



**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.**

**Grand Lake Sleep Center**



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

## Patient Information

The Grand Lake Sleep Center is a Hospital Based Specialty outpatient department of Joint Township District Memorial Hospital. We are not a free standing facility. Your bill for office visits will have a facility charge and a Doctor’s charge. Any diagnostic sleep study performed here will also have a facility charge and a Doctor’s charge for interpretation.

### CLINIC APPOINTMENTS

**Sleep Center Facility Fee for office visits Range: 204.00-413.00**

**AND**

**Sleep Center Doctor’s Fee for office visits Range: 76.00-168.00**

The range depends on the level of care received at the visit.

### DIAGNOSTIC SLEEP STUDIES

Sleep Study Type	Sleep Center Fee	AND	Doctor’s Fee
Sleep Study (PSG)	2946.00		321.00
Sleep Study with CPAP	3433.00		321.00
MSLT (Daytime/Naps)	1445.00		147.00
**MSLTs are always done the morning after a sleep study (PSG) **			
HOME SLEEP APNEA TEST	753.00		97.00
OVERNIGHT PULSE OXIMETRY	354.00		N/A

- The staff at the sleep center submits information to insurance for prior authorization prior to any studies being completed. Prior authorization is not a guarantee of payment.

**PLEASE NOTE:** It is the patient’s responsibility to check individual insurance policies regarding the physician’s participation and **JTDMH** in your plan as well as payment policies, prior to your initial appointment. Due to variability in insurance plans we are not able to determine a patient’s out of pocket cost. All unpaid balances by your insurance company potentially can become the patient’s responsibility. It is impossible to determine the full cost of the treatment before your examination because insurance coverage varies as well as plan deductibles.



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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<sup>TM</sup>

# 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



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

Table with 2 columns: SITUATION and CHANCE OF DOZING. Rows include: Sitting and reading, Watching TV, Sitting inactive in a public place (ex. theater or meeting), As a passenger in a car for an hour without a break, Lying down to rest when circumstances allow, Sitting and talking to someone, Sitting quietly after lunch without alcohol, In a car, while stopped for a few minutes in traffic.

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?

\_\_\_\_\_



NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**SLEEP TEST**

To take the sleep test, check the line beside each statement that is true for you. 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 <b>bad dreams</b> as an adult (if so, what part of the night; early, late etc.) _____
I cannot sleep on my back.
I <b>grind my teeth</b> at night.
I have been told I <b>talk</b> in my sleep.
I have been told I <b>sleep walk</b> .
I have issues <b>bedwetting</b> 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. <b>If so, this happens (circle one) Often or Rare</b>
I have episodes of feeling paralyzed during my sleep ( <b>circle one</b> ) <b>During the day or during the night? If so, this happens: Often or Rare</b>
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 <b>kick at night</b> .
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:**

- Abdominal pain\_\_\_
- Blood in stools\_\_\_
- Constipation\_\_\_
- Diarrhea\_\_\_
- Nausea\_\_\_
- Vomiting\_\_\_
- Black Tarry Stool\_\_\_
- Change in bowel habits\_\_\_
- Heartburn\_\_\_
- Rectal Pain\_\_\_
- Stool incontinence\_\_\_
- Bloating\_\_\_

**Genitourinary:**

- Urinary Burning\_\_\_
- Urinary bleeding\_\_\_
- Sexual Dysfunction\_\_\_
- Urinary Frequency\_\_\_
- Urinary hesitancy\_\_\_
- Nighttime urination\_\_\_
- Low sex drive\_\_\_
- incomplete emptying of bladder\_\_\_
- Decrease in stream\_\_\_

**Musculoskeletal:**

- 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**

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

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**GENERAL PREVENTATIVE SCREENING** (pertaining to just the patient)

- \_\_\_\_\_ Pneumonia vaccination    \_\_\_\_\_ Flu shot    \_\_\_\_\_ Tetanus shot    \_\_\_\_\_ Hepatitis shot
- \_\_\_\_\_ Pap Smear    \_\_\_\_\_ Mammogram    \_\_\_\_\_ Prostate issues    \_\_\_\_\_ Cancer screening
- \_\_\_\_\_ Colonoscopy



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: \_\_\_\_\_

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? \_\_\_\_\_

BED PARTNER'S COMMENTS:

Five horizontal lines for writing comments.