Dear _______________________________,

Your initial evaluation has been scheduled with ______________________ on ___________________.

Please arrive at ________________ AM/PM for your appointment at ________________ AM/PM.

The Huntsville Sleep Center is located inside the WOMEN & CHILDREN’S HOSPITAL (formerly Huntsville Hospital East) on the ground floor. You may park in any patient parking area around the Women & Children’s Hospital. There is limited free parking in the front of the hospital. There is additional parking available in the lot beside the hospital for a $2.00 fee. Valet parking is also available for a $5.00 fee. The Sleep Center is able to validate under special circumstances ONLY. Please speak with the office staff when you arrive or call prior to your appointment for more information.

The Madison Sleep Center is located on the corner of Highway 72 West and Wall Triana Hwy, in the old Southern Family Market complex. We are beside Madison Hospital, Physical Therapy.

Please complete the enclosed paperwork and bring it with you to your appointment. You will also need to bring your insurance card(s) and a photo ID. We ask that you arrive 30 minutes early in order to process this paperwork into your medical records. If you are late by 10 minutes or more, your appointment may have to be rescheduled. If you are scheduled for a 1:00 p.m. appointment, please do not arrive early as our office is closed for lunch from 12:00 – 1:00 p.m.

Our office staff will contact you to confirm your appointment. Please call us at least 24 hours in advance if you need to cancel or reschedule your appointment. Excessive cancellations or no shows may only be rescheduled with the Sleep Center’s physician’s approval or a new referral.

Your initial evaluation allows you to speak with the doctor, one on one, regarding any symptoms and/or concerns you may have with your sleep. Plan to be here approximately an hour. If it is deemed necessary by the physician that you undergo sleep testing, an appointment will be scheduled before you leave the Sleep Center.

In consideration of those with breathing disorders and other sensitivities, we are a fragrance free facility. Please refrain from wearing perfume, scented lotions or cologne to any appointments or sleep testing.

Please contact us if we can be of further assistance. Our business hours are 8:00 a.m. - 4:30 p.m. Monday through Thursday, closed for lunch 12:00 - 1:00 p.m., and 8:00 a.m. - 12:00 noon Friday.
Sleep Center Registration

Patient Name ________________________________________ DOB _______________________
SS#__________________________________________________ Marital Status (circle one) S M D W Sex M / F
Primary Care Physician __________________________________

Race (circle one) Asian  Black/African American  White/Caucasian  American Indian or Alaska Native
Hispanic/Latino  Other Pacific Islander  More than 1 race  Do not wish to report

Preferred Language ___English  ___Spanish  ___French  ___Creole  ___Other ______________

Address______________________________________________________________
City______________________________    State______ Zip__________
County_____________ Home Phone___________________ Cell_________________
Email Address___________________________________________________________

Employment Status (circle one) Full  Part  Self  Retired  Unemployed  Active Duty Military
Employer_____________________________________________
Address____________________________________________________
City________________________________ State_______ Zip_________
Phone_________________

Spouse Name _____________________________________________ DOB ______________
Address____________________________________________________
City________________________________ State_______ Zip_________
Cell Phone___________ Work _____________________
Spouse Employer___________________________________________
Address__________________________________________________
City ____________________ State__________ Zip_____________

Emergency Contact _____________________________________Relationship to Patient___________
Address____________________________________________________
City________________________ State______ Zip________________
Phone________________________ Work _________________________

Guarantor if other than Patient ________________________________ Relationship to Patient___________
Relationship________________ DOB________________ SS#________________
Address_________________________________________
City__________________State______ Zip__________
Home Phone________________ Cell ___________________Work________________

Primary Insurance
Subscriber Name ______________________________ Relationship to Patient_____________________
Insured SS#__________________ DOB________________
Insured Employer________________________________
Address__________________________________________
City________________________ State______ Zip________________

Secondary Insurance
Subscriber Name ______________________________ Relationship to Patient_____________________
Insured SS#__________________ DOB________________
Insured Employer________________________________
Address__________________________________________
City________________________ State______ Zip________________
Sleep disorders are recognized as medical problems. However, individual insurance carriers vary in their claim submission requirements and reimbursement policies. For this reason, the Sleep Center handles billing in the following manner:

**OFFICE VISITS**

The Sleep Center collects copayments at the time of service. The amount of your copay is determined by your insurance company. Any questions regarding insurance coverage or status of your bill should be directed to your physician’s private office.

*Dr. Robert Serio or Reiga Luedemann, MSM, PA-C: Huntsville Lung Associates can be reached at 256-533-6003. Forms of payment accepted are cash, check, Visa, Master Card, Discover Card, and American Express.*

*Dr. Darren Gannuch: Alabama Sleep Disorder Center can be reached at 256-882-2003. Forms of payment accepted are cash or check only.*

*Dr. Bahador Tafazoli: Cullman Primary Care, Family/Sleep Medicine can be reached at 256-775-1090. Forms of payment accepted are cash and check only.*

*In addition, Huntsville Hospital’s business office will file a claim with your insurance for the services rendered by the hospital. For billing inquiries please call 256-265-9569.*

**SLEEP CENTER TESTING**

If testing is scheduled for you, we recommend that you contact your insurance carrier to verify coverage. The Sleep Center does not verify coverage. Some carriers may require prior authorization or precertification for your testing. It is your responsibility to notify your physician and the Sleep Center if prior authorization or precertification is required for your services to be covered.

If you find that your insurance carrier does not cover sleep testing, please contact us.

Diagnostic testing includes any procedure performed overnight or the next day. Any diagnostic procedure your physician orders will be explained prior to scheduling.

For insurance purposes the following codes are provided:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure Code</th>
<th>Procedure</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Polysomnography (NPSG)</td>
<td>95810</td>
<td>Child Polysomnography (NPSG)</td>
<td>95782</td>
</tr>
<tr>
<td>Adult Polysomnography with CPAP/BIPAP</td>
<td>95811</td>
<td>Child Polysomnography with CPAP/BIPAP</td>
<td>95783</td>
</tr>
<tr>
<td>Multiple Sleep Latency Test (MSLT)</td>
<td>95805</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance Wakefulness Test (MWT)</td>
<td>95805</td>
<td></td>
<td></td>
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<tr>
<td>ARES (Home testing device)</td>
<td>95800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overnight Pulse Oximeter (Home testing)</td>
<td>94762</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

After your overnight sleep study you will receive two billing statements. One statement will be from the hospital for the diagnostic testing. The second will be for the interpretation fee from your physician. Please know that you may be scheduled for multiple procedures depending on your clinical condition. Any questions regarding the status of the bill should be directed to the phone number on your statement. Any questions regarding insurance coverage should be directed to your physician’s private office.

*Huntsville Lung Associates: 256-533-6003 for Dr. Serio*

*Pulmonary and Sleep Assoc. of Huntsville, PC: 256-883-2112 for Dr. Sneeringer or Dr. Vuppala*

*Roy Sleep Medicine: 256-213-1800 for Dr. Roy*

*Alabama Sleep Clinic: 256-539-2531 for Dr. Hearn*

*Alabama Sleep Disorder Center: 256-882-2003 for Dr. Gannuch*

*Cullman Primary Care, Family/Sleep Medicine: 256-775-1090 for Dr. Tafazoli*

Revised: 1/20/15 DA
Name______________________________  Age____  □Female □Male DOB____/____/_____ Today’s Date ____/____/_____

What brings your child to our office today?

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Child’s Main Complaints:  Parent’s main complaint (about child’s sleep)

- Daytime sleepiness
- Insomnia
- Snoring
- Interruptions in breathing
- Leg jerks
- Other

- Daytime sleepiness
- Insomnia
- Snoring
- Interruptions in breathing
- Leg jerks
- Other

Sleep history:
How long has your child’s complaints bothered him/her?
- Last 3 months
- 6-12 months
- 1-2 years
- >2 years

How would you rate the severity of your child’s complaints:
- Mild
- Moderate
- Severe

Has the child had a previous sleep study?
- Yes…..
- No….When___________ Where___________ Physician______________

What was recommended? ______________________

Sleep Schedule
1. During the week …..What time does your child normally go to bed ____________ a.m. / p.m.  Total sleep time in 24hrs______
   What time does your child normally awaken ____________ a.m. / p.m.
2. During the weekend..What time does your child normally go to bed ____________ a.m. / p.m.
   What time does your child normally awaken ____________ a.m. / p.m.
3. How long does it take your child to get to sleep? _______________ min / hours
4. Approximately how many times does the child awaken during their sleep cycle? ________  How long to get back to sleep? ________
5. What are the usual reasons that awaken the child?
   - Urination
   - Heat
   - Shortness of breath
   - Cold
   - Heartburn
   - Light
   - Body Jerks
   - Pain
   - Noise
   - Sibling
   - Other

   Check if applicable

6. Does your child sleep through the night? ......................................................... yes  no
7. Does your child sleep with parents bed/bedroom?................................. yes  no
8. Does anyone leave the bedroom b/c of your child’s sleep problem? ............... yes  no
9. Does the child awaken feeling tired and not refreshed?............................... yes  no
10. Take naps on arrival home from work/school? ........................................... yes  no
11. Are short naps refreshing?........................................................................... yes  no
12. Does your child fall asleep while driving or riding in a car? ....................... yes  no
13. Have trouble at work or school b/c of sleepiness?........................................ yes  no
14. Snore loud enough for others to complain?............................................... yes  no
15. Stop breathing?......................................................................................... yes  no
16. Awakened short of breath or choking?...................................................... yes  no
17. Awakened with heart burn belching or coughing?.................................... yes  no
18. Awakened with chest pain or chest heaviness?......................................... yes  no
19. Awakened with heart racing or pounding?............................................... yes  no
20. Wake up with morning headache?.............................................................. yes  no
21. Have poor memory?................................................................................. yes  no
22. Trouble concentrating?.......................................................... yes  no
Have morning jaw pain? ................................................................. [ ] yes [ ] no

Clench their teeth? .............................................................................. [ ] yes [ ] no

Wake up stiff in the morning? .......................................................... [ ] yes [ ] no

Watch the clock while trying to fall asleep? ........................................... [ ] yes [ ] no

Feel depressed or sad? ........................................................................ [ ] yes [ ] no

Wake up with sore achy muscles? ........................................................ [ ] yes [ ] no

Awaken from sleep confused / inconsolable? ....................................... [ ] yes [ ] no

Experience crawling and aching feeling in arms or legs which makes
him/her want to move them? .............................................................. [ ] yes [ ] no

Leg move throughout the night? .......................................................... [ ] yes [ ] no

Awakened panicked or anxious? .......................................................... [ ] yes [ ] no

Awakened confused / inconsolable? ..................................................... [ ] yes [ ] no

Sleepwalk? ......................................................................................... [ ] yes [ ] no

Act out his/her dreams (talk or move)? ................................................. [ ] yes [ ] no

Have nightmares? ................................................................................ [ ] yes [ ] no

Wake up 1 or 2 hours early in the morning? .......................................... [ ] yes [ ] no

Unable to fall asleep in 15 minutes or less? .......................................... [ ] yes [ ] no

Experience vivid dream-like scenes upon awakening or falling asleep? ................................. [ ] yes [ ] no

Do you feel the uncontrollable urge to sleep while sad, happy or mad? ....[ ] yes [ ] no

Have thoughts racing through his/her mind while trying to sleep? ...........[ ] yes [ ] no

Leg cramps at bedtime? ....................................................................... [ ] yes [ ] no

Awakened 1 or 2 hours after going to sleep? ......................................... [ ] yes [ ] no

Feel unable to move (paralyzed) when waking from or falling asleep? ........................ [ ] yes [ ] no

Have leg cramps at bedtime? ................................................................ [ ] yes [ ] no

Leg move throughout the night? .......................................................... [ ] yes [ ] no

Feel unable to move (paralyzed) when waking from or falling asleep? ........................ [ ] yes [ ] no

Awakened 1 or 2 hours after going to sleep? ......................................... [ ] yes [ ] no

Experience crawling and aching feeling in arms or legs which makes
him/her want to move them? .............................................................. [ ] yes [ ] no

Awaken suddenly with a jerk soon after falling asleep? ......................... [ ] yes [ ] no

Activity crawling and aching feeling in arms or legs which makes
him/her want to move them? .............................................................. [ ] yes [ ] no

Europth Sleepiness Scale Please check all that applies to your child.
How likely is your child to doze off to sleep in the following situations?

<table>
<thead>
<tr>
<th>Situation</th>
<th>(0) would never doze</th>
<th>(1) slight chance of dozing</th>
<th>(2) moderate chance of dozing</th>
<th>(3) high chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Sitting Reading</td>
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<tr>
<td>2- Watching TV</td>
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<tr>
<td>3- Sitting, inactive in a public place (i.e. theater or meeting)</td>
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<tr>
<td>4- As a passenger in a car for an hour without break</td>
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<td>5- Lying down to rest in the afternoon when circumstances permit</td>
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<td>6- Sitting down talking with someone</td>
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<td>7- Sitting quietly after lunch without alcohol</td>
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<td>8- In a car, while stopped for a few minutes in traffic</td>
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</tbody>
</table>

Epworth Total ______/ 24

Birth history: Please answer to the best of your recollection regarding child:

Did the child’s mother receive regular prenatal care while pregnant?   Yes…   No…
Were there any complications during pregnancy with this child?   Yes…   No…   If yes, explain
Were there any complications post delivery with this child?   Yes…   No…   If yes, explain
Birth Weight __________    #wks of gestation ________    Length of labor _________    APGAR score _______@ 5 mins
Type of delivery?  SVD (vaginal)…..  C-section  Any birth defects / trauma ….  Yes…   No…   If yes, explain
Jaundice… Yes…   No  Prolonged neonatal stay?   Yes…   No…   If yes, explain
Other__________________________

Epworth Sleepiness Scale

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Epworth Total ______/ 24

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Did the child’s mother receive regular prenatal care while pregnant?   Yes…   No…
Were there any complications during pregnancy with this child?   Yes…   No…   If yes, explain
Were there any complications post delivery with this child?   Yes…   No…   If yes, explain
Birth Weight __________    #wks of gestation ________    Length of labor _________    APGAR score _______@ 5 mins
Type of delivery?  SVD (vaginal)…..  C-section  Any birth defects / trauma ….  Yes…   No…   If yes, explain
Jaundice… Yes…   No  Prolonged neonatal stay?   Yes…   No…   If yes, explain
Other__________________________
Social History: Please check all that applies to your child:

<table>
<thead>
<tr>
<th>Number of siblings</th>
<th>Does child have own room?</th>
<th>Does the child sleep in their own bed?</th>
<th>Are there pets in house</th>
<th>If yes, do the pets sleep with the child</th>
<th>Is there any smoking in house (2nd hand tobacco smoke)</th>
<th>Home family status:</th>
<th>Does your child have special needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____</td>
<td>Yes… No</td>
<td>Yes… No</td>
<td>Yes… No</td>
<td>Yes… No</td>
<td>Yes… No</td>
<td>Married</td>
<td>____________________________________________________________</td>
</tr>
</tbody>
</table>

To the best of your knowledge, does your child use the following: Please check (if applicable):

<table>
<thead>
<tr>
<th>Alcohol use</th>
<th>Illicit drug use</th>
<th>Nicotine abuse</th>
<th>Caffeine</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Type/how much?</td>
<td>What drug?</td>
<td>Type/Packs per day?</td>
<td>How many cups/glasses/cans per day?</td>
</tr>
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</tbody>
</table>

Past Medical History: Please check any of the following conditions that apply to your child or your family:

<table>
<thead>
<tr>
<th>Alcoholism</th>
<th>Arthritis pain</th>
<th>Asthma</th>
<th>Cancer</th>
<th>Congestive Heart Failure</th>
<th>Depression</th>
<th>Diabetes</th>
<th>Emphysema / COPD</th>
<th>Fibromyalgia</th>
<th>Acid reflux</th>
<th>Heart attack</th>
<th>Heart Arrhythmia</th>
<th>High Blood Pressure</th>
<th>High Cholesterol</th>
<th>Narcolepsy</th>
<th>Migraine Headache</th>
<th>Psychiatric problem</th>
<th>Restless Legs</th>
<th>Seizures / Epilepsy</th>
<th>Stroke</th>
<th>Sleep Apnea</th>
<th>Tuberculosis</th>
<th>Thyroid disease</th>
<th>Other</th>
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</tbody>
</table>

Past Surgeries: What surgeries has your child had in the past?

<table>
<thead>
<tr>
<th>Abdominal surgery</th>
<th>Appendectomy</th>
<th>Hernia</th>
<th>Ear Tubes</th>
<th>Circumcision</th>
<th>Brain/ Head</th>
<th>Heart surgery</th>
<th>Gallbladder</th>
<th>Tonsillectomy</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Current medication: Please indicate any vitamins, herbs, and over the counter medications that your child currently takes.

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
<th>9.</th>
<th>10.</th>
<th>11.</th>
<th>12.</th>
</tr>
</thead>
</table>

Allergies: List any medication, food, or chemicals which your child is allergic to or has a major side effect to:

<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
</tr>
</thead>
</table>

Allergic to Latex – Yes or No
**Review of Symptoms:** Check any symptom that applies to your child at this time.

<table>
<thead>
<tr>
<th>Sleep</th>
<th>Eyes / ENT</th>
<th>Musculoskeletal</th>
<th>Pulmonary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Daytime sleepiness</td>
<td>• Sinus trouble</td>
<td>• Muscle pain</td>
<td>• Chronic cough</td>
</tr>
<tr>
<td>• Dry mouth</td>
<td>• Difficulty hearing</td>
<td>• Joint pain</td>
<td>• Coughing blood</td>
</tr>
<tr>
<td>• Snore</td>
<td>• Difficulty seeing</td>
<td>• Back pain</td>
<td>• Shortness of breath</td>
</tr>
<tr>
<td>• Sore throat</td>
<td>• Sneezing / watery eyes</td>
<td>• Leg jerks</td>
<td>• Sputum production</td>
</tr>
<tr>
<td>• Apnea</td>
<td>• Nose bleed</td>
<td>• Leg pain with walking</td>
<td>• Wheezing</td>
</tr>
<tr>
<td>• Daytime naps</td>
<td>• Snore</td>
<td>• Cardiovascular</td>
<td>• Use of Oxygen</td>
</tr>
<tr>
<td>• Insomnia</td>
<td>• Insomnia</td>
<td>• Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>• General</td>
<td>• Nausea / vomiting</td>
<td></td>
</tr>
<tr>
<td>• Night sweats</td>
<td>• Night sweats</td>
<td>• Heart burn</td>
<td>• Memory Loss</td>
</tr>
<tr>
<td>• Weight gain</td>
<td>• Weight gain</td>
<td>• Irritable bowel</td>
<td>• Dizziness</td>
</tr>
<tr>
<td>• Fatigue</td>
<td>• Fatigue</td>
<td>• Difficulty swallowing</td>
<td>• Difficulty walking</td>
</tr>
<tr>
<td>• Weight loss</td>
<td>• Weight loss</td>
<td>• Depression</td>
<td>• Difficulty talking</td>
</tr>
<tr>
<td>• Hot flashes</td>
<td>• Hot flashes</td>
<td>• Anxiety</td>
<td>• Tremors</td>
</tr>
<tr>
<td>Urinary</td>
<td>• Urinary</td>
<td>• Hallucinations</td>
<td>• Numbness/tingling</td>
</tr>
<tr>
<td>Frequent urination</td>
<td>• Frequent urination</td>
<td>• One-sided weakness</td>
<td>• One-sided weakness</td>
</tr>
<tr>
<td>Nighttime urination</td>
<td>• Nighttime urination</td>
<td>• Difficulty walking</td>
<td>• Urinary incontinence</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>• Urinary incontinence</td>
<td>• Shortness of breath</td>
<td></td>
</tr>
</tbody>
</table>

Rate of Pain today 0-10 (0=none, 10=severe) _____ Type of Pain ________________  Location of Pain ________________

Do you wish your child to be on life support? ………………... □ Yes … □ No

Do you have some one else to make health decisions for you regarding your child in case you were incapacitated… □ Yes … □ No ….. If yes, please list the names of persons who can also make health decisions for your child.

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
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I certify that the above information is accurate to best of my knowledge. I understand withholding information be it intentional, or by negligence to fill out this form, could result in improper medical care and could be a detriment to my health or even life threatening.

__________________________________
Patient/Guardian Signature
For Physician Use Only (Do Not Write Below This Point)

<table>
<thead>
<tr>
<th>Wt</th>
<th>BP</th>
<th>Neck Circ.</th>
<th>Pulse</th>
<th>Pulse ox</th>
<th>BMI</th>
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Allergies:

CC:

ROS:

- Education provided

Figure 5. Mallampati presentation. Grades 1–3.
Example of sleep diary as shown below:
e.g. sleep time 10:30pm-7am
and 10:30pm – 7am with waking up 3:30-4:30am

<table>
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<tr>
<th>Date</th>
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</table>

Now please show us your sleep pattern; when you go to bed ↓, and wake up and out of bed ↑
The Sleep Center is located on the Ground floor of Huntsville Hospital for Women & Children
245 Governors Dr. SE
Huntsville, AL 35801
(256) 265-8553

Take the elevator in the main lobby to the ground level, turn left when you step off the elevator. We are down the first hallway to the left.