975 Hager Street ✶ St. Marys, Ohio 45885
Phone: 419-394-9992 ✶ Fax: 419-394-9629
www.grandlakehealth.org

Welcome to Grand Lake Sleep Center. Our physician and staff appreciate your choice of our center.

Consultation Appointment Date: _______________________________________

Time: ____________________

IF YOU CANNOT KEEP YOUR APPOINTMENT KINDLY GIVE 24 HOUR NOTICE.

The field of sleep medicine is highly specialized and requires expertise. Your sleep specialist will take an extensive sleep history on the day of your clinic appointment, this will aide in the diagnostic process the day of your consultation.

Enclosed are the following forms. Please complete them prior to your appointment.

- **Please return this packet by: __________________________ with a list of current medications.**

PLEASE BRING THE FOLLOWING FOR YOUR APPOINTMENT:

- **Insurance Cards**
- **Photo I.D.**
- **If you have a CPAP machine, please bring it with you the day of your appointment.**

Thank You.

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Patient Name: ______________________________________ **Sex:** **M** **F**

Date of Birth: ________________________ **SSN:** ___________________________________

Home Phone: ________________________ **Alt Phone:** ______________________________

Address: __________________________________ **City:** ____________________________

State/Zip: _________________________________ **Work Phone:** _____________________

Emergency Contact and Phone:____

Referring Physician:____

Primary Physician:____

Any other physician you wish your information sent to: ______________________________

Parent's Names (if minor): ____

INSURANCE INFORMATION

Primary Insurance:____ **Co-pay:**___________

Claims Address: ______________________ **City:**______________ **State/Zip:** _________

Subscriber's Name: ___________________________________ **D.O.B.:** ________________

SSN: ________________________________ **ID#:** ____________________________________

Group Number:_______________________________________

Secondary Insurance:______________________________________ **Co-pay:**___________

Claims Address: ______________________ **City:**______________ **State/Zip:** _________

Subscriber's Name: ___________________________________ **D.O.B.:** ________________

SSN: ________________________________ **ID#:** ____________________________________

Group Number:_______________________________________

GRAND LAKE
SLEEP CENTER™

SLEEP LOG

Name: ______________________

DAY/DATE	# OF NAPS DURING DAY AND LENGTH	BEDTIME	HOW LONG TO FALL ASLEEP	TIMES UP AT NIGHT AND WHY	WAKE-UP TIME	TOTAL SLEEP TIME

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NAME: ______________________________________ DATE: _______________

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:

0 = no chance of dozing

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 inactive in a public place (ex. theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest when circumstances allow	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL:

______

Have you ever had a sleep consult or sleep study done in the past? ________________________

If yes, where and in what year? __________________________________ & _______________

Are you on oxygen? ___________________

If yes, how much and which DME company did you go through?

____

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NAME: ____ DATE: ____________________

SLEEP TEST

To take the sleep test write in the answer. If a statement does not apply or is false, simply go on to the next statement.

Sleep Pattern:

1. Typical bedtime: ____________________________
2. Typical amount of time to fall asleep: ____________________________
3. Typical number of awakenings per night: ____________________________
4. If you wake at night list things you do: ____________________________
   (ex: use restroom, watch TV etc.)
5. Typical amount of time to fall back to sleep: ____________________________
6. Typical wake-up time: ____________________________
7. Total amount of sleep per night: ____________________________
8. Are you claustrophobic? (ex: mask on face, closed spaces) ____________________________
9. Do you have trouble sleeping in a new environment? Yes or No

Please check any of the following that apply to you:

	I have been told that I snore.
	I have been told that I stop breathing while I sleep.
	My friends and family say that I'm often grumpy and irritable.
	I wish that I had more energy.
	I sweat during the night.
	I have noticed my heart pounding, palpitations or racing fast.
	I get morning headaches.
	I have trouble sleeping when I have a cold.
	I suddenly wake up gasping for breath or choking during the night.
	I am overweight.
	I seem to be losing my sex drive.
	I often feel sleepy and struggle to remain alert.
	I frequently wake with a dry mouth.
	I usually watch TV or read in bed prior to sleep.
	I frequently travel across 2 or more time zones.
	I drink alcohol prior to bedtime.
	I smoke prior to bedtime or when I awaken during the night.
	I eat a snack before bedtime.
	I have **bad dreams** as an adult (if so, what part of the night; early, late etc.) ______________________
	I cannot sleep on my back.
	I **grind my teeth** at night.
	I have been told I **talk** in my sleep.
	I have been told I **sleep walk**.
	I have issues **bedwetting** at night.
	Thoughts race through my mind and prevent me from sleeping.
	I anticipate a problem with sleep almost every night.
	I wake earlier in the morning than I would like to.
	I feel depressed.
	I have trouble concentrating on my everyday tasks.

	When I am angry or surprised, I feel like my muscles are going weak. If yes, explain: ________________________
	I have dozed off or fallen asleep while driving.
	If yes, have you had any accidents: YES or NO
	I often feel like I am going around in a daze.
	I have experienced vivid dream-like scenes upon falling asleep or awakening or during naps.
	I feel like I am hallucinating when I fall asleep.
	Are naps (please circle one): Refreshing or Non-Refreshing?
	I have fallen asleep in a social setting such as movies, watching TV, at a party or while a passenger in a car. **If so, this happens (circle one) Often or Rare**
	I have episodes of feeling paralyzed during my sleep **(circle one) During the day or during the night? If so, this happens: Often or Rare**
	I wake up at night with an acid/sour taste in my mouth.
	I wake up at night coughing or wheezing.
	I have frequent sore throats.
	Other than exercising, I still experience muscle tension in my legs.
	My legs are restless during the day.
	I have been told that I **kick at night.**
	When trying to sleep I experience an aching or crawling sensation in my legs.
	Sometimes I can't keep my legs still at night, I just have to move them to make them comfortable.
	I awaken with sore or achy muscles.
	Even though I slept during the night, I feel sleepy during the day.
	Any other unusual behavior you want the doctor to be aware of ?
	____________________________________
	____________________________________
	____________________________________

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NAME: ____ DATE: ________________

REVIEW OF SYSTEMS: Check any that apply to you today

General:
Chills___
Fever____
Malaise/Fatigue____
Feeling well____
Unwanted weight loss_____
Loss of appetite_______

Skin:
New Lesions___
Rash_____
Skin color change____
Itching_____

Neck:
Swollen Glands_____
Neck Pain_____
Stiffness______

Eye:
Discharge___
Itching ______
Pain_____
Visual Changes____
Watering ______
Light Sensitivity______

Ear:
Discharge ____
Hearing Loss_____
Pain _____
Ringing in the ears____

Nose:
Congestion____
Discharge_____
Nose bleeds____
Sneezing______
Decreased sense of smell_____
Blocked Nose ______

Sinus:
Facial Pain____
Facial Pressure____

Mouth/Throat:
Hoarseness____
Lesions______
Throat Pain____
Coated tongue/mouth__
Dental problems ___
Sore throat____
Voice changes____

Respiratory:
Cough____
Coughing up blood____
Difficulty breathing with activity__
Difficulty breathing at rest___
Wheezing____

Cardiovascular:
Chest Pain ____
Pain in Calves when walking___
Lower extremity swelling___
Shortness of Breath while
Lying flat____
Feeling faint at times___
Irregular Heart Beat___

Neurological:
Confusion_____
Dizziness ___
Headache____
Weakness____
Change in level of
Consciousness____
Change in speech__
Difficulty walking___
Tingling___
Loss of balance__
Seizures___
Memory Loss___
Numbness____

Psychiatric:
Anxiety____
Depression___
Hallucinations___
Insomnia_____
Mood problems___
Suicidal ideations___
Delusions ___

Gastrointestinal:

Genitourinary:

Musculoskeletal:

Abdominal pain___
Blood in stools___
Constipation___
Diarrhea___
Nausea___
Vomiting___
Black Tarry Stool___
Change in bowel habits__
Heartburn___
Rectal Pain___
Stool incontinence___
Bloating___

Urinary Burning___
Urinary bleeding___
Sexual Dysfunction___
Urinary Frequency___
Urinary hesitancy___
Nighttime urination___
Low sex drive___
incomplete emptying of bladder___
Decrease in stream___

Back Pain__
Joint swelling___
Joint Redness___
Muscle Pain___
Joint Stiffness___
Muscle Weakness___
Joint Pain____

Heme/Lymph:
Enlarged lymph nodes___
Night Sweats___
Abnormal bleeding___
Abnormal bruising___
Tender lymph nodes___

Endocrine:
Cold intolerance___
Heat intolerance___
Excessive thirst___
Excessive urination___
Appetite Changes___

PAST MEDICAL HISTORY

______ Hypertension (high blood pressure)
______ Heart disease
______ Diabetes
______ Stomach or colon problems
______ Lung problems/COPD/asthma
______ Hepatitis/jaundice
______ Back or joint problems (arthritis)
______ Fibromyalgia
______ Stroke
______ TIA "Light Strokes"
______ Any pets
______ Level of Education __________

______ Hearing impairment
______ Depression or severe anxiety
______ Alcoholism
______ Chemical dependency/abuse
______ Thyroid problems
______ Cancer
______ Reflux (acid reflux)
______ Seizures
______ Blackouts
______ Any other medical problems? ________________
____
____

SURGICAL HISTORY

____
____

FAMILY MEDICAL HISTORY (parents of patient, grandparents, siblings or children of patient)

____
____
____

GENERAL PREVENTATIVE SCREENING (pertaining to just the patient)

_____ Pneumonia vaccination _____ Flu shot _____ Tetanus shot _____ Hepatitis shot
_____ Pap Smear _____ Mammogram _____ Prostate issues _____ Cancer screening
_____ Colonoscopy

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NAME: ____ DATE: _______________

SOCIAL HISTORY AND GENERAL SCREENING:

Sex: ☐ Male ☐ Female

Height: __________ **Weight:** __________ **Weight 5 yrs. ago:** __________

Marital Status: Single Married Widowed Divorced Other

Number of Children:____________

Employment Status: Employed Unemployed Homemaker Retired Disabled

What is or was your occupation:____

My job required driving a vehicle: YES or NO If yes, what type: _________________

I work with dangerous equipment: YES or NO

I am a shift worker or rotating shifts: YES or NO If yes, what shift: _________________

I am currently a student: YES or NO

Do you smoke? YES or NO If yes, how long: __________________

How many packs per day: ___________

How many years: ___________

If no, quit date: ___________

How much did you smoke:___________

How many years: ___________

Do you drink alcohol? YES or NO If yes, what and how long: __________

Do you drink caffeine? YES or NO If yes, what and how much?

___ Coffee ________________
___ Tea ________________
___ Cocoa ________________
___ Pop ________________

Do you use controlled substances and/or street drugs? YES or NO

If yes, what and how long? ____

Do you use marijuana or THC products? YES or NO

BED PARTNER'S COMMENTS:

____
____
____
____
____