Medical History

□ Hypertension (High Blood Pressure)	□ Hepatitis	□ Jaundice
□ Heart Disease	□ Hearing Impairment	□ Diabetes
□ Depression	□ Anxiety	□ Fibromyalgia
□ Chemical dependency or abuse	□ Alcoholism	□ Reflux
□ Lung problems	□ COPD	□ Asthma
□ Stroke	□ TIA "Light Stroke"	□ Blackouts
□ Seizures	□ Cancer	□ Thyroid problems
□ Stomach or colon problems	□ Back or joint problems (arthritis)	

□ Other: _____

Female □ Premenstrual Syndrome □ Menopause □ Other:_____

Male □ Prostate problems □ Erectile dysfunction/impotence □ Other:_____

Family History

Has an immediate blood relative had any of the following?

Yes	***No***	***Relation***	***Yes***	***No***	***Relation***
□	□ Cancer	_____	□	□ Stroke	_____
□	□ Diabetes	_____	□	□ Anxiety	_____
□	□ Hypertension	_____	□	□ Sleep Apnea	_____
□	□ Heart Disease	_____	□	□ Narcolepsy	_____
□	□ Thyroid Disease	_____	□	□ Other	_____

Current Medications	**Reason**	**How Long have you been taking**

Epworth Sleepiness Scale

Use the following scale to select the most appropriate number for the situation

0*= would never doze* ***2****=moderate chance of dozing* ***1****=slight chance of dozing* ***3****=high chance of dozing*

Sitting and reading ----------	0	1	2	3
Sitting inactive in a public place----------	0	1	2	3
As a passenger in a car for an hour without a break----------	0	1	2	3
Lying down to rest in the afternoon when permitted----------	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
Watching TV----------	0	1	2	3

With the help of a bed partner please circle one of the following as it applies to a typical night.

Snoring	□ Nightly	□ Weekly	□ Rarely	□ Never
Observed pauses in breath	□ Nightly	□ Weekly	□ Rarely	□ Never
Restless or interrupted sleep	□ Nightly	□ Weekly	□ Rarely	□ Never
Awaken short of breath gasps, or snorts	□ Nightly	□ Weekly	□ Rarely	□ Never
Awaken coughing	□ Nightly	□ Weekly	□ Rarely	□ Never
Difficulty falling asleep	□ Nightly	□ Weekly	□ Rarely	□ Never
Leg or body jerks	□ Nightly	□ Weekly	□ Rarely	□ Never
Teeth grinding	□ Nightly	□ Weekly	□ Rarely	□ Never
Vivid dreams	□ Nightly	□ Weekly	□ Rarely	□ Never
Headache	□ Nightly	□ Weekly	□ Rarely	□ Never
Acid indigestion	□ Nightly	□ Weekly	□ Rarely	□ Never
Night sweats	□ Nightly	□ Weekly	□ Rarely	□ Never
Heart palpitations	□ Nightly	□ Weekly	□ Rarely	□ Never
Night time urination	□ Nightly	□ Weekly	□ Rarely	□ Never
Refreshed with morning wake up	□ Yes	□ No		
Dry mouth in morning wake up	□ Yes	□ No		
Sore jaw with morning wake up	□ Yes	□ No		

To the best of my knowledge all of the above information is true and correct.

_____ _____

Patient's Signature Date

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Pre-Sleep Questionnaire

Patient Name: _____ DOB: _____

Do you feel today has been an unusual day? ☐ Yes ☐ No
If yes, please explain_____

How much sleep did you have last night? _____Hours

Did you take a nap today? ☐ Yes ☐ No
If yes, how long was your nap _____Hours?

Approximately what time was your last full meal? _____

Did you drink any caffeine or alcohol today? ☐ Yes ☐ No
If yes, list type, amount, and time consumed _____

How are you feeling now?
☐ Alert and wide awake ☐ Relaxed and awake ☐ A little foggy, not great ☐ Sleepy, ready for bed

List any medications you have taken today? (Include OTC or prescription)

Medication Name	Amount/Dose	Approximate Time Taken

Any physical complaints? _____
_____

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Authorization for Services Provided, Payment Agreement, and Release of Information

Patient Name: _____ Social Security Number: _____

Age: _____Date of Birth: _____Sex: M / F Telephone: _____

Address: _____ City: _____State: _____Zip: _____

Referring Physician: _____Primary Care Physician: _____

Emergency Contact:_____Phone: _____Relation: _____

Type of Insurance: □ HMO □ PPO □ Medicare □ TriCare □Other:_____

Name of Insurance Carrier: _____

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I hereby authorize Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. to submit a claim to my insurance carrier or it's intermediaries for all covered services rendered by the physician rendering the covered services for the next twelve (12) months period. Our office will file your claims to your insurance carrier(s) as a courtesy to you. Your insurance coverage is a contract between you and your insurance carrier, thus your entire account balance, including those charges filed to your insurance company, remains your responsibility; thus you are responsible for follow-up communication with your insurance company, should there be a problem in processing a claim. 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 fees and charges not directly reimbursed to Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D., by any insurance policy, self-insurance program, or other benefit plan. I also authorize Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. to furnish complete information to my insurance carrier. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for deductible, coinsurance, and non-covered services. I request that payment of authorized Medicare benefits be made either to my or in behalf of Dr. Neelam Gupta, M.D and/or Rakesh Gupta, M.D. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any other information needed to determine these benefits or the benefits payable to the related service. To the best of my knowledge all of the above information is true and correct. I acknowledge I have read the notice of privacy practices.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____