America's Favorite Sleep Center Inc.

Wake up to Better and Brighter Days!

10290 Baltimore National Pike
Ellicott City, MD 21042

Dear Patient,

Your physician has requested a "sleep study" to evaluate your present medical condition. There are a few things thatwe need to inform you of:

- There will be several sensor probes placed on the legs, face, chest, and scalp. These sensors allow us to monitor your brain wave activity, eye movement, heart rate, respiration, and muscle activity. Most of the sensors will be taped into position, and because the sensors are placed on the skin and scalp, **we ask that you bathe and shampoo and dry your hair before coming to the center.** Please do not use hair spray or hair oils. Please do not apply lotions or oils to your skin.

- Please eat dinner **two to three hours** ***BEFORE*** coming to the Sleep Center. **PLEASE DO NOT DRINK ANY ALCOHOL OR CAFFEINE BEVERAGES *AT ALL ON THE DAY* OF THE SLEEP CENTER.**(No tea, coffee, soft drinks), or take non-prescription drugs on the day of study as these may effect the validity of the sleep study except for Tylenol, Advil or Sinus Meds. Please note that your may take vitamins as they are not classified as medication in most cases.

- If possible please restrain from taking naps on the day of the study.

- Please be sure to bring pajamas or night clothes with you, for women a night gown with sleeves is acceptable. For men/women a shirt must be worn at all times while in the sleep center, the chest area must be covered, wearing a tee-shirt is acceptable.
  No one may sleep without clothing_____
  Your Initial's Please

- All partially or completely non ambulatory patients are required to have a family member or caregiver stay with them to assist the patient with moving and ambulation during the night.

- "Lights Out" are no later than 11:00pm. This means that patient's may read or watch T.V. until 11:00pm, and then the patient must make an attempt to sleep.

- Please Do Not Bring Non-Essential Valuable Items to the Sleep Center, the sleep center will not accept responsibility for any lost items.

- Please feel free to bring your own pillow or blanket if you prefer; however these will be provided in your room. If you do elect to bring these items from home, please remember to take them with you in the morning as the sleep center will only hold them for up to 24 hours.

- **Please initial the three areas of this sheet, Complete the history form included in this packet and bring this entire packet with you to your appointment. Please also remember to bring in your most current insurance cards and a photo I.D.**
- Co-pays are due at time of visit. **You may pay by check, cash or money order only.** (Please refer to the front of your insurance card).

- The sleep center will forward a copy of your sleep study report to your referring physician. The copy that is forwarded to your doctor is hand delivered and is not faxed unless requested by your doctor. There is not a fee for this copy and is normally delivered to your referring doctor in 5 to7 business days. **The sleep center will not be responsible for forwarding your sleep study report to any other doctor other than the one that referred you.** If you would like a copy of your sleep study to go to a different doctor in addition to your referring doctor you must provide that copy to that doctor. You may request a copy in advance and pay the discounted fee of $20.00 dollars per sleep study report. This fee must be paid at the time of service. This fee is not apart of your co-pay, coinsurance or deductible and is only for your copy of the sleep study. This fee is not covered by your insurance company. This fee may be made in cash only. If you wish your report to be mailed to you, you will also need to provide a self addressed, $1.00 postage paid envelope, other wise you will need to pick up your copy during office hours. Sorry, no exceptions will be made to this policy. _____
  Your Initial's Please

For your convenience there is a shower in the sleep center, however you will need to provide your own shower supplies (i.e. towel, wash cloth, soap) ect. If you plan to take a shower in the morning, please inform your technician so that arrangements may be made for you to wake up early.

- **Cancellations must be made 48 hours prior to your appointment date, there is a $250.00 cancellation fee for appointments not cancelled with a 48 hour prior notice. Notice must be given during business hours M-T, 9:00 a.m. to 4:00 p.m. Friday 9:00 a.m. to 1:00 p.m_____.**
  Your Initial's Please

If for any reason you might be late or need to cancel your appointment please call 410-465-8503. If you have any questions, please call us at the center M-T, 9:00 a.m. to 4:00 p.m. Friday 9:00 a.m. to 1:00 p.m.

Patient Signature_____Date_____

Technician Signature_____Date_____

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Directions to America's Favorite Sleep Center Inc.

---- From Route 29

- **Take Route 29 North**
- Take Exit 24B (US 40 West/Baltimore National Pike).
- Travel 2.8 miles on Baltimore National Pike

<u>You should go through Five traffic lights.</u>

Light 1. Saint Johns Lane
Light 2. North Chatham Road
Light 3. The Ingoing Shopping Center Light
Light 4. Bethany Lane
Light 5. Pine Orchard

- At the corner of Pine Orchard and Baltimore National Pike there is a Sunoco Gas Station on the right. (Drive Slowly)
- After you pass the Sunoco you will see the Centennial Square Office Park Sign (It is a tall blue & white sign)
- **Make a <u>right turn</u> into Centennial Square Office Park**
- Go over two speed bumps and then keep to the right.

10290 is on the Left side of the road.

---- From Baltimore

- **Take 95 South**
- To route 100(Ellicott City/Glen Bernie)
- Route 100 Ends at Route 29, Bare to the right to take 29 North toward Ellicott City
- Take Exit 24B (US 40 West/Baltimore National Pike).
- Travel 2.8 miles on Baltimore National Pike

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PATIENT SLEEP HISTORY

Name: _____ Date ____/____/_____
Last First Middle

Address:_____
Street City State Zip

Date of Birth: ____/____/_____ Sex: ☐ Female ☐ Male Age: _____ Height:_____ Weight_____lbs. Neck Size _____inches

Marital Status: ☐ Married ☐Single ☐Widowed ☐Divorced ☐Separated Social Security # _____-_____-_____

Employer's Name_____Occupation _____My normal work hours/ days are:_____

Please List a good daytime phone number where the doctor can reach you if necessary._____

Weight gain or lost (10 lbs or more)? ☐Yes ☐No If yes, I☐ GAINED _____lbs. or ☐ LOST _____lbs. over a _____period of time.

Health Care Professional who referred you to us for sleep testing (Referring Physician/ Primary Physician) and their specialty:_____

Medical History:
Do you, or have to ever had: (please check all that apply)

☐High Blood Pressure	☐Bypass surgery	☐Heart Attack	☐Congestive Heart Failure
☐Asthma	☐COPD (emphysema, bronchitis)	☐Hiatal hernia	☐Reflux/GERD
☐Stroke	☐Diabetes	☐Thyroid Disease	☐Tonsillectomy/Adenoidectomy
☐Depression	☐Anxiety	☐High Cholesterol	☐ Multiple Sclerosis

☐Other (please comment)_____
Please list all surgeries: _____
_____

The following question will help us understand more about you. These questions will also help the physician when interpreting your sleep study. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months (unless otherwise indicated). Do not leave any question unanswered.

Main complaint(s) is (are):	I have been experiencing these symptoms for:					
☐Snoring	☐never	☐1-18 months	☐19mo-5yrs	☐6-10yrs	☐11-20yrs	☐20yrs+
☐My breathing stops	☐never	☐1-18 months	☐19mo-5yrs	☐6-10yrs	☐11-20yrs	☐20yrs+
☐I'm Sleepy	☐never	☐1-18 months	☐19mo-5yrs	☐6-10yrs	☐11-20yrs	☐20yrs+
☐I talk or walk in my sleep	☐never	☐1-18 months	☐19mo-5yrs	☐6-10yrs	☐11-20yrs	☐20yrs+
☐I can't fall asleep / stay asleep	☐never	☐1-18 months	☐19mo-5yrs	☐6-10yrs	☐11-20yrs	☐20yrs+

☐Other (please explain) _____
_____
_____

How long does it take you to fall asleep? _____minutes _____hours. On average how may hours of sleep do you get?_____
On average, how many times do you wake up during the night _____ times. How long are you awake? _____
What do you think is the cause? _____What is your weekday bedtime? _____
What is your weekday wakeup time? _____. What is your weekend bedtime? _____
What is your weekend wake up time? _____
Please Circle one

Please Rate Your Snoring	None	Mild	Moderate	Severe
Please Rate Your Daytime Sleepiness	None	Mild	Moderate	Severe

Here's how to answer the questions using our number scale:

1 =*rarely*	2 =*sometimes*	3 =*often*	4 =*frequently*	5 =*always*
Less than once a month	1-3 times a month	4-8 times a month	3-4 times a week	5-7 times a week

No matter how much sleep I get I wake up feeling tired.	NO	1	2	3	4	5
If you were able to sleep longer would you feel rested?	NO	1	2	3	4	5
Do you have a problem with your performance at work because you are sleepy or tired?	NO	1	2	3	4	5
Have you fallen asleep at work?	NO	1	2	3	4	5
Do you take regular naps?	NO	1	2	3	4	5
Have you fallen asleep while driving?	NO	1	2	3	4	5
Does your snoring disturb others?	NO	1	2	3	4	5
Have I wake up short of breath or gasping.	NO	1	2	3	4	5
I have asthma attacks during sleep.	NO	1	2	3	4	5
I sweat excessively during the night.	NO	1	2	3	4	5
I wake up in the morning with a headache.	NO	1	2	3	4	5
I wake up with a sour/ bitter taste in my mouth or burning in my chest.	NO	1	2	3	4	5
I have a problem falling asleep at night.	NO	1	2	3	4	5
I awaken because of aches, pains and headaches.	NO	1	2	3	4	5
I have trouble going back to sleep if I wake up during the night.	NO	1	2	3	4	5
I wake up absolutely unable to move.	NO	1	2	3	4	5
I have muscle weakness or fall asleep without warning brought on by laughter, surprise, or other strong emotions.	NO	1	2	3	4	5
I have a creeping, crawling, restless feeling, and desire to move my legs which keeps me from falling asleep. The discomfort is quickly relieved for the duration of movement.	NO	1	2	3	4	5
My legs seem to kick rhythmically during sleep.	NO	1	2	3	4	5
I get frequent leg cramps.	NO	1	2	3	4	5
Do you act out your dreams?	NO	1	2	3	4	5
Do you awaken screaming in fear or agitated?	NO	1	2	3	4	5
Do you now, or did you as a child, wet the bed?	NO	1	2	3	4	5
Have you been a sleepwalker as an adult?	NO	1	2	3	4	5
Do you have or are you treated for seizures in your sleep?	NO	1	2	3	4	5
Do you grind your teeth during the night?	NO	1	2	3	4	5
Have you been told that you hold your breath or gasp for air during sleep?	NO	1	2	3	4	5

Have you ever had a sleep study before? ☐ Yes ☐ No If yes, when and where? _____
Results of the study _____
Do you have any relatives with sleep disorders? ☐ Yes ☐ No If yes, what? _____
Do you have significant stress in your life at the present time? ☐ Yes ☐ No If yes, please explain: _____
_____
Are you allergic to any medications that you are aware of? ☐ Yes ☐ No If yes, what? _____

PLEASE LIST YOUR MEDICATIONS, BOTH PRESCRIPTION AND OVER THE COUNTER **(Please Print)**

Medications Name	Dosage taken	How Often	Medication taken for	Reason Medication was Prescribed

PLEASE LIST YOUR TYPICAL INTAKE OF THE FOLLOWING:

LIST ONLY CAFFEINATED BEVERAGES:

Coffee: _____ cups per day
Tea: _____ cups per day
Soda: _____glasses per day

Other:
Beer: _____ cans per day
Wine: _____ glasses per day
Liquor: _____shots per day

Cigarettes: _____ per day
Cigars:_____ per day

The Epworth Sleepiness Scale:

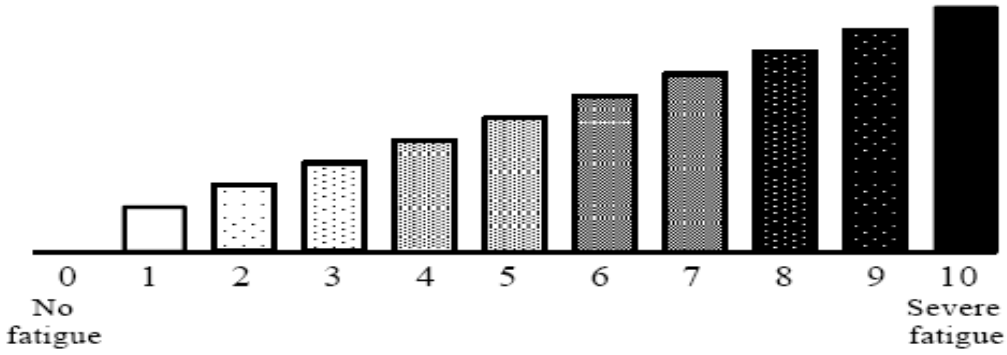
How likely are you to doze off or fall asleep in the following situations, in contrast to feeling "just tired"? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation.

O=would never doze l=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

Situation	Chance of Dozing
Sitting and reading:	_____
Watching television:	_____
Sitting, inactive in a public place (e.g., theater or 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 quietly to someone:	_____
Sitting quietly after lunch without alcohol:	_____
In a car, while stopped for a few minutes in traffic:	_____
	_____ Total

Fatigue Scale

*Please circle the number below that describes your **fatigue over the past 2 weeks**.*



Thank you for helping us to help you!