East Coast Wellness at Sleep-Wake Disorder Center of Daytona
Addressing Your Wellness from the Ground Up
Nashwa M. Wahba, DO

810 Wildwood St. Suite 1
Daytona Beach, Florida 32117
SWDCFront@gmail.com

(386)258-7100
(386)253-1843

New Patient Questionnaire – Wellness Program

Full Name: _____ DOB: _____

NUTRITION & WEIGHT HISTORY

Current Height: _____ Weight goal: _____

How much did you weigh 1 year ago? _____ 5 years ago? _____ 10 years ago? _____

Have you been trying to achieve weight loss for more than 6 months with diet and exercise? ☐ YES ☐ NO

When did you first notice weight gain? (Select one)

☐ in childhood ☐ as a teenager ☐ in adulthood ☐ post-pregnancy ☐ post-menopause

If unsure, please explain briefly: _____

Life events associated with weight gain (Select all that apply)

☐ quitting smoking	☐ medication	☐ job change	☐ retirement
☐ injury	☐ menopause	☐ marriage	☐ night-shift work
☐ pregnancy	☐ divorce	☐ abuse	☐ alcohol intake
☐ drug use	☐ traveling	☐ stressful job	☐ stressful event

If other, please explain briefly: _____

_____

Previous weight-loss programs (Select all that apply)

☐ Weight Watchers	☐ Nutrisystem	☐ Jenny Craig	☐ LA Weight Loss	☐ HCG
☐ Atkins	☐ Ketogenic diet	☐ Medifast	☐ South Beach	☐ No prior programs
☐ Zone diet	☐ DASH	☐ Mediterranean	☐ Paleo	

MAX weight loss in a diet/program: _____ Greatest challenge when dieting: _____

Have you ever taken medication for weight loss? ☐ YES ☐ NO

Which medication/supplement (if any) was helpful? _____

Current diet (Select all that apply)

☐ Carbohydrate restricted	☐ Fat restricted	☐ Vegetarian	☐ Vegan
☐ Salt restricted	☐ Calorie restricted	☐ Low Cholesterol	☐ Other: _____

Diet recommended by: _____

Food triggers (Select all that apply)

☐ Stress	☐ Anger	☐ Boredom	☐ Insomnia	☐ Seeking reward
☐ Alcohol intake	☐ Social events	☐ Food availability	☐ Eating out	☐ Constant hunger

Food cravings (Select all that apply)

☐ Sugar	☐ Starches	☐ Chocolate	☐ Salty food
☐ Fast food	☐ High fat	☐ Large portions	

Is there any specific time of the day or month that you crave food? _____

Do you have a good support system with your weight loss efforts? ☐ YES ☐ NO

If NO, please explain briefly: _____

EATING HABITS

Do you skip meals? ☐ YES ☐ NO

Number of times you eat per day: _____

How many days per week do you eat BREAKFAST? ___ A typical BREAKFAST consists of: _____

_____

How many days per week do you eat LUNCH? _____ A typical LUNCH consists of: _____

_____

How many days per week do you eat DINNER? _____ A typical DINNER consists of: _____

_____

How many days per week do you eat SNACKS? _____ A typical SNACK consists of: _____

Is it a planned snack? ☐ YES ☐ NO _____

What do you add to your food? (Select all that apply)

☐ Salt	☐ Salt Substitute	☐ Sugar	☐ Sugar substitute
☐ Butter	☐ Margarine	☐ Hot sauce	☐ Ketchup
☐ Mayonnaise	☐ Dressing	☐ Mustard	☐ Other: _____

Do you get up at night to eat? ☐ YES ☐ NO

Do you eat in the car? ☐ YES ☐ NO

Do you eat while standing up? ☐ YES ☐ NO

Do you eat while watching TV? ☐ YES ☐ NO

Do you eat while reading or on the computer? ☐ YES ☐ NO

Do you sit down to eat with others? ☐ YES ☐ NO

Do you eat fast? ☐ YES ☐ NO

Do you have any foods you can't stop eating once you start? ☐ YES ☐ NO

If YES, which foods? _____

Do you tend to clean your plate even if you are full before the meal is over? ☐ YES ☐ NO

Do you gulp or inhale your food? ☐ YES ☐ NO

Do you feel that your eating is sometimes out of control and you can't seem to change it? ☐ YES ☐ NO

If I eat food that is not part of a diet, I will: (select one)

☐ Eat less the rest of the day ☐ Eat more the rest of the day ☐ Continue to eat the same

Do you feel that you eat significantly less than others do and still gain weight? ☐ YES ☐ NO

DRINKING HABITS

How many glasses of WATER do you drink per day?____

How many glasses of JUICE do you drink per day? _____ DIET juice? _____

How many glasses of SODA do you drink per day? _____ DIET soda? _____

How many glasses of SWEET tea per day? _____ DIET tea?_____

How many glasses of GREEN/CHAI tea per day?_____ CAFFEINE FREE tea? _____

How many glasses of MILK do you drink per day? _____ What type of milk? _____

How many cups of COFFEE do you drink per day? _____ What type of coffee? _____

How many servings of Creamer/Half&Half/Sugar do you add per day? _____

PHYSICAL ACTIVITY

Which of the following describes your CURRENT physical activity (select one)

- □ Inactive (No regular physical activity with a sit-down job)
- □ Light activity (No organized physical activity during leisure time)
- □ Moderate activity (Occasionally activities such as weekend golf, jogging, hiking, swimming, or cycling)
- □ Heavy activity (Consistent activity or regular participation in active sports at least 3 times per week)
- □ Vigorous activity (Extensive physical exercise for at least 60 minutes per session 4 times per week)

Does anything limit you from doing physical activity? _____

Do you have any serious injuries that might prevent you from physical activity? □ YES □ NO

List your injuries: _____

_____

Are you having pain currently or have you experienced pain in the recent past several weeks? □ YES □ NO

Is your chronic or acute pain currently being treated by a medical specialist? □ YES □ NO

If you answered YES above, did your pain interfere with your physical activity level? □ YES □ NO

ENVIRONMENTAL FACTORS

Who does the meal planning most frequently? (Select one)

□ Self □ Partner □ Both □ Other Family Member(s) □ No Meal Planning

Who does the grocery shopping most frequently? (Select one)

□ Self □ Partner □ Both □ Other Family Member(s)

What day(s) of the week do you shop for groceries? (Select all that apply)

□ Sundays □ Mondays □ Tuesdays □ Wednesdays □ Thursdays □ Fridays □ Saturdays

□ Daily □ No set days

What time of the day do you typically shop for food/groceries?

□ No set time □ Early morning (before lunch) □ During lunch time

□ Early afternoon □ Prior to dinner time □ At nighttime (after dinner)

Who prepares the food at home most frequently?

□ Self □ Partner □ Both □ Other Family Member(s) □ Other pre-made meals

Is income a factor in your selection of food? □ YES □ NO

FOOD BEHAVIOR

Do the weekends affect your eating habits? ☐ YES ☐ NO

If YES, please explain: _____

Do you frequently eat meals outside of the home? ☐ YES ☐ NO

How many days per week do you eat out for BREAKFAST? _____

How many days per week do you eat out for LUNCH? _____

How many days per week do you eat out for DINNER? _____

What fast food(s) and restaurants do you visit frequently? Please list. _____

_____

Do you read food labels? ☐ YES ☐ NO

If YES, what do you look for on a label? _____

Do the nutrition facts on the label influence your decision to eat the food or drink the item? ☐ YES ☐ NO

GENERAL BEHAVIOR

I would describe myself as: (select the item that best describes you)

- ☐ Always calm and easygoing
- ☐ Usually calm and easygoing
- ☐ Sometimes calm with frequent impatience
- ☐ Seldom calm and persistently driving for advancement
- ☐ Never calm and have overwhelming ambition
- ☐ Hard-driving and can never relax

What is your highest level of education:

- ☐ Middle School ☐ High School ☐ Vocational
- ☐ Associate ☐ College ☐ Master or Doctoral
- ☐ If OTHER, please explain briefly: _____

I learn best by: (select one)

- ☐ Reading ☐ Watching ☐ Talking
- ☐ Practicing ☐ Explaining ☐ Other: _____

What is your primary language? (If not English) _____

Do you have a learning or physical disability? ☐ YES ☐ NO

If YES, please explain briefly: _____

Do you need assistance to perform the activities of daily living? ☐ YES ☐ NO

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Your Appointment is scheduled on: **at:**

Today's Date:

Name: ☐ M ☐ F Date of Birth:

Mailing Address:

City: State: Zip Code:

Home Phone: Cell Phone: Email:

SSN: Ethnicity/Race:

Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced

Spouse/Partner Name: Phone No.:

Emergency Contact: Phone No: Relationship:

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Employer: Occupation: Work Phone No.:

Primary Care Doctor: Referring Doctor:

Insurance Information:

Primary Insurance Name:	Secondary Insurance Name:
Address:	Address:
Insured Name: DOB:	Insured Name: DOB:
Policy ID:	Policy ID:
Group #:	Group #:
Employer Name:	Employer Name:
Employer Address:	Employer Address:
Phone No.:	Phone No.:
Relationship of Patient to Insured:	Relationship of Patient to Insured:
I hereby authorize SWDC and the undersigned physicians to release any information acquired during the course of my examination for treatment to my referring physician or insurance carrier listed above.	Do we have permission to: - Leave a voicemail on your answering machine? ☐ Y ☐ N - Leave a message at your place of employment? ☐ Y ☐ N - Send a text or email message? ☐ Y ☐ N

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. It is also customary to pay for service when rendered unless other arrangements have been made in advance with the office billing department.

I request that payment of authorized medicare/insurance company benefits be made to me or on my behalf to Sleep Wake Disorder Center of Daytona Beach (Dr. Wahba W. Wahba), for any services furnished by that party who accepts assignments/physician. Regulations pertaining to Medicare assignment of benefits apply.

Signature: Date:

SWDC Representative/Scanned: Date:

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Consent for Purposes of Treatment
Information Release Form

Name:_____D.O.B_____

Consent to Treatment

I hereby give my permission for the providers of Sleep Wake Disorder Center of Daytona, PA to examine, treat, and prescribe medication(s) for the condition(s) I present with.

Signature: _____ _Date:_____

Release of Information

I consent to the release of information of medical records and/or the discussion of my condition to family and caregivers as listed below.

☐ Yes

☐ No

If yes, please name those valid individuals:

Name: Phone Number:

1) _____

2) _____

3) _____

Signature:_____ Date:_____

SWDC Staff Notes:

SLEEP-WAKE DISORDE CENTER OF DAYTONA, PA FINANCIAL POLICY

Patient Responsibility
You are financially responsible for the services we provide you at Sleep-Wake Disorder Center of Daytona, PA (SWDC). As a courtesy, we will file insurance claims on your behalf, when you have supplied SWDC with current and precise insurance information. If you present without this information, please be prepared to either pay cash or reschedule your visit. It is your sole responsibility to know the individual coverage and benefits of your insurance plan. It is your responsibility to ensure our practice is a contracted provider with your plan. If you fail to keep this information updated, your claim may be denied and you will be responsible for any charges due for services rendered.

Patients Without Insurance (self-pay)
It is our pleasure to provide services to patients that do not have insurance. However, you will be expected to pay for your services at the time of the visit. We do not bill self-pay accounts. Estimations of cost can be discussed with our Billing Department prior to scheduling to plan for anticipated cost of services.

Medicare Patients
SWDC accepts Medicare assignment. We will bill your secondary insurance if you provide us with the proper insurance information. You are, however, solely responsible for any coinsurance, deductibles, or any charges for non-covered services. You will be required to sign an advanced beneficiary notice for any procedure performed.

Private Insurance Patients
SWDC accepts assignment for most major insurances. It is your responsibility to confirm that we are a contracted Provider with your plan. You will be required to pay any applicable copayments, coinsurance, deductibles, and/or any non-covered services rendered or ordered by the clinic Providers at SWDC.

HMO Patients
It is the patient's responsibility to ensure our practice is a contracted provider, and that your Primary Care Physician has obtained prior authorization from your insurance carrier. If your plan requires referrals to specialty physicians you must adhere to your plan and our practice referral policy. If you seek care without prior authorization, you will be financially responsible for the specialist visit(s).

We Do Not File Third Party Liability Insurance Claims
We will provide medical care for you in accident cases, but will only file with your medical insurance or accept cash at the time of visit.

Methods of Payment
We accept cash, checks, Visa, MasterCard or Discover cards only. A $20.00 charge will be assessed for any returned checks (NSF).

Prior Balances
Patients with an account showing a prior balance will be asked to pay the balance in full before being seen. If the balance cannot be paid in full, you may be asked to meet with our billing department to arrange for payment.

Form Charges
There will be a charge assessed for the completion of any disability, insurance, or special forms. Rates are $25.00 for one to multiple pages. These charges are not covered by insurance carriers and are due at time of service, in addition to any applicable office visit fees.

Information Change
Please advise us of any address, phone number, or insurances changes promptly. You will be asked at least once a year to fill out new demographic information, or to initial that what is on file is current and correct.

Appointments: Reschedule and Cancelations
Please notify SWDC at least 24 hours in advance if you must cancel or reschedule your appointment. This allows us time to schedule another patient. Patients with consecutive missed or cancelled appointments will be billed a $25.00 charge per missed appointment and may be dismissed from SWDC and will need to find a new Provider accepting their plan.

Collection Procedures
Prompt payment for services rendered is expected in full. Failure to reply to communications from our office may result in your account being turned over to an outside collection agency and discharge from our practice. If your insurance company has not paid your account in full within 120 days, you will be billed the balance. Balances on accounts that are not paid after 2 billing cycles (60 days) will be sent a 'final notice" letter. If still not satisfied within 30 days, the account will be turned over to an outside collection agency at that time.

I HAVE READ AND AGREE TO THE ABOVE POLICY. I UNDERSTAND THAT REGARDLESS OF MY INSURANCE, I AM FINANCIALLY RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED BY SWDC. I AUTHORIZE RELEASE OF INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OF CLAIMS FOR SERVICES RENDERED. I ASSIGN ALL INSURANCE BENEFITS TO AFMC. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

_____

Patient Name **Patient Signature** **Date**

_____

Name of Parent/Guardian of minor **Parent/Guardian Signature** **Date**

SWDC Staff Member: _____ **DATE:** _____

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Authorization for the Disclosure of Medical Records

1. **Regarding the Patient:**

Name: Last, First, MI		
Street Address		Telephone Number
City	State	Zip Code
	Date of Birth (MM/DD/YYYY)	

2. **Records Released From:**

3. **Records Released To:**

Name: (Health Facility, Physician)		Name: (Physician, Lawyer, Ins Co.) Nashwa Wahba, DO	
Street Address		Street Address 810 Wildwood Street, Suite 1	
City State	Zip Code	City State DAYTONA BEACH, FL 32117	Zip Code
Phone Number	Fax Number	Phone Number 386-258-7100	**386-253-1843**

4. **Information to Be Released**: (Check all applicable)

☐ Complete Copy of All Records
☐ Special Procedures/Outpatient Procedures
☐ Other: (Please Specify)_____
☐ Lab Reports
☐ Radiology
☐ Doctor's Notes

_____

5. **Purpose or Need of Disclosure**: (Check all applicable)

☐ Further Medical Care
☐ Legal Investigation
☐ Other: (Specify)_____
☐ Payment of Insurance Claim
☐ Personal
☐ Application for Insurance
☐ Academics

6. This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. (Written consent is necessary to revoke this request).

☐ Additional time period. Specify:_____ ☐ None

7. I hereby authorize the release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

Signature of Patient:_____ Date:_____

Witness:_____

Medical History Form

Review Of Systems: (Please Check off all that are present ***at this time***)	
General:	☐Fever, ☐Chills, ☐Weight Loss, ☐Weight Gain
HEENT:	☐Change in Vision, ☐Blurry Vision, ☐Sore Throat, ☐Dry Mouth, ☐Grind Teeth, ☐Ear Ringing, ☐Ear Pain, ☐Hearing Loss
Respiratory:	☐Cough, ☐Wheezing, ☐Shortness of Breath, ☐Sputum ☐Coughing up Blood
Cardiac:	☐Chest Pain, ☐Racing Heart Beats, ☐Leg Swelling, ☐Atrial Fibrillation, ☐Heart Attack ☐Sleep on Multiple Pillows due to Breathing, ☐Wake up Gasping for Air
Gastrointestinal:	☐Abdominal Pain, ☐Constipation, ☐Diarrhea, ☐Nausea, ☐Vomiting, ☐Reflux
Neurologic:	☐Seizures, ☐Headaches, ☐Dizziness, ☐Numbness, ☐Tingling, ☐Vertigo, ☐Stroke, ☐Memory Loss, ☐Dementia,
Psychiatric:	☐Depression, ☐Anxiety, ☐Hallucinations, ☐ADD/ADHD, ☐bipolar disorder
Endocrine:	☐Heat Intolerance, ☐Cold Intolerance, ☐Diabetes, ☐Hypothyroidism
Hematologic:	☐Easy Bruising, ☐Easy Bleeding, ☐Anemia, ☐Blood Clot
Sleep:	☐Snoring, ☐Pauses in Breathing, ☐Sleepy during the Day, ☐Insomnia

Medical Conditions: (Please check any that you have been diagnosed with)

Sleep:	**Endocrine:**	**Neurological:**	☐ALS
☐Sleep Apnea	☐Diabetes	☐Cerebral Palsy	☐Parkinsons Disease
☐Restless Leg Syndrome	☐Type I	☐Muscular Dystrophy	☐Alzheimer's Disease
☐REM sleep Behavior D/O	☐Type 2	☐Multiple Sclerosis	☐Down's Syndrome
☐Insomnia	☐Hypothyroidism	☐Stroke	**Psychiatric:**
☐Periodic Limb Movements	☐Hyperthyroidism	☐Seizures	☐Autism
☐Narcolepsy	☐Cushing's Disease	**Cardiac:**	☐ADHD
☐Idiopathic Hypersomnia	☐Low Testosterone	☐Heart Attack	☐Depression
	☐Erectile Dysfunction	☐Stent Placement	☐Anxiety
Pulmonary:	☐PCOS	☐Defibrillator	☐Bipolar Disorder
☐COPD	**Gastrointestinal:**	☐Atrial Fibrillation	☐PTSD
☐Asthma	☐Heartburn/Reflux	☐Heart Failure	☐Schizophrenia
☐Pulmonary Fibrosis	☐IBD (Crohn's or UC)	☐Pacemaker	**Cancer:**
☐Lung Cancer	☐Celiac Disease	☐Coronary Bypass	
☐Pulmonary Nodule	☐Gallstones	☐High Blood Pressure	
		☐High Cholesterol	

Surgical History:

☐Appendix	☐Septum	☐Sinuses		☐Weight Loss Surgery
☐Gallbladder				☐Gastric Sleeve
☐Colon Surgery	☐Knee Replacement:	☐R	☐L	☐Gastric Bypass
☐Tonsils	☐Hip Replacement	☐R	☐L	Other:
☐Adenoids	☐Shoulder Replacement	☐R	☐L	
☐Hysterectomy	☐Spinal Surgery – Cervical/Thoracic/Lumbar			
☐Breast Surgery				

Social History:

Smoking	☐Yes	☐No	☐Quit Amount: PPD Years		
Alcohol Use	☐Yes	☐No	☐Amount: drinks/wk		Kind:
Drug Use	☐Yes	☐No	☐Amount: uses/wk		Kind:
Marital Status	☐Married	☐Engaged	☐Single	☐Divorced	☐Widowed
Employment Status	☐Fulltime	☐Parttime	☐Retired	☐Student	☐Unemployed
Caffeine Use	☐Yes	☐No	Amount: cups/day		Kind:
Physical Activity	☐Yes	☐No	Amount: days/wk		Kind:

Family History:

Mother	☐Alive	☐Deceased	Conditions:
Father	☐Alive	☐Deceased	Conditions:
Siblings:			
	☐Alive	☐Deceased	Conditions:
	☐Alive	☐Deceased	Conditions:
	☐Alive	☐Deceased	Conditions:

Allergies to Medications:

Medication List:

	Medication Name, Dose, Frequency
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	

Pharmacy:	Name:
	Address:
	Phone:
Secondary Pharmacy:	Name:
	Address:
	Phone:
Mail Order Pharmacy:	Name:
	Address:
	Phone: