Milford Regional Physician Group
Milford Regional Sleep Center
194 West St.
Westview Plaza, Suite 10
Milford, MA 01757
Voice: 508-381-6590
FAX: 508-381-6593
www.milfordregionalphysicians.or

SLEEP QUESTIONS

NAME:_____
DATE:_____HEIGHT:_____WEIGHT:_____
Has your weight changed in the past 5 years? YES NO Gained ___lbs Lost ___lbs
Do you snore or do people tell you that you snore? YES NO _____
If so, for how long? _____
Has anyone told you that you stop breathing while asleep? YES NO
When you wake up in the morning do you feel un-refreshed? YES NO
How long have you felt extra sleepy during the day? _____
Do you frequently awaken with a headache? YES NO
How many automobile accidents have you been involved in the past 5 years? _____
What time do you usually go to bed? _____AM PM Wake up at: _____ AM PM
On a typical night at bedtime, do you leave on TV____ Music___ Light____ Other_____
Comment:_____

Do you have: Difficulty falling asleep? YES NO Difficulty staying asleep? YES NO
Does anything frequently awaken you at night? HEARTBURN____ PAIN _____
GO TO BATHROOM ____BREATHING____ OTHER_____

Do you have an urge to move your legs and an uncomfortable feeling in your legs? YES NO
If so: Does this urge to move or discomfort increase when you are inactive? YES NO
Does this urge to move decrease or go away when you walk or stretch? YES NO
Is this urge to move or leg discomfort worse in the evening/night? YES NO

Please 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

SITUATION	CHANCE OF DOZING (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place at a theater or meeting	
As a passenger in a car for 1 hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (when you have had no alcohol)	
In a car while stopped in traffic	
TOTAL	

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MEDICAL DATA & INFORMATION

NAME: _____
AGE: ____ BIRTHDATE: _____
SEX: MALE FEMALE
Do you have any problem caring for yourself at home? YES NO
Do you need someone to assist caring for you at night? YES NO
Do you use a wheelchair or a walker? YES NO
Do you need a handicapped equipped (electric hospital style) bed or shower? YES NO
Do you have the following: Scalp/skin sensitivities___ Wig or hairpiece___
Operations and Surgery: Please indicate if you have had any of the following surgeries:
Cardiac/Bypass Surgery_____ Tracheostomy_____ Uvuloplasty (UPPP)_____
Nasal septal surgery or rhinoplasty ____ Tonsillectomy_____
Lung Surgery(indicate type) _____Other: _____
Medical Conditions: Check if you have or have had any of the following problems or conditions.

Heart Problems	Lung Problems	Sleep Problems	Other
__Angina / Chest Pain __Palpitations /Arrhythmia __Heart attack/ MI __Heart Failure/CHF __High Blood pressure __Pacemaker: rate__ __Atrial Fibrillation	__Asthma __COPD __Use oxygen __Tuberculosis	__Snoring __Fall asleep slowly __Fall asleep quickly __Wake up frequently __Sleep walking __Sleep talking	__Depression __Anxiety __Thyroid problem __Seizures __Heartburn/GERD __Stroke __Arthritis __Cancer __Fibromyalgia __Diabetes

OTHER PROBLEMS:_____
IF YOU ARE NEW TO MILFORD REGIONAL PHYSICIAN GROUP, FILL OUT ALLERGY AND MED LIST BELOW:
Allergies and Sensitivities: Please list foods, medications, or substances you are allergic to:

What are you allergic to?	What happens?	What are you allergic to?	What happens?

Medicines: Please list all medicines you are now taking. Please include all prescription and non-prescription drugs, herbals, vitamins, eye drops and inhalers.

Drugs/Medicines	Amount/Dose	How often/time taken	Reason taken	

MILFORD REGIONAL SLEEP CENTER
PATIENT REGISTRATION
PLEASE COMPLETE AND SIGN
(FOR NEW PATIENTS)

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*****ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE CARD******
Date:_____

Patient Name: _____Date of Birth: _____
Address: _____
City/town_____State:_____Zip:_____
Home Phone: _____Work/Cell Phone: _____
Employer if applicable:_____
Primary Care Physician: _____
Physicians phone #:_____fax #:_____
Type of Medical Insurance: _____
Name of Cardholder: _____
Certificate #: _____ Group #: _____
Relationship of Cardholder to Patient: self spouse parent
**In case of emergency, notify name: _____
Relationship: _____** Phone Number: _____

Due to HIPAA guidelines we will not share any information (scheduling or medical) with anyone but you unless we have written permission. If you wish to give permission for us to speak to anyone other than yourself, please list them here and sign below.
Name_____relationship_____
Name_____relationship_____
I understand I will be undergoing a sleep test (polysomnography). I understand there may be video monitoring during the set up or monitoring. I authorize payment of benefits from the government and /or my insurance company, to Milford Regional Physician Group for services rendered. I also authorize the release of any medical or other information necessary to process claims.
I authorize Milford Regional Sleep Center to leave messages on my answering machine at the following phone numbers:
Home YES/NO_____, Cell YES/NO_____.
I understand that messages may contain protected health information, including diagnosis and treatments about me.

****Signed_____Date_____

Have you been seen by any of our physicians? _____ If so, which one?
Dr. Curley___ Dr. Aras-Richard___ Dr. Curl___ Dr. Arpin___ Dr. DeMarco___
Rebekah Marshall NP___ Mary Lange NP ___