PATIENT SLEEP & HEALTH QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____

Male / Female Height _____ Weight: _____ Referring Physician: _____

Best # to reach you: _____ Email Address: _____

Ballantyne Diagnostic & Sleep Center

PLEASE COMPLETE QUESTIONS 1-17 PRIOR TO YOUR SLEEP STUDY. BRING THIS WITH YOU ON THE EVENING OF YOUR SCHEDULED SLEEP STUDY APPOINTMENT.

1) Do you have trouble falling asleep? No ____ Yes _____ How long does it take you to fall asleep?_____

2) Do you have trouble staying asleep? No _____ Yes _____ If yes, why do you think this is? _____

_____

3) If you wake up during the night, do you have trouble falling back asleep? No_____ Yes _____

4) Do you have fears or anxieties about having trouble sleeping? No _____ Yes _____

5) Do you nap during the day? No _____ Yes _____

6) **Please rate how often you:**	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
Have vivid dream-like scenes upon awakening or going to sleep (dream while awake)	_____	_____	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____	_____	_____
Experience loss of muscle tone when extremely emotional	_____	_____	_____	_____	_____
Kick during the night	_____	_____	_____	_____	_____
Experience crawling and aching feelings in your legs	_____	_____	_____	_____	_____
Toss and turn while sleeping	_____	_____	_____	_____	_____
Urinate frequently at night	_____	_____	_____	_____	_____
Sweat excessively during the night	_____	_____	_____	_____	_____
Awaken at night with your heart pounding or beating irregularly	_____	_____	_____	_____	_____
Have difficulty waking up in the morning	_____	_____	_____	_____	_____
Awaken from sleep short of breath	_____	_____	_____	_____	_____
Awaken with dry mouth	_____	_____	_____	_____	_____
Awaken with a headache	_____	_____	_____	_____	_____
Have “sleep attacks” during the day	_____	_____	_____	_____	_____
Snore	_____	_____	_____	_____	_____

7) With 10 being the loudest, how would you rate your **snoring** on a scale from 1 to 10 ? _____ or No Snoring _____

8) Do you experience fatigue, sleepiness, or decreased energy during the day? No_____ Yes_____

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9) Do you use tobacco products? No_____ Yes_____, If Yes, what form/ how much per day? _____

10) Do you eat/ drink caffeine products? No_____ Yes_____, If Yes, how much per day? _____

11) Do you consume alcohol? No_____ Yes_____, If Yes, How much per day? _____

12) Do you exercise? No_____ Yes_____, If Yes, How often? _____

13) List all medication (**prescription, over-the-counter, and supplements**)

Name of Drug	Amount/dose	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14) List any medication allergies: _____

_____

15) Please place a check mark next to any conditions you have ever had:

___ Anemia
___ Arthritis
___ Asthma
___ Breathing trouble at night
___ Chronic pain
___ Decreased sexual interest
___ Dental problems
___ Depression
___ Diabetes
___ Drug / alcohol problems
___ Emphysema
___ Epilepsy/ seizures
___ Fibrositis
___ Frequent headaches
___ Hallucinations/ delusions
___ Head injury/ surgery
___ Heart attack
___ Heart burn/ ulcers
___ Heart disease/ heart failure/ CHF
___ Hiatal hernia
___ High blood pressure
___ Hyperactivity as a child
___ Kidney problems
___ Nose & throat problems
___ Panic attacks
___ Parkinson's disease
___ Severe anxiety/ nervousness
___ Sexual problems
___ Shortness of breath
___ Suicide attempts
___ Thyroid problems
___ Wear dentures

16) Please list any medical condition/ problem not listed above? _____

_____

17)

EPWORTH SLEEPINESS SCALE

Please rate how likely you are to doze off or fall asleep in the following situations, in contrast to "just feeling tired." This refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to work out how they would affect you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (theater, meeting, etc.)	_____
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 to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

_____ _____

Patient' Signature Date

Ballantyne Diagnostic & Sleep Center

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Charlotte, NC 28277

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Consent to Perform Polysomnography and Related Services

_____**Initials** **Diagnostic Procedures:**
In order to measure the various physiologic parameters during my sleep, I understand that small sensors, wires, and belts will be applied to my scalp, face, legs, chest, abdomen, and fingers. I understand that my entire sleep study will be monitored and recorded by a trained Polysomnograhpy technologist via computer and audio/visual infrared CCTV. I understand it is important to notify my technologist of any discomfort with the testing procedure so appropriate action can be taken to provide me with the best possible testing experience.

_____**Initials** **Therapeutic Procedures:**
If, as a result of the diagnostic procedures, my physician has pre-determined that nasal continuous positive airway pressure (NCPAP), bi-level positive airway pressure (BiPAP) or oxygen therapy should be administered to treat my breathing during sleep, I agree to at least try the treatment for a period of time. I understand that the use of any of these treatments is a common, medically accepted procedure. I understand it is important to notify my technologist if I have any difficulties during these treatments so appropriate action can be taken to help optimize my compliance to therapy.

_____**Initials** **MSLT/MWT Testing:**
If my physician has ordered daytime testing (MSLT or MWT), I understand I will be required to complete 4 to 5 nap opportunities spaced approximately 2 hours apart. I understand that the MSLT and MWT testing will most likely be completed in the late afternoon to early evening and have made arrangements to allow for this. I understand that a urine drug screen is also a part of the testing procedure and do voluntarily consent to provide a urine sample for the purpose of the MSLT/MWT test.

_____**Initials** **Financial Agreement:**
I hereby authorize and request that payments under my insurance plans be made directly to Carolina Family Healthcare d/b/a Ballantyne Diagnostic & Sleep Center for any services furnished to me. I also authorize the release of any information required to process insurance claims. I understand that I am responsible for any amount not covered by insurance.

_____**Initials** **Privacy:**
Our privacy policy has been posted for your review. The privacy policy includes important notices about your rights under the Health Insurance Portability and Accountability Act (HIPAA). Upon request, we will provide you with a copy of the Notice of Privacy Practices.

_____**Initials** **Special Needs Patients and Minors:**
Patients who need additional care or assistance may bring along an attendant to stay with them during the testing procedures provided prior authorization is obtained from the scheduling coordinator. Some patients may be required to bring an attendant with them for testing if Ballantyne Diagnostic & Sleep Center deems the patient's needs and care requirements are beyond the standard practice for patient care in the sleep disorder center.

Minors, defined as individuals under the age of 18, must be accompanied by a parent or legal guardian at all times.

If an assistant/parent/guardian is unavailable to stay with the patient during testing, then the appointment will have to be rescheduled to another date when an assistant/parent/guardian is available. Any special exceptions will need signed authorization by the clinic manager of Ballantyne Diagnostic & Sleep Center.

The undersigned voluntarily requests Ballantyne Diagnostic & Sleep Center, it's physicians, associates, technical assistants and other health care providers as they may deem necessary, to treat my condition as a possible sleep disorder. I understand that the following diagnostic and or treatment procedures are planned for me, and do voluntarily consent to and authorize these procedures and treatment. I agree that I have read and understand this document.

Patient/Parent/Guardian Signature: _____ Date: _____