



Adult History

Personal

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Phone # (home): \_\_\_\_\_ Work Phone # \_\_\_\_\_

Social Security # \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

PLEASE MAIL OR FAX AS SOON AS POSSIBLE TO AN ADDRESS BELOW

SANTA CLARITA  
Tel: 661-799-1428  
Fax: 661-799-0968  
25050 Peachland Ave., Suite 125, Santa Clarita, CA 91321

PASADENA  
Tel: 626-795-9090  
Fax: 626-795-9605  
1W. California, Suite 514 Pasadena, CA 91105

Chief Complaint

Please Explain:

<input type="checkbox"/>	Trouble falling asleep	_____
<input type="checkbox"/>	Sleepy all day	_____
<input type="checkbox"/>	Unwanted behaviors while sleeping	_____
<input type="checkbox"/>	Other	_____

	Yes	No
***Do you need extra assistance (use of restroom, getting dressed, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
***Are you currently on Oxygen day/ night	<input type="checkbox"/>	<input type="checkbox"/>

Habits

Please give details of your personal habits

Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

Caffeine \_\_\_\_\_

Medication

Name of Drug	Dosage	Doses per day	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



# NYX Sleep Disorders Centers

**Allergies**                      **Please give details, describe your reaction**

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**Previous Sleep Study? (date)** \_\_\_\_\_ **current settings** \_\_\_\_\_

**Surgeries / Operations**                      *Please give details, date*

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**Other Medical Problems**                      *Please give details, date*

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**Family History**                      **Does anyone in your family have a sleep disorder,  
List significant family illnesses, give details**

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## Epworth Sleepiness Scale

**Referring to your usual way of life, how likely are you to doze off or fall asleep during the following situations? Or refer to a specific time when the following does apply!**

*( 0=No Chance, 1=Slight Chance, 2= Moderate Chance, 3= High Chance)*

	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, in a public place (e.g. A theater or meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances allow it				
Sitting down and talking to someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped in traffic for a few minutes				

**Total Score:**



## Sleep Questionnaire

### Sleep – Wake Schedule:

Bedtime? \_\_\_\_\_

Awakening time? \_\_\_\_\_

Alarm clock? \_\_\_\_\_

Do you wake up during the night? (yes,no) \_\_\_\_\_

How many times? \_\_\_\_\_

For how long? \_\_\_\_\_

How long does it take you to fall asleep? \_\_\_\_\_

### Disturbed Sleep:

	Yes	No
Do you snore?		
Have you lost your bed partner because of this?		
Have breathing pauses been observed?		
Have you been told your limbs kick or twitch?		
Talk in your sleep?		
Walk in your sleep?		
Act out vivid or violent dreams?		

### Insomnia:

	Yes	No
Do you have trouble falling asleep?		
How long does it take you?	_____	
How many nights per week?	_____	
If you wake up during the night, do you		
Have trouble going back to sleep?		
How long does it take you?	_____	
How many nights per week?	_____	
Do you have an aching, uncomfortable or squirmy sensation in your legs, which keep you from sleeping?		
Are you a light sleeper, easily awakened?		

### Past Sleep History:

	Yes	No
Did your current sleep problem begin in childhood?		
Were you considered hyperactive or hyper kinetic as a child or teenager (Attention Deficit Disorder)?		





Insurance Information

PRIMARY INSURANCE:

Company Name: \_\_\_\_\_
Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_
City/State: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
Name of Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_
Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_
ID Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

SECONDARY INSURANCE COMPANY:

Company Name: \_\_\_\_\_
Mailing Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_
City/State: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_
Name of Subscriber: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_
Policy Number: \_\_\_\_\_ Group #: \_\_\_\_\_
ID Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Payment Policy: Payment is due at the time services are rendered unless other arrangements have been made. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance. Our Policy allows a maximum of 90 days for insurance companies to pay claims. If this does not occur, you will be expected to pay the balance to NYX.

Patient Authorization: I hereby authorize the release of any medical information necessary to process my insurance claim. I hereby authorize payment of medical benefits to the named provider for services rendered. I also authorize Palmetto GBA to release information regarding Medicare claims submitted by the named provider.

This office requires a 48-hour advance notice of cancellation when a sleep study has been scheduled. If not given, NYX reserves the right to charge a \$175 non-refundable fee to the person responsible for the patient listed above and/or decide if the patient will be re-scheduled for a later date.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_
(Patient or Guardian if Minor)