KIMBERLY A. VORSE, M.D.

(208) 726-0000
(877) 726-0005

SLEEP AND HEALTH HISTORY

Please take the time to read each question carefully and complete every question. The more complete this form is, the more time the Doctor will have to address your sleeping problem, examining you and educating you on your treatment options. *Thank you*.

Last Name	First Name	Middle Name	SS#
Today's Date	Birthdate	Primary Doctor	Who Referred You?
Mailing Address	City	State	Zip Code
Home Phone	Work Phone	Cell Phone	E-mail
Height	Weight		

HISTORY OF PRESENT ILLNESS:

PROBLEM: ☐ Non-restorative sleep ☐ something else? Explain: _____
QUALITY OF SLEEP: ☐ Poor ☐ Feel Rested
SEVERITY: *Does your bedmate complain?* ☐ Yes ☐ No ☐ N/A
IS THE PROBLEM: ☐ Mildly Upsetting ☐ Moderately Severe ☐ Totally Incapacitating
ONSET: How did it begin? ☐ Gradually ☐ Suddenly ☐ Specific to an Event
DURATION: How many months/years have you had the problem? _____
TIMING: When is it worse? ________________
COURSE: ☐ Worsening ☐ Improving ☐ Unchanged

INSENSITY: VISUAL ANALOG SCALE OF ALERTNESS AND WELL-BEING:
Mark '***x***' at the appropriate level
How alert do you feel? *Very sleepy* ________________ *Very alert*
How good do you feel? *Very bad* ________________ *Very good*

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to you usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = No chance of dozing
1 = Slight chance of dozing
2 = moderate chance of dozing
3 = High chance of dozing

Click on the arrow to choose appropriate number

SITUATION	CHANCE OF DOZING
Sitting and reading	_
Watching TV	_
Sitting inactive in a public place (e.g. theater or a meeting)	_
As a passenger in a car for an hour without a break	_
Lying down to rest in the afternoon when circumstances permit	_
Sitting and talking to someone	_
Sitting quietly after lunch without alcohol	_
In a car, while stopped for a few minutes in traffic	_

STANFORD SLEEPINESS SCALE:

Choose the ONE number that best describes your level of alertness or sleepiness RIGHT NOW.

- ☐ 1) Wide awake, fully awake, functioning at a high level, head clear.
- ☐ 2) Functioning at a high level, but not at peak, able to concentrate.
- ☐ 3) Relaxed, awake, not at full alertness, responsive.
- ☐ 4) A little groggy, clearly not at peak, let down.
- ☐ 5) Fogginess, beginning to lose interest in remaining awake, slowed down.
- ☐ 6) Sleepiness, prefer to be lying down, fighting sleep, woozy.
- ☐ 7) Almost in reverie, sleep onset soon, lost struggle to remain awake.

AGGRAVATORS: What factors aggravate your symptoms? ______________________________

RELIEVERS: What remedies relieve your symptoms? ______________________________

SYMPTOMS/RELATED:

Yes	No	
☐	☐	**Do you ever snore?**
☐	☐	Is your snoring heard outside the bedroom?
☐	☐	Do you have nightly snoring interrupted by pauses in breathing?
☐	☐	Is it worse on your back or on your side?
☐	☐	Do others complain about your snoring?
☐	☐	Do you have night sweats?
☐	☐	Do you have multiple nighttime awakenings?
		What wakes you up? ____________________ *When?* _____
☐	☐	Do you fall asleep when you should not; i.e. at work, while driving, etc.
☐	☐	Do you have a loss of energy, fatigue?
☐	☐	Do you choke and/or gasp during sleep?
☐	☐	Restless sleep
☐	☐	High blood pressure
☐	☐	Overweight
☐	☐	Depression
☐	☐	Trouble concentrating
☐	☐	Irritability
☐	☐	Forgetfulness
☐	☐	Morning headaches
☐	☐	Sexual dysfunction
☐	☐	Need to urinate at night
☐	☐	PREVIOUS TREATMENTS FOR SLEEP DISORDER: _____
☐	☐	PAST HISTORY OF A SLEEP DISORDER: _____

NARCOLEPSY

The uncomfortable urge to sleep during the day, especially during emotional events (feeling happy, sad, or mad).

Yes	No	
☐	☐	Do you feel your knees buckle or, your arms feel weak, or jaw drop when you are happy or sad? (*cataplexy*)
☐	☐	Do you experience vivid dream-like episodes or scenes upon awakening or falling asleep that you cannot tell whether they are real or not? (*hypnagogic hallucinations*)
☐	☐	Do you feel paralyzed when waking or falling asleep? (*sleep paralysis*)
☐	☐	Do you have automatic behavior? For instance, while driving do you have periods when you go past a landmark and are uncertain whether you've done something only to find out it was already done, or find yourself in places and not sure where you should be?
☐	☐	Do you have a history of head trauma or loss of consciousness?

PERIODIC LEG MOVEMENTS OF SLEEP

Yes	*No*	
☐	☐	Do you have leg cramps at bedtime?
☐	☐	Do you experience crawling and achy feelings in your legs which makes you want to move them or walk?
☐	☐	Do you notice that these achy feeling in your legs are worse at nighttime?
☐	☐	Have you been told that your legs or arms move every 20 seconds or so during the night?
☐	☐	Are your bedcovers in total disarray in the morning?
☐	☐	Have you ever awakened suddenly with a jerk after falling asleep?

PARASOMNIAS

Things that go bump in the night including REM behavior disorder and include disorders of sleepwalking or sleep talking.

Yes	*No*	
☐	☐	Do you remember your dreams?
☐	☐	Do you have nightmares?
☐	☐	Do act out your dreams in nightmares by swinging your arms, legs or by moving or yelling?
________		If so, do they occur in the 1st third of the night or in the latter third of the night?
☐	☐	Do you sleepwalk?
☐	☐	Do you sleep talk, and if so, can people understand what you are saying?
________		If so, do they occur in the 1st third of the night or in the latter third of the night?
☐	☐	Have you been told that you arose from sleep totally confused or are inconsolable?
☐	☐	Have you awakened feeling panicked with your heart beating?
☐	☐	Have you experience uncontrollable urination in your sleep either as a child or an adult?
☐	☐	Do you have a history of seizures?

INSOMNIA

Yes	*No*	
☐	☐	Are you unable to fall asleep in 15 minutes or less?
☐	☐	Do you wake up several times during the night and cannot get back to sleep?
☐	☐	Do you wake up or two hours early in the morning?
☐	☐	Do you have thoughts racing through your mind while trying to fall asleep?
☐	☐	Do you watch a clock while trying to fall asleep?
☐	☐	Do you have anxiety which keeps you from sleeping?
☐	☐	Do you have muscle tension which can disrupt sleep onset?
☐	☐	Are you bothered by pain during the day or night?
☐	☐	Do you wake up feeling stiff in the morning or have sore, achy muscles?

BRUXISM

Yes	*No*	
☐	☐	Do you have morning jaw pain?
☐	☐	Do you grind your teeth during sleep?

SLEEP HYGIENE

What time do you go to bed? ______________________________
What time do you usually awaken during the weekends? ______________________________
What time do you usually awaken during the weekday? ______________________________

NOCTURNAL AWAKENINGS

How many times do you wake up during the night? __________

If so, what part of the night does this occur? ☐ Beginning ☐ Middle ☐ End

What are the usual causes? ☐ Shortness of breath ☐ Urinate ☐ Heartburn ☐ Body jerking ☐ Not sure ☐ Other

WORK SCHEDULE

Yes	No	
☐	☐	Are you a shift worker
☐	☐	Do you work swing shifts at work that require shift changes from one week to the other?
☐	☐	Do you get jet lag?

CIRCADIAN RHYTHM

☐	☐	Do you have trouble waking up in the morning and would rather stay up later (i.e. 2-3am) and sleep in until noon? (*Delayed Sleep Phase – more common in adolescents*).
☐	☐	Do you ever go to bed at 8pm only to find yourself awake at 3am? (*Advanced Phase Syndrome – more common in the elderly*).

Choose the appropriate number to indicate the extent of the problem you are having with each of the following:

	None					Moderate					Severe
Anxiety	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
Depression	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
Irritability	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

What has been you weight gain or loss over your lifetime? _____

Active Medical Problems: (e.g. diabetes. Do not leave this blank if you are taking any medication for any condition, please name the condition).

Inactive Medical Problems: (e.g. hypothyroid. Do not leave this blank unless you have never been sick).

Surgeries: (Include all operations and approximate **date**, even your childhood tonsillectomy).

Medications currently taking:

Past Medications: (Prescription and non-prescription and herbal) **<u>used in the past</u>**, other than those listed above which were. (e.g. Vicodin, Celebrex, Vioxx, Amitriptyline, Ultram, Valium, Xanax).

Name of medication:	**Dosage:**	**Name of medication**:	**Dosage:**

Medication allergies (if none, state none):

Family History:

	Living?	**Current Age or Age at Death**	**Present Health or Cause of Death**
Father			
Mother			
Brothers			
# Deceased			
Sisters			
# Deceased			
Children			
# Deceased			

Any family history of cancer, diabetes or heart disease not explained above needs to be explained here:

Social History:

Place of Birth: ______________________________

Highest level of education completed: ______________________________

Employer: ______________________ Occupation: ______________________

If retired, state so and list your former occupation: ______________________

Are you on disability? ______________________________

Did your pain begin after a work-related injury? ______________________

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Caffeine use:

_______ Number of cups of coffee per day
_______ Number of cups of tea per day
_______ Ounces of caffeinated soda per day

Substance Abuse:

Have you ever used illicit drugs or abused alcohol? Please explain (if none, state none).

☐ Drugs ______________________________
☐ Alcohol ______________________________
☐ None

Tobacco use:

Have you ever smoked? ☐ Yes ☐ No

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco

Age Began: __________ If you quit, at what age? _________

During the time you smoked, average number smoked daily?

☐ > 1 pack ☐ 1 Pack ☐ 1-2 Packs ☐ < 2 Packs

Alcohol use:

Have you ever used alcohol to control your pain? ☐ Yes ☐ No ☐ N/A

Have you ever?

Yes	No	
☐	☐	Felt you should cut down on your drinking?
☐	☐	Felt annoyed by others criticizing your drinking?
☐	☐	Felt badly or guilty about your drinking?
☐	☐	Had a drink first thing in the morning to steady your nerves or rid of hangover?
☐	☐	Were either of your parents alcoholics?

What is your approximate weekly use of alcoholic beverages?

☐ < 1-2 drinks per week
☐ 3-6 drinks per week
☐ Drink some alcohol on a daily basis
☐ I don't drink alcohol

What is your preferred drink? _______________

REVIEW OF SYSTEMS: Indicate symptoms you have had since your symptoms began:

GENERAL

- ☐ Allergies
- ☐ Decreased Appetite
- ☐ Bleeding
- ☐ Chills
- ☐ Cold Intolerance
- ☐ Fat Intolerance
- ☐ Fatigue
- ☐ Fever
- ☐ Hiccups
- ☐ Hot Flashes
- ☐ Lethargy
- ☐ Lymph Node Swelling
- ☐ Malaise
- ☐ Masses
- ☐ Night Sweats
- ☐ Excessive Thirst
- ☐ Excessive Appetite
- ☐ Recent Infection
- ☐ TB Exposure
- ☐ Transfusions
- ☐ Trauma
- ☐ Weakness, generalized
- ☐ Weight Gain
- ☐ Weight Loss

HEENT (HEAD, EYES, EARS, NOSE AND THROAT)

- ☐ Profuse Nasal Discharge
- ☐ Dental or Teeth Problems
- ☐ Toothache
- ☐ Drooling
- ☐ Dry Mouth
- ☐ Difficulty Swallowing
- ☐ Nose Bleeds
- ☐ Facial Pain
- ☐ Gingivitis
- ☐ Tongue Pain
- ☐ Bad Breath
- ☐ Exceptionally Good hearing
- ☐ Jaw Pain
- ☐ Eye Pain
- ☐ Oral Ulcers
- ☐ Ear Aches
- ☐ Drainage from Ear
- ☐ Post Nasal Drainage
- ☐ Runny Nose
- ☐ Sinus Pain
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Ringing in Ears
- ☐ Poor Vision

NECK

- ☐ Hoarseness
- ☐ Neck Limited Motion
- ☐ Neck Pain
- ☐ Neck Swelling

LUNGS/RESPIRATORY

- ☐ Cough
- ☐ Short of Breath
- ☐ Wheezing
- ☐ Bloody Mucous from Chest
- ☐ Short of breath when lying on back
- ☐ Sputum

HEART/CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Murmur
- ☐ Palpitations

ABDOMINAL/GASTROINTESTINAL

- ☐ Abdomen Swelling
- ☐ Abdomen Pain
- ☐ Belching
- ☐ Constipation
- ☐ Diarrhea
- ☐ Flank Pain
- ☐ Excessive Gas
- ☐ Vomiting Blood
- ☐ Bloody Stools
- ☐ Hernia
- ☐ Black Stools
- ☐ Nausea
- ☐ Heartburn
- ☐ Regurgitation
- ☐ Fatty Stools
- ☐ Stool Changes
- ☐ Pain over Bladder
- ☐ Vomiting

GENITAL/URINARY/RECTAL/BREAST

- ☐ Breast Discharge
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Dark Urine
- ☐ Bloody Urine
- ☐ Groin Pain
- ☐ Hemorrhoids
- ☐ Excessive Urination at Night
- ☐ Urine Urgency
- ☐ Urinary Incontinence
- ☐ Urine Flow Slow
- ☐ Urine Frequency

☐ Decreased Libido	☐ Pelvic Pain	☐ Painful Urination
☐ Excessive Urination	☐ Rectal Pain	☐ Urine Hesitancy
☐ Genital Ulcers	☐ Stool Incontinence	☐ Urine Retention

FEMALES

☐ Pregnancy	☐ Lack of Periods	☐ Irregular Periods
	☐ Painful Periods	☐ Genital Pain
	☐ Painful Intercourse	☐ Menstrual Changes
	☐ Vaginal Discharge	☐ Vaginal Irritation

MALES

☐ Impotence	☐ Scrotal Mass	☐ Testicle Pain

BONES

☐ Joint Pain	☐ Back Pain	☐ Dusky Blue Skin
☐ Edema	☐ Heel Pain	☐ Hip Pain
☐ Joint Stiffness	☐ Joint Swelling	☐ Knee Pain
☐ Leg Pain	☐ Muscle Cramps	☐ Muscle Twitching
☐ Muscle Pain	☐ Pale, Cold Finger/Toes	☐ Varicose Veins

NEUROLOGICAL/PSYCHIATRIC

☐ Headache	☐ Clumsiness	☐ Confusion
☐ Double Vision	☐ Disorientation	☐ Dizziness
☐ Falls	☐ Incoordination	☐ Memory Loss
☐ Numbness	☐ Paralysis	☐ Pins and Needles
☐ Seizures	☐ Speech Impairment	☐ Fainting Spells
☐ Tremor	☐ Room Spinning	☐ Agitation
☐ Anxiety	☐ Apathy	☐ Apprehension
☐ Depression	☐ Hallucinations	☐ Insomnia
☐ Irritability	☐ Restlessness	☐ Suicidal Ideation

SKIN

☐ Deficiency of Sweat	☐ Bite, Animal	☐ Bite, Spider
☐ Bite, Tick	☐ Bruising	☐ Cysts
☐ Excessive Sweating	☐ Hair Problems	☐ Jaundice
☐ Mole Changes	☐ Nail Problems	☐ Large Bumps
☐ Itching	☐ Rash	☐ Skin Lesions

What other doctors have been involved in the problem you present with today?

____

Continued on next page.

Have you had any diagnostic studies for your sleep issues?

Yes	No		Date and Results of Study:
☐	☐	X-Rays	______________________
☐	☐	MRI	______________________
☐	☐	Sleep Study	______________________
☐	☐	Myelogram	______________________
☐	☐	Blood Work	______________________
☐	☐	Other	______________________

Thank you very much for taking the time to complete this form.
You may sign at your appointment .if you received this form electronically.

______________________________ ______________
Patient's Signature ***Date***

Continued on next page.

SUN VALLEY PAIN AND SLEEP CENTER * PATIENT INFORMATION

Patient Name: ______________________ Birthday: __________ SS# __________

Home Phone: __________ Mailing and Physical Address: ______________________

Cell Phone: __________ City, State, Zip ______________________

Work Phone: __________ Employer Name: __________ Address: __________

If Child, Guardian Name: __________ Phone: ______________________

Emergency Contact: ______________________ Phone: __________

Who Referred you to our office? ______________________ Phone: __________

What type of claim will the treatment be rendered for? ☐ Health Ins. ☐ Auto Ins. ☐ Workers Comp. ☐ Cash

If this is an accident have you called your insurance company and reported the accident? ☐ Yes ☐ No

If related to work, have you reported this accident and have filled out Workers Compensation forms? ☐ Yes ☐ No

Does your insurance company require pre-authorization for surgery and/or admission? ☐ Yes ☐ No

Does your insurance company require a second opinion? ☐ Yes ☐ No

HEALTH INSURANCE

(Note: please indicate Health Insurance even is this is an accident claim)

Insurance #1 ______________________ Phone # __________

Policy # ______________________ Group # __________

Policy Holder's Date of Birth __________ Policy Holder __________ Relationship to Patient __________

Healthy Connection Provider #: ______________________

Insurance #2 ______________________ Phone # __________

Policy # ______________________ Group # __________

Policy Holder's Date of Birth __________ Policy Holder __________ Relationship to Patient __________

YOUR AUTOMOBILE INSURANCE

Please note: In Idaho, we are required to bill your auto insurance if you have Personal Injury Protection on your policy, even if the third party is at fault.

Insurance Carrier: ______________________ Phone # __________

Policy # __________ Claim # __________ Date of Accident: __________

WORKERS COMPENSATION INSURANCE

Insurance Carrier: ______________________ Phone # __________

Contact Name: __________ Claim # __________ Date of Accident: __________

Recognizing the inherent risks of transmission of contagious diseases, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/Aids, herpes, etc. when deemed necessary by the physician/surgeon. Questions should be discussed with your physician. I hereby authorize the attending physician to furnish the insurance company all information which the said insurance company may request from time to time. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me in the proper case, to my employer or other provider of insurance, when my bill is paid in full. I understand I am financially responsible to my physician and or surgeon for charges not covered by my insurance company. I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and be able to retain the original copy in the doctor's files and authorize the insurance company to accept the photocopy. I release you from all legal responsibility of liability that may arise from this authorization. This authorization shall continue and be in force and affect until revoked in writing by me. I request the payment of authorized Insurance and/or Medicare benefits to be made to Sun Valley Pain and Sleep Center on my behalf for any services furnished to me by the physician/surgeon.

______________________ __________

PATIENT'S SIGNATURE *DATE*

Kimberly A. Vorse M.D.
P.O. Box 5000
380 Washington Avenue, Suite 201
Ketchum ID 83340-5000
(208) 726-0000

Patient education and agreement

As a patient of Sun Valley Pain and Sleep Center and Dr. Vorse, I agree:

1. I will schedule an office appointment if I have questions about my care or my medications.
2. I accept that Dr. Vorse will not refill medications without an office re-evaluation.
3. I accept that it is my responsibility to maintain an accurate count of my medication and to call to insure I have an appointment before I run out of medication.
4. I will not have my family or friends call the office for any reason, as the Patient Privacy Act will not allow the office to communicate with them.
5. To allow Sun Valley Pain and Sleep Center to leave a message at any of the telephone numbers that I have provided to the office.
6. To schedule a follow up appointment to discuss test results for any diagnostic study I undergo and I will bring the actual films of any radiographic study performed.

Sincerely,

Kimberly A. Vorse MD

Diplomate of The American Board of Pain Medicine
Diplomate of The American Board of Anesthesiology with Subspecialty Certification in Pain Management

________________________ ________________________

Signature of patient Date

Svpm 2/03/02

PATIENT INFORMATION **Kimberly A. Vorse MD PC**

Patient Name: ______________________ Birthday: __________ SS# __________

Home Phone: __________ Mailing and Physical Address: ______________________

Cell Phone: __________ City, State, Zip ______________________

Work Phone: __________ Employer Name: __________ Email: __________

If Child, Guardian Name: __________ Employer Address: ______________________

Emergency Contact: ______________________ Phone: __________

Who Referred you to our office? ______________________ Phone: __________

What type of claim will the treatment be rendered for? ☐ Health Ins. ☐ Auto Ins. ☐ Workers Comp. ☐ Cash

If this is an accident have you called your insurance company and reported the accident? ☐ Yes ☐ No

If related to work, have you reported this accident and have filled out Workers Compensation forms? ☐ Yes ☐ No

Does your insurance company require pre-authorization for surgery and/or admission? ☐ Yes ☐ No

Does your insurance company require a second opinion? ☐ Yes ☐ No

HEALTH INSURANCE

(Note: please indicate Health Insurance even is this is an accident claim)

Insurance #1 ______________________ Phone # __________

Policy # ______________________ Group # __________

Policy Holder's Date of Birth __________ Policy Holder __________ Relationship to Patient __________

Healthy Connection Provider #: ______________________

Insurance #2 ______________________ Phone # __________

Policy # ______________________ Group # __________

Policy Holder's Date of Birth __________ Policy Holder __________ Relationship to Patient __________

YOUR AUTOMOBILE INSURANCE

Please note: In Idaho, we are required to bill your auto insurance if you have Personal Injury Protection on your policy, even if the third party is at fault.

Insurance Carrier: ______________________ Phone # __________

Policy # __________ Claim # __________ Date of Accident: __________

WORKERS COMPENSATION INSURANCE

Insurance Carrier: ______________________ Phone # __________

Contact Name: __________ Claim # __________ Date of Accident: __________

Recognizing the inherent risks of transmission of contagious diseases, especially during surgery, I voluntarily agree to be tested for such diseases as hepatitis, syphilis, HIV/Aids, herpes, etc. when deemed necessary by the physician/surgeon. Questions should be discussed with your physician. I hereby authorize the attending physician to furnish the insurance company all information which the said insurance company may request from time to time. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me in the proper case, to my employer or other provider of insurance, when my bill is paid in full. I understand I am financially responsible to my physician and or surgeon for charges not covered by my insurance company. I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and be able to retain the original copy in the doctor's files and authorize the insurance company to accept the photocopy. I release you from all legal responsibility of liability that may arise from this authorization. This authorization shall continue and be in force and affect until revoked in writing by me. I request the payment of authorized Insurance and/or Medicare benefits to be made to Sun Valley Pain and Sleep Center on my behalf for any services furnished to me by the physician/surgeon.

______________________ __________

PATIENT'S SIGNATURE DATE

Revised 02-18-09 sm

RECORDS RELEASE AUTHORIZATION

To: __ ______________________________________
Doctor or Hospital

__ ______________________________________

___ ______________________________________
Address

I hereby authorize and request you to release a summary of my medical records to:

Kimberly A. Vorse MD
P.O. Box 5000
380 Washington Avenue, Suite 201
Ketchum ID 83340
(208) 726-0000
www.kimvorsemd.com

Patient's Name __ ______________________________

Address __ ____________________________________

_ ____________________________________

Signature ______________________________________ Date ____________________

Witness ______________________________________
(If relative, state relationship)

SVPM: REVISED 2/4/03