GRAND LAKE SLEEP CENTER™
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.

Grand Lake Sleep Center

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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: _____

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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: 212.00-430.00

AND

Sleep Center Doctor's Fee for office visits Range: 79.00-175.00

*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)	3064.00	334.00
Sleep Study with CPAP	3570.00	334.00
MSLT (Daytime/Naps)	1503.00	153.00
**MSLTs are always done the morning after a sleep study (PSG) **		
HOME SLEEP APNEA TEST	783.00	101.00
OVERNIGHT PULSE OXIMETRY	368.00	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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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, 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 **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:
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

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: _____
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:

_____
_____
_____
_____
_____