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 <u>bring it with you to your Sleep Study</u>
All of our rooms are private, and have satellite TV

Our <u>Concord</u> address is:
130 Lake Concord Road
Concord, NC 28025

Our <u>Harrisburg</u> address is:
5427 Highway 49. S
Harrisburg, NC 28075

One of our patient rooms at the Concord Sleep Center

<u>Directions to Sleep Center:</u>

<u>Concord</u>

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)

<u>Harrisburg</u>

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

(sign out front reads: **Harrisburg Medical Mall**)

If you have questions or for directions from locations other than 85 don't hesitate to contact us at 704.403.1136

Patient Information for Sleep Studies

What is Polysomnogram?

A polysomngram 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 stall 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 mot 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**. <u>It is important not to consume excess alcohol or caffeinated beverages on the day of your study.</u>**

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 etst 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

Sleep Medicine Patient History- ADULT

Patient Name: __________________ DOB: _______________

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

	Weekdays	Weekends
2. What time do you usually go to bed?	________	________
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
or tingling in your legs that are relieved by moving your legs? **Yes or**
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**

Patient Name: ________________________ DOB: _________________

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.**

Name: Amount/Dose How often Reason

________________________ ____________ ___________ __________

________________________ ____________ ___________ __________

________________________ ____________ ___________ __________

________________________ ____________ ___________ __________

________________________ ____________ ___________

____

_________________________ _____________ ____________
____

FAMILY HISTORY

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

40. List of all surgeries you have had:
____
___
____
___
____
___

Patient Name: __________________________ DOB: __________________

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: ______________________

45. ENT
-Nose bleeds
-Facial surgery
-Sinus disease
-Tonsillectomy
-Adenoidectomy
-Deviated Spectrum
-Other: _____________________

47. Iron Deficiency
- Anemia

48. Psych
-ADHD
-Depression
-Anxiety
-Panic attacks
-Eating disorder
-Post- Traumatic Stress
-Schizophrenia
-Other: _______________________

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

- MS
- Parkinson
- Head trauma/brain contusion
- Stroke
- Restless
-Legs
-Brain tumor
-Seizures
-Other: _____________________

46. GI:
-Stomach surgery
-Liver disease
-Ulcers
-Reflux
-Other: ______________________

49. Musculosketal:
-Fibromyalgia
-Chronic fatigue
-Mono
-Kyphosis/Scoliosis
-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

Situation	**Chance of dozing**
Sitting and reading	_______
Watching TV	_______
Sitting inactive in a public place such as a theater or a meeting	_______
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 lunch without alcohol	_______
In a car, while stopped for a few moments in traffic	_______
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.

Patient/Legal Responsible Party Signature: ______________________________

Date: ________________________