

Pediatric History Update

Patient Name: _____ **DOB:** _____ **Date:** _____

Answer below and enter information if applicable:

Do you eat/drink caffeine? (Chocolate, soda, coffee, tea, etc.)	☐ YES	☐ NO	How much per day?
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Medical History (Mark all that apply)

☐ No Medical History	☐ Allergies or Allergic Rhinitis	☐ Asthma
☐ Acid Reflux or GERD	☐ Enuresis/Urinating in Sleep	☐ Genetic Disease
☐ Enlarged Tonsils/Hypertrophy	☐ Heart Disease	☐ HBP/Hypertension
☐ Headaches	☐ Seizures/Epilepsy	☐ Sickle Cell Disease
☐ Poor or Delayed Growth	☐ Sinus Problems/Sinusitis	☐ Trouble Breathing through Nose
☐ Sleep Talking/Somnambulism		
☐ Thyroid Disorder/Type: _____		
☐ Cancer - Type: _____		Other: _____

Please List any Prescription Medications you currently take with the dosage:

☐ No Medication changes since last visit

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Allergies: _____

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 your usual way of life in the past few months. Even if you have not done some of these things recently, try to work out how they would have affected you. Choose the most appropriate number for each situation.

0 = Would never fall asleep 1 = Slight chance of dozing 2 = Moderate chance of dozing, 3 = High chance of dozing

Situation	Chance of Dozing
Sitting and reading	☐ 0 ☐ 1 ☐ 2 ☐ 3
Watching TV	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting in a public place (i.e., theater or classroom)	☐ 0 ☐ 1 ☐ 2 ☐ 3
As a passenger in a car for an hour without a break	☐ 0 ☐ 1 ☐ 2 ☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting and talking to someone	☐ 0 ☐ 1 ☐ 2 ☐ 3
Sitting quietly after a lunch	☐ 0 ☐ 1 ☐ 2 ☐ 3
Doing homework or taking a test	☐ 0 ☐ 1 ☐ 2 ☐ 3
Epworth Sleepiness Scale Total=	

PATIENT RIGHTS AND REQUIREMENTS

- A patient is treated with dignity, respect, and consideration;
- A patient is not subjected to Abuse, Neglect, Exploitation, Coercion, Manipulation, Sexual abuse, Sexual assault, restraint or seclusion (except as allowed by ARS R9-10-1012B, Retaliation for submitting a complaint to the Department of Health Services or another entity, misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student.
- A patient or patient's representative, except in an emergency, may either consent to or refuse treatment and may refuse or withdraw consent for treatment before treatment is initiated. Except in an emergency, a patient or a patient's representative is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic drug or surgical procedure.
- A patient or patient's representative is informed of the following;
 - The outpatient treatment centers policy on health care directives and the patient complaint process.
 - Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes.
 - Except as otherwise permitted by law, provides written consent to the release of information in the patient's Medical or Financial records.
- A patient has the following rights:
 - Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis.
 - To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities.
 - To receive privacy in treatment and care for personal needs.
 - To review upon written request, the patient's own medical record according to ARS 12-2293, 12-2294, and 12-2294.01.
 - To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient.
 - To participate or have the patient's representative participate in the development of, or decisions concerning treatment.
 - To participate or refuse to participate in research or experimental treatment.
 - To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting, or exercising the patient's rights
- The handling of patient complaints is generally taken care of by staff members, however, if patient complaints are above a simple fix or are not to their satisfaction these complaints should be addressed in writing to the Administrator or Director of Patient Services. Patients and staff members have the ability to inform the Administrator or Director of Patient Services to file a formal complaint or incident

SERVICES AND ACKNOWLEDGMENT OF CONSENT

I consent to Physician services included in any sleep consultation or follow up that may include but not limited to general physical examinations including ear, nose and throat; cardio/pulmonary, PAP Therapy trial and/or mask fitting, other therapy or services and gathering of general vitals. (Blood pressure, Height/Weight, neck circumference, etc.) By signing below I request that Valley Sleep Center/Physicians and its associates perform consultations and related services and sign this voluntarily to consent and authorize these procedures. I understand that if it is determined during any exam/consultation that my health requires urgent care beyond what the Sleep Center can provide, emergency services may be contacted for support. I have been given the opportunity to review and sign this consent form and I agree and understand this document.

ADVANCED DIRECTIVE

Healthcare Directives information is provided by the state of Arizona and has a system for patients to apply and store documents for healthcare provider access. Advance directives are documents that outline what healthcare and treatment decisions should be made if you are unable to communicate these wishes. Please visit <https://healthcurrent.org/azhdr/> to learn more. There is no filing fee, and the process takes up to three weeks. A Healthcare Directive is not required for your visit.

Patient or Guardian Signature: _____ **Date:** _____