Patient data sheet

Name .....

Address .....

.....

.....

Birthday .....

Phone number .....

Mobile number .....

E-Mail .....

Job .....

Insurance .....

Name Privately insured? ☐ Yes ☐ No Which? .....

Family doctor .....

Family doctor address .....

.....

.....

Referrer .....

Referrer address .....

Marital status ☐ living together ☐ living allone

Children ☐ Yes ☐ No How many? .....

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Daytime sleepiness

Name ..... First name ..... Date .....

Date of birth .....

The following questions relate to your everyday life recently, even if you have not experienced some of these situations, try to imagine them anyway.

How likely do you think it would be that you would doze off or fall asleep (not just feeling tired) in any of the following situations?

Scale goes from 0 (never) to 3 (very likely)

Situation / behavior	**Probability of falling asleep?**			
Reading while sitting	0	1	2	3
Watching television	0	1	2	3
Sitting passively (as a listener) in public (e.g. theater, cinema, etc.)	0	1	2	3
As a passenger in the car during a 1 hour drive without a break	0	1	2	3
When you lay down to rest in the afternoon	0	1	2	3
When you are sitting down and talking to someone	0	1	2	3
When you sit quietly after lunch (without alcohol)	0	1	2	3
If you have to stop for a few minutes while driving due to traffic	0	1	2	3
Please do not fill!	Toatal:			

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Sleep quality

The following questions relate to your usual sleeping habits and only during the last 4 weeks! Your answer should be as specific as possible. Please answer all questions.

Name ..... First Name ..... Age.....

Body size: ..... cm Body weight: ..... Kg Gender: ☐ female ☐ male

Employment: ☐ student ☐ Worker ☐ independent activity ☐ Employee ☐ unemployed ☐ housewife / -man

1. When are you during the last 4 weeks usually went to bed in the evening?	usual time: .....
2. How long has it been in the last 4 weeks usually took you to fall asleep?	in minutes: .....
3. When are you during the last 4 weeks usually got up in the morning?	usual time: .....
4. How many hours do you have during slept a night for the past four weeks?	effective sleep time (hours) per night: .....

Please tick the answer that applies to you for each of the following questions.

5. How often have you slept badly in the last 4 weeks ...

a) ... because you didn't do it within the first 30 minutes could fall asleep:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
b) ... because you are in the middle of the night or early in the morning have woken up:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
c) ... because you had to get up to go to the toilet:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
d) ... because you had difficulty breathing:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night

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5. How often have you slept badly in the last 4 weeks ...

e) ... because you had to cough or loudly have snored:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
f) ... because you felt too warm:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
g) ... because you were too cold:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
h) ... because you had a bad dream:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
i) ... because you were in pain:	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
j) ... for other reasons:	**How many times have you had poor sleep for these reasons?** ☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
6. How would you rate the overall quality of your sleep over the past 4 weeks?	☐ Very good ☐ Pretty good ☐ Pretty bad ☐ Very bad
7. How often have you been taken sleeping pills during the past 4 weeks?	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
8. How often have you had difficulty staying awake in the last 4 weeks, for example while driving, eating or at social events?	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night

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9. During the past 4 weeks, have you had problems doing normal, everyday tasks with enough momentum?	☐ No problems ☐ Hardly any problems ☐ Some problems ☐ Heavy problems
10. Do you sleep alone in your room?	☐ Yes ☐ Yes, but a partner / roommate is sleeping in another room ☐ No, the partner sleeps in the same room but not in the same bed ☐ No, the partner sleeps in the same bed

If you have a **roommate / partner**, please ask whether and **how often he / she** has noticed the following.

a) Loud snoring	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
b) Long pauses in breathing during sleep	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
c) twitching or jerking of the legs during sleep	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
d) Nocturnal phases of confusion or disorientation during sleep?	☐ Not at all for the last 4 weeks ☐ Less than once a week ☐ Once or twice a week ☐ three times or more per night
e) Other forms of restlessness during sleep	Type and frequency..... ....

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The following questions are intended to help your treating therapist assess your sleep disorder. Please answer the questions by ticking the appropriate answer below. Only one cross per question or statement may be made. The questions relate to the past four weeks.

Name .....

First Name .....

Birthday .....

My usual bed times are from ..... at night until ..... o'clock the next day.

How many minutes do you usually need to fall asleep?	1-20 Min.	20-40 Min.	40-60 Min.	60-90 Min.	More than 90 Min.
	0	1	2	3	4

How many hours do you think you sleep on average at night?	7 and more	5-6	4	2-3	0-1
	0	1	2	3	4

	always	mostly	sometimes	rare	never
I can't sleep through the night	4	3	2	1	0
I wake up too early	4	3	2	1	0
I wake up with slight sounds	4	3	2	1	0
I feel like I haven't closed my eyes all night	4	3	2	1	0
I think a lot about my sleep	4	3	2	1	0
I am afraid to go to bed because I fear that I will not be able to sleep	4	3	2	1	0
I feel fully capable	0	1	2	3	4
I take sleeping pills to fall asleep	4	3	2	1	0

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HADS Test

HADS: Hospital Anxiety and Depression

Name ..... First Name ..... Date .....

Date of birth .....

I am today as happy as before:	☐ exactly like that ☐ not quite so much ☐ only a little bit more ☐ hardly or not at all	**I can laugh and see the funny side of things:**	☐ yes, as much as always ☐ not so much anymore ☐ meanwhile much less ☐ not at all
I feel happy:	☐ mostly ☐ sometimes ☐ rare ☐ not at all	**I feel myself slowed down in my activities:**	☐ not at all ☐ rare ☐ sometimes ☐ mostly
look with joy into the future:	☐ yes, very ☐ rather less than before ☐ much less than before ☐ hardly not at all	**I can enjoy a good book, a radio or television program:**	☐ yes, often ☐ sometimes ☐ rather rare ☐ very rare
I have lost interest in my outward appearance:	☐ I'll take care of it as usual ☐ maybe I care too little about it ☐ I do not care as much as I wanted ☐ yes, that's right		

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STOP-BANG-Questionnaire

Yes	No	
☐	☐	**Snoring?** Do you snore loudly (so loudly that it can be heard through closed doors or that your bed neighbor bumps you at night with your elbow because you snore)?
☐	☐	**Tired?** Are you often tired, exhausted or sleepy during the day (e.g. do you fall asleep while driving a car)?
☐	☐	**Noticed?** Has anyone ever noticed that you stop breathing in your sleep or don't get any air / gasp for air?
☐	☐	**Blood pressure?** Do you have high blood pressure or are you being treated for it?
☐	☐	**Body mass index over 35 kg/m2?**
☐	☐	**Are you over 50 years old?**
☐	☐	**Large collar size? (Measured around the larynx)** For men: do you have a collar size of 43 cm or more? For women: do you have a collar size of 41 cm or more?
☐	☐	**Gender = Male**

Evaluation criteria:

For the general population:

Low risk of OSA: 0-2 questions answered yes
Medium risk of OSA: 3-4 questions answered yes
High risk of OSA: 5-8 questions answered yes
or at least 2 of the 4 first questions answered yes + male gender
or at least 2 of the 4 first questions answered yes + BMI> 35 kg/m²
or at least 2 of the 4 first questions answered yes + neck circumference
(43 cm for men, 41 cm for women)

Property of the University Health Network, more information at: www.stopbang.ca
Modified from Chung F et al. Anesthesiology 2008; 108: 812-21, Chung F et al Br J Anaesth 2012; 108: 768-75, Chung F et al J Clin Sleep Med Sept 2014

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General questions

We would like to ask you to complete the following questionnaire to clarify your findings.
Please tick the appropriate box. Many Thanks.

Name ..... First Name ..... Date of birth .....

If the following symptoms apply to you, please tick:

Dry mouth ☐ Headache ☐ Shortness of breath ☐ Night sweats ☐ Cardiactachycardia ☐ Nocturia ☐

Sleepwornness ☐ Sleep-through disorders ☐ Wake-up reaction ☐ Daytime tiredness ☐ RLS ☐ Depression ☐

1. Are you tired during the day?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

2. Do you fall asleep during the day?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

3. Is it hard for you to stay focused for a long time?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

4. Do you feel limited in your performance lately?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

5. Does it happen that you fall asleep badly in the evening?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

6. Does it happen that you wake up in the middle of the night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

7. Does it happen that you wake up earlier than usual?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

8. Do you feel heart stumbling, tachycardia at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

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9. Are you wet with sweat at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

10. Do you have shortness of breath, feelings of suffocation at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

11. Do you feel a headache at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

12. Do you feel coughing at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

13. Do you feel pressure in the chest at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

14. Do you need to go to the toilet at night?

☐ never 0	☐ rare 0-1	☐ occasionally 1-2	☐ often 2-3	☐ very often more than 3x

15. If you suffer from sleep disorders, can you think of a reason?

☐ no	☐ Yes, physical	☐ Noises, noise	☐ Work problems	☐ Shift-Nightwork	☐ Excitement, Nervousness	☐ Other complaints ....

16. Are your legs swollen?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

17. Are you limited in your capacity to exercise due to shortness of breath when performing heavy physical work?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

18. Are you limited in your capacity to exercise due to shortness of breath when doing light physical work?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

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19. Are you limited in your capacity due to shortness of breath if you do not do any physical work?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

20. Has your partner noticed respiratory arrest at night? ☐ **I do not have a partner**

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

21. Do you wake up fresh and rested in the morning?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

22. Do you feel limp and skidded in the morning?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

23. Do you have a headache in the morning?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

24. Does your partner report that you are snoring loudly and irregularly?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

25. Does your partner report that you move frequently at night?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

26. Do you tend to fall asleep while driving?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

27. Have you recently caused a car crash or a small damage?

☐ never	☐ rare	☐ occasionally	☐ often	☐ very often

28. Do you sleep longer than before? / What are your sleep times?

☐ Yes	☐ No	Mostly sleep at ..... o'clock.	Wake up in the morning at .....

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29. Do you take sleeping pills?

☐ Yes ☐ No If yes, which ..... ☐ rare ☐ occasionally ☐ often ☐very often

30. Do you have high blood pressure?

☐ Yes ☐ No If yes, how high: ..... / ..... (mmHg) ☐ I don't know

31. Do you consume?

Alcohol ☐ THC/CBD ☐ other Drugs ☐ Coffee yes ☐ no ☐ if yes, how many cups .....

32. Do you smoke cigarettes regularly?

☐ No ☐ Yes, up to 10 cigarettes/day ☐ Yes, up to 20 cigarettes/day ☐ Yes, over 21 cigarettes/day If yes, for how many years .....

33. Please state your body weight and size

Body weight: ..... kg Body size: ..... cm

34. Are you working?

☐ Yes, I am ..... (occupation / Activity) ☐ No ☐ Retired

35. Which medications do you take and how often?

.....
.....
.....

36. Do you have any other illnesses?

.....
.....
.....

37. Do you have allergies?

☐ Yes if yes, how many ..... ☐ No

38. Do you have pets?

☐ Yes if yes, how many ..... ☐ No

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Date .....

Signature .....

Data protection and data processing

Welcome to our practice

With this flyer we would like to comply with the data agreement in our data protection information obligation from the European General Data Protection Regulation (GDPR) and the Federal Data Protection Act (BDSG). The data agreement is based on a basis or your consent. The legal basis for the data agreement of your health data is Article 9 Paragraph 2 Lit. h) GDPR in conjunction with Section 22 Paragraph 1 No. 1 Lit. B) Federal Data Protection Act.
If your consent is required for the data agreement, you can revoke or restrict this at any time with effect for the future. You have the right, insofar as the prerequisites are met, to receive information about your processed data and to correct or delete them, to restrict processing and to transfer them.

If you have any questions about data protection, please contact the practice management. If further questions arise, you have the right to contact the Hessian representative for data protection and freedom of information.

Contact details for data protection officer:

The Hessian representative for data protection and freedom of information
Box 3163
65201 Wiesbaden
Tel .: 0611-1408 0
Fax .: 0611-1408 611

Data acquisition

Every time you contact us, your insurance card is read into our electronic practice management system (PVS). The following data is collected: Name, address, insurance provider and insurance number.
In further contact, we collect findings and diagnoses from you, prescribe therapies and fill out the sample forms (prescriptions, AU, transfers, etc.) specified by KV Hessen. All of this must be stored in a verifiable patientrelated manner in our PVS. Subsequent processing and changes to your data are clearly documented by the PVS. Written (thirdparty) findings are scanned electronically and cannot be changed in our PVS (document scanner). Each new patient receives this flyer when they first contact us in our practice, which we use to inform them about which data we collect, on what legal basis this is done and to whom we forward your data. In the case of a transfer, we assume tacit consent. Please note that there may also be a legal obligation to pass on the data.

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Data protection and data processing

What happens to your data?

We need your data in order to be able to treat you verifiably for KV Hessen and the cost objects. All regulations are patientrelated and require a name, address, cost unit and insurance number. If we do not have this data, we can e.g. do not issue recipes. Data collection is therefore necessary for your treatment.
The following data is saved on our server with password protection:

- Acute (for the current quarter) and permanent diagnoses (cross-quarter).
- Findings, medical histories, therapy suggestions, billing figures for the respective quarter.
- All electronically created forms as well as all regulations have to be stored permanently so that they can be checked.

Only authorized practice personnel have access.
Your data (findings, doctor's letters etc.) will be kept according to the respective statutory periods (doctor's letter 10 years, X-ray recordings 30 years).

Who receives your data?

- The Kassenärztliche Vereinigung Hessen for billing and checking for correctness
- Upon request, your data and all regulations must be sent to the review committee as part of a recourse review
- At the request of the medical service of the health insurance companies to check the treatment
- Your health insurance company receives relevant data for billing Laboratory doctors or histology, if appropriate diagnostics are required for the treatment
- The use of legal or judicial help may be necessary to protect the legitimate interests of the doctor's office.
- Other doctors, insurance companies, private accounting offices and other institutions will only receive the data necessary for the respective case with your separate consent.

Note: .....

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Internal intensive care medicine and emergency medicine

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