Inspiration Medic

PATIENT INFORMATION

www.inspirationmedic.com

Name: ______________________________
Last First

DOB: ______________ Health Card #: ______________
DD / MMM / YYYY Version Code

Address: ______________________________
Postal Code

City: ______________ Email: ______________
Province

Phone: ______________________________
Home Cell Work

Alternate Contact: ______________________________
(If we can't reach you) Name Phone or Email

PREFERRED METHOD OF COMMUNICATION ☐ Phone ☐ Email ☐ Day ☐ Evening ☐ No Preference

Private Insurance: ______________________________
Name Employer Plan # ID

Secondary Insurance: ______________________________

Other Funding: ☐ OW (Ontario Works) ☐ ODSP ☐ VAC ☐ RCMP ☐ NIHB ☐ None

SYMPTOMS

- ☐ SNORING
- ☐ RESTLESS SLEEP
- ☐ GASPING FOR AIR / CHOKING
- ☐ WITNESSED APNEA
- ☐ TIRED
- ☐ NEED TO NAP
- ☐ MORNING HEADACHES
- ☐ MEMORY LOSS
- ☐ IRRITABILITY (IMPATIENT)
- ☐ INSOMNIA

Height: ______________

Weight: ______________

ASSOCIATED CONDITIONS

- ☐ HIGH BLOOD PRESSURE
- ☐ CHRONIC PAIN
- ☐ DEPRESSION / ANXIETY
- ☐ DIABETES
- ☐ HEART DISEASE
- ☐ THYROID DYSFUNCTION
- ☐ ACID REFLUX
- ☐ NASAL CONGESTION
- ☐ DEVIATED SEPTUM
- ☐ SEASONAL ALLERGIES / POST NASAL DRIP
- ☐ MIGRAINES
- ☐ PERIODIC LIMB MOVEMENT (PLM)
- ☐ DENTURES / MOUTH GUARD

SLEEP PATTERN

Bed Time: ______________

Wake up time: ______________

How long to fall asleep? ______________

Position: ☐ Side ☐ Back ☐ Stomach

Number of pillows: ______________

Bathroom: ______________ times per night

Do you smoke ? Y ☐ N ☐

Sleep medication Y ☐ N ☐

Why did you choose Inspiration Medic ?

____

Have you purchased a device before ?

Date: ______________

Provider: ______________

SN#: ______________

TO BE COMPLETED BY CLINICIAN

HC # VERIFICATION ☐

SLEEP LAB: ______________ ORIGINAL REQUEST / Rx: ______________

SLEEP PHYSICIAN: ______________ NEXT APPOINTMENT: ______________