Please call patient registration @ (704- 403- 1285) to pre-register prior to appointment

You are scheduled for a sleep study on _______________________________ at ___________pm

Your sleep study will take place at our Harrisburg or Concord Center

Please complete the attached questionnaire and bring it with you to your Sleep Study

All of our rooms are private, and have satellite TV

Our Concord address is:
130 Lake Concord Road
Concord, NC 28025

Our Harrisburg address is:
5427 Highway 49. S
Harrisburg, NC 28075

One of our patient rooms at the Concord Sleep Center

Directions to Sleep Center:

Concord
Traveling from I-85
Take Exit 58 merge onto US 29/Concord Pkwy
Continue on Hwy 29 driving past CMC-NorthEast
In front of CMC_NorthEast, bear left on CHURCH ST N (NC-73)
Turn left on LAKE CONCORD RD NE- go 0.5 mi
Arrive at 130 LAKE CONCORD RD NC CONCORD (on right)

Harrisburg
Traveling from I-85
Take exit 49 for Concord Mills toward Bruton Smith Blvd.
once on Bruton Smith, Speedway will be straight ahead. At Speedway:
Turn right onto Hwy 29 S/Concord Pkwy
Make 1st left onto Morehead RD- go 2.7mi
Turn right on Hwy 49 S- go 0.5 mi
Sleep Center is on the left, next to Harrisburg Family Restaurant
Patient Information for Sleep Studies

What is Polysomnogram?
A polysomnogram is a procedure, which means measures bodily functions during sleep. Each study will vary depending on the individual case. Some of the measurements taken will include:
- EEG/Brain Waves (Electrodes placed on the head)
- EKG/Heartbeat (Electrodes placed on the chest)
- EOG/Eye movements (Electrodes placed above/below the eyes)
- EMG/Muscle movement (Electrodes placed on the chin)
- Breathing (Sensor placed under nose)
- Respiratory Effort (Belts placed around the chest and abdomen outside of clothing)
- Pulse Oximetry/Oxygen levels (Sensor taped to finger)

Why record all these things?
During sleep, the body functions are different than while awake. Disrupted sleep can disturb daytime activities, and sometimes medical problems during sleep involve a risk to your basic health

How can I sleep with all these things on me?
Surprisingly, most people sleep reasonably well. We are only looking to obtain a sample of your sleep. The body sensors are applied so that you can turn and move during sleep. None of the electrodes break the skin. The entire procedure is painless. Our staff will try to make your sleeping environment as comfortable as possible

Will the sensor devices hurt?
No. The sensors are padded and painless. Sometimes, in the rubbing the skin or putting on the electrodes, there are mild or temporary skin irritations. These do not normally cause any significant discomfort.

Will I receive a drug to help me sleep?
No, the sleep lab will not provide any sleep aids. You should continue to take any medications, unless otherwise instructed by your doctor. It is important not to consume excess alcohol or caffeinated beverages on the day of your study.

What is a Multiple Sleep Latency Test (MSLT)?
In some cases the doctor may order a MSLT. This test consists of a series of naps occurring about every 2 hours. The same kind of information is measured as for a polysomnogram. In most cases, the MSLT is completed by 5:00pm the following day.

What should I bring?
Your own pillow (if you prefer to sleep on your pillow)
Bed clothes (two piece sleep apparel is preferred, but not required)
Something to read, work on, etc while awake prior to the start of your sleep study.
A change of clothing for the next day.
Your personal toiletry items.
Any necessary medications

8. Is the test covered by insurance?
For most patients’ sleep studies are covered under major insurance plans. The amount of overage depends upon your specific plan. The best place way to find out about your insurance coverage is by contacting your insurance company’s customer service (check the back of your card for the phone number). The doctor’s office who scheduled this test is responsible for obtaining pre-certification.

9. What happens to the polysomnogram?
Sleep studies are reviewed within 5 business days by one of our Board Certified sleep doctors. It takes about one week for the final report and interpretation to be completed. You should contact the doctor that ordered the test for the results and treatment plan. In many cases your doctor may request an appointment with the sleep doctor to review the test in greater detail.

PRINT NEATLY
Please answer the following questions are completely as you can.
Use the assistance of your bed partner or other observer of your sleep if necessary.
When ‘night’ is mentioned, it means your longest regular period of sleep, and when day is mentioned, it means the rest of the time.

Today’s Date: _______________________

Name:________________________________ Street:____________________________________

City:________________________ State:___________ Zip:____________________________

Home Phone:____-________________ Alternate phone Number:______________________

Date of Birth:_____________ Sex: ___ Height:________________

Weight:________________

Referring Doctor Name:______________________________________________

Briefly describe your sleep problem:

______________________________________________________________

______________________________________________________________

______________________________________________________________

Instructions for Sleep Study
DO NOT stop taking your medications prior to the sleep study unless otherwise directed by your doctor.
DO NOT take a nap the day your test is scheduled.

If you are a 3rd shift worker and have been scheduled for a night time study, please call the sleep lab at (704) 403-1136. We will gladly reschedule your study around your normal sleep time.

Limit your caffeine.

Have your hair and/or skin free of any gel, oil, or other greasy product before coming for your test. These products make it difficult to apply our monitoring equipment.

Call the Patient Registration Department, at (704) 403-1285 to pre-register prior to your appointment.

Bring your insurance card and the enclosed packet with you.

Call your referring doctor to schedule a follow up appointment to discuss the results of your sleep study. In some cases your doctor may schedule an appointment with the sleep physician to review your results.

If you have any special needs, i.e., handicapped bathroom, wheelchair, oxygen, etc., please contact the sleep lab PRIOR to your scheduled appointment so that we may accommodate your needs.

Your referring doctor’s office is responsible for insurance authorization and/or pre-certifications. If you have any questions concerning your insurance coverage for the test, please contact your doctor’s office or your insurance company (to insurance: your study is considered an outpatient diagnostic test).

To change or cancel your appointment, we require 48 hours notice:

704-403-1136

Thank you for choosing Sleep Medicine Services at CMC-Northeast

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Sleep Medicine Patient History- ADULT

Patient Name: ________________ DOB: ________________

1. How long have you had a sleeping problem? _____Years_____ months

Weekends
2. What time do you usually go to bed? __________

Weekdays
3. What time do you usually wake up? __________
4. How long do you usually sleep each night? __________
5. How much sleep do you think you need? __________ hours
6. Do you have difficulty falling asleep?  
   Yes or No  
   - If so how long does it take you to fall asleep? __________
7. Do you have difficulty arising in the mornings?  
   Yes or No

8. Do you have difficulty staying asleep at night?  
   Yes or No  
   - About how many times do you awaken during the night? __________ times

9. How many restroom trips do you take on an average night? __________

10. Do you nap during the day?  
    Yes or No  
    - If so, how long? __________ minutes  
    - How many naps per day? __________ naps  
    - Are they refreshing? Yes or No

11. Are you sleepy during the day?  
    Yes or No  
    - If so, how long have you been during the day __________ years  
    __________ months

12. Do you fall asleep while driving?  
    Yes or No

13. Do you snore?  
    Yes or No

14. Do you awaken with a headache?  
    Yes or No

15. Do you awaken gasping and choking?  
    Yes or No
16. Do you awaken with a dry mouth?

Yes or No

17. Do you stop breathing? Yes

or No

18. Do you have discomfit, numbness, itching, crawling sensation Yes or
or tingling in your legs that are relieved by moving your legs? No

19. Do your legs jump while you sleep? Yes or

No

20. Do you awaken with a bitter or sour taste in your mouth? Yes or

No

Patient Name: ________________________   DOB: _________________

21. Is your bedroom quiet and dark when you are sleeping? Yes or

No

22. Do you worry during the day? Yes or

No

23. Do you consider yourself a “light sleeper”? Yes or

No

-If so, did you have problems as a child? Yes or
No

How often do you do the following activities in bed during the average week?

24. Watch TV in bed: _______ times per week
25. Read in bed: _______ times per week
26. Eat in bed: _______ times per week
27. Work in bed: _______ times per week
28. Argue in bed: _______ times per week
29. Worry in bed: _______ times per week

30. Do you drink alcohol? Yes or No
   - If so, on average how many alcoholic beverages do you drink on:
     _________weekends    _________weekdays

31. How many caffeinated drinks, hot or cold, do you have per day? _________
   How many after 6pm: _________

32. Does your bed partner snore? Yes or No
   - If yes, does your spouse’s snoring keep you awake? Yes or No

33. Do you become limp with laughter, anger or other emotion? Yes or No

34. Do you fall asleep dreaming? Yes or No

35. Do you ever awaken “paralyzed or unable to move?” Yes or No

36. Do you fall asleep standing up? Yes or No
MEDICATIONS

37. Please list any drug **allergies** or environmental allergies (such as latex, tape, etc.):
   Allergic to:                                Reaction:
   ______________________________  ____________________________
   ______________________________  ____________________________
   ______________________________  ____________________________
   ______________________________  ____________________________
   ______________________________  ____________________________

38: What medications are you currently taking? Please list all **over-the-counter medications, prescription medication, and vitamins/supplements**.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Amount/Dose</th>
<th>How often</th>
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</tbody>
</table>
FAMILY HISTORY

(Please circle all that apply)
39. Narcolepsy - Apnea - Snoring – other Sleep Problems (describe)-

40. List of all surgeries you have had:

PAST MEDICAL HISTORY

Please circle all that apply:

41. Cardiac:
- Heart attack
- Bypass surgery
- High blood pressure
- Congestive Heart Failure
- Other: _______________________

42. Pulmonary:
- Asthma
- COPD/Emphysema
- High Blood Pressure
- Other: _______________________

44. Neurological:
43. Endocrine:
- Thyroid Disease
- Pituitary disease
- Diabetes
- Other: ______________________
- MS
- Parkinson
- Head trauma/brain contusion
- Stroke
- Restless
- Legs
- Head trauma/brain contusion
- Stroke
- Restless
- Legs

45. ENT
- Nose bleeds
- Facial surgery
- Sinus disease
- Tonsillectomy
- Brain tumor
- Other: ______________________
- Seizures
- Other: ______________________

46. GI:
- Adenoidectomy
- Deviated Spectrum
- Liver disease
- Ulcers
- Reflux
- Stomach surgery
- Liver disease
- Ulcers
- Reflux

47. Iron Deficiency
- Anemia
- Other: ______________________

48. Psych
- ADHD
- Depression
- Anxiety
- Panic attacks
- Eating disorder
- Post-Traumatic Stress
- Schizophrenia
- Other: ______________________
- Fibromyalgia
- Chronic fatigue
- Mono
- Kyphosis/Scoliosis
- Other: ______________________

49. Musculoskeletal:
- Kyphosis/Scoliosis
- Other: ______________________

50. Kidney
- Kidney disease
- Dialysis
- Other: ______________________
- Kidney disease
- Dialysis
- Other: ______________________

Patient Name: ________________________  DOB: _______________

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 work usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0= NEVER doze  
1= SLIGHT chance of dozing  
2= MODERATE chance of dozing  
3= HIGH chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing</th>
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<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
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<tr>
<td>Sitting inactive in a public place such as a theater or a meeting</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking to someone</td>
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<td>Sitting quietly after lunch without alcohol</td>
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<tr>
<td>In a car, while stopped for a few moments in traffic</td>
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</tbody>
</table>

Total scores (add all responses)  

All information I have given in this packet is accurate and true representation of my sleep problems. I understand that all of the given information is intended for the purpose of this sleep study. It is my responsibility to discuss any health concerns with my doctor.