SLEEP HEART
Getting to the heart of sleep!

Virginia 703-348-7857
Maryland 301-693-7001
Fax 703-485-1020
email: info@SleepHeart.com

Home Sleep Testing Questionnaire

Patient First Name: .....
Middle Name: .....
Last Name: .....
Date of Birth: ....
SSN: ....
Phone
Home: ....
Cell: .....
Work: ....
Email: ....
email results to patient: ☐yes ☐*no*
Home Address
Street: ....
City, State Zip: .....

Height: ……feet ……inches
Weight: ……lbs, Neck Size: ……inches
Marrital Status ☐S*ingle* ☐*married* ☐*other*
☐E*mployed* ☐*FullTmStdnt* ☐*PartTmStdnt*
Insurance Company: ....
ID#..... .....
Group/FECA/Enroll #.....
Relation to Insured ☐*self* ☐*spouse* ☐*child* ☐*other*
Insured's (if different from patient)
Full Name: ....
Date of Birth .....SSN……..
Street Address.....
City, State Zip..... .....

Please complete one form for each insurance.

Please check all that <u>currently</u> apply:

☐ Snoring
☐ Stopping breathing at night
☐ Difficulty falling asleep
☐ Leg discomfort / restlessness in the evening.or at night
☐ Difficulty staying asleep
☐ Peeing at night
☐ Unusual behaviors during sleep (walking, talking, ...)

☐ Tired or Sleepy during the day
☐ Concentration difficulties
☐ Memory Problems

☐ Grinding Teeth
☐ Headaches
☐ Chronic Body Pains
☐ Impotence / Low Libido

Please check all that have <u>ever</u> applied:

☐ High blood Pressure
☐ Diabetes
☐ Heart Disease
☐ Arrhythmia (unusual heart beat)
☐ Stroke
☐ Seizure
☐ Heartburn (GERD)
☐ Fibromyalgia
☐ Asthma
☐ ADD / ADHD

☐ Depression
☐ Anxiety

☐ Sleep Apnea
☐ Insomnia
☐ Narcolepsy
☐ Restless Leg Syndrome

Fax Completed form to
FAX # 703-485-1020 or scan & email

I, the above named patient, or guardian or otherwise financially responsible party, do hereby authorize SleepHeart at Home to bill and receive all benefits to which my dependents or I are entitled under my health insurance plan. I understand that I am responsible for fees not paid by my insurance. I understand that email is not secure and may not be confidential.

Patient Printed Name:..... Signature……Date……..

Additional Clinical History (e.g. patient has previously diagnosed OSA, changes since last study, devices used and settings)

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Ordering Doctor:……., Phone #....., Location kit received (if not ordering doc's office):.....