



Leading-edge testing ~ Patient-centered care

Sleep Medical Centers

Durham, Burlington, Jacksonville

Second Breath

Oxygen, CPAP/BiPAP, Nebulizers

Ph: 919-477-1588 or 866-499-1588

Fax: 919-477-1688 or 866-499-1288

Website: www.FeelingGreatSleepCenter.com

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name _____ Gender () M () F Date of Birth _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Marital Status () Married () Single () Divorced

Home Ph: _____ Cell: _____ Work: _____ Email: _____

Emergency Contact _____ Ph: _____ Relationship _____

Referring Physician _____ Primary Physician _____

PATIENT EMPLOYMENT () Employed () Retired () Unemployed () Other

Employer _____ Phone _____

PRIMARY INSURANCE () Patient () Guarantor () Other

Insurance Company _____

ID# _____ Insurance Co Phone _____

Policy Holder's Name _____

If other than Patient

Relationship to Patient: () Spouse () Parent () Other _____

Guarantor Name _____ Phone _____

Guarantor Social Security _____ Date of Birth _____

Guarantor Employer _____ Phone _____

SECONDARY INSURANCE () Patient () Guarantor () Other

Insurance Company _____

ID# _____ Insurance Co Phone _____

Policy Holder's Name _____

If other than Patient

Relationship to Patient: () Spouse () Parent () Other _____

Guarantor Name _____ Phone _____

Guarantor Social Security _____ Date of Birth _____

Guarantor Employer _____ Phone _____

I understand that I am responsible for all charges on my account regardless of insurance. I authorize payment of any benefits due from my insurance company to Feeling Great! Sleep Medical Center for services rendered to myself and/or my dependents. I authorize governing or accrediting agencies to review my information when required.

Patient's Signature _____ Date _____



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Sleep Study Questionnaire

General Information

Name: _____ Birth Date: _____ Email: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Home Ph: _____ Cell Ph: _____ Work Ph: _____
 Emergency Contact: _____ Phone: _____
 Gender: M F Weight: _____ Height: _____
 Primary Physician: _____ Phone: _____
 Referral Physician – sleep study: _____ Phone: _____

Sleep History

My Main Sleep Complaint

_____ trouble sleeping at night How long? _____
 _____ being sleepy all day How long? _____
 _____ snoring How long? _____
 _____ unwanted behaviors during sleep, please explain: _____

Nighttime Sleep Patterns

Work Days

Days Off

| | | |
|-------------------------------------------|-------|-------|
| Typical bedtime | _____ | _____ |
| How long it takes you to fall asleep | _____ | _____ |
| Typical number of awakenings per night | _____ | _____ |
| Typical time it takes to fall back asleep | _____ | _____ |
| Typical wake up time | _____ | _____ |
| Desired wake up time | _____ | _____ |
| How do you usually awaken(alarm clock) | _____ | _____ |
| Typical time you actually get out of bed | _____ | _____ |
| Total amount of sleep per night | _____ | _____ |

Daytime Sleep Patterns and History

- Do you have a problem with sleepiness throughout the day? Yes No
- Do you usually take naps throughout the day? Yes No How many naps? _____
- What time of the day do you usually feel fatigued or sleepy? _____
- Does your job require that you change shifts? Yes No
- Does your job require you to drive a company vehicle? Yes No
- How much of the following do you consume during an average day?
 a) alcohol _____ c) tea _____ e) cigarettes _____
 b) coffee _____ d) soft drinks _____ f) other tobacco products _____

Please indicate if you have noticed - or if someone has told you - that you:

- A. Snore frequently and loudly? Yes No
- B. Your snoring causes people to get up and leave the room? Yes No
- C. Suddenly wake up gasping for breath or short of breath? Yes No
- D. Awaken with morning headaches? Yes No
- E. Notice your legs jerking or twitching during the night? Yes No
- F. Wake up confused and / or wander during the night? Yes No
- G. Are unable to move when falling asleep or immediately upon waking? Yes No
- H. Have episodes of sudden muscular weakness when laughing, angry, or in other emotional situations? Yes No
- I. Have vivid or life-like visual images while falling asleep or upon awakening? Yes No
- J. Have witnessed apnea (stop breathing) while you sleep? Yes No
- K. Grind your teeth? Yes No
- L. Talk in your sleep? Yes No
- M. Have thoughts that race through your mind while you are trying to fall asleep? Yes No
- N. Sweat a great deal during sleep? Yes No

Sleep Habits

- Do you frequently travel across 2 or more time zones? Yes No
- Do you usually watch TV or read in bed prior to sleep? Yes No
- Do you frequently get up at night to urinate? Yes No
- Do you sleep alone? Yes No

History of Previous Sleep Studies

- Have you ever had a sleep study? Yes No
- If yes, where was it? _____
- How long ago was it? _____
- Who has a copy of the results? _____

History of Owning a CPAP/BiPAP Machine

- Have you been prescribed a CPAP/BIPAP machine? Yes No
- What company provided the machine? _____
- What was the date you received the machine? _____
- What insurance did you have when you received your machine? _____
- Are you currently using your CPAP/BiPAP machine? Yes No
- Are you trying to get a new machine? Yes No
- Is your machine broken? Yes No

History of Home Oxygen

Are you currently on any home oxygen? Yes No
What liter flow are you on? _____
What company supplies your oxygen? _____

Female

Premenstrual Syndrome Yes No Menopause Yes No

Male

Prostate problems Yes No Erectile dysfunction/impotence Yes No

Personal Needs During Your Sleep Study

Will you need a caregiver? Yes No
Are you disabled? Yes No
Are you in a retirement home? Yes No
Do you use a wheelchair? Yes No

Do you have a DNR (Do not resuscitate) form? Yes No
If yes, please bring it to your study so a copy may be placed in your medical record.

Past Medical History

- | | | |
|------------------------------------------------|------------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hallucinations or delusions | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcer / heartburn |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Heart disease (ischemia) |
| <input type="checkbox"/> Chronic sinus disease | <input type="checkbox"/> Hyper / Hypo thyroidism | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Depression | <input type="checkbox"/> Back pain |

Allergies Yes No **Please explain** _____

Medications

Are you currently on any medications? Yes No
Please write the name and dose of your medications.

Do you have any other information that you know is related to your sleeping problem?

Feeling Great! Sleep Medical Center

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired.

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.

What are the chances of you dozing off

0= would never doze

1= slight chance I would doze off

2= moderate chance I would doze off

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. (example, theatre or a meeting) | 0 | 1 | 2 | 3 |
| As a passenger in a care for an hour without a break. | 0 | 1 | 2 | 3 |
| Lying down to rest in the afternoon when circumstances permit | 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 |

4111 Capitol Street • Durham, NC 27704 – *Administrative Office*

115 Olympic Avenue • Durham, NC 27704 – *Oxygen Equipment*

4007 Roxboro Road • Durham, NC 27704 – *Sleep Center*

6011 Fayetteville Road, Suite 102 • Durham, NC 27704 – *Sleep Center*

1161 Huffman Mill Road • Burlington, NC 27216 – *Sleep Center*

3642 Henderson Drive Ext. • Jacksonville, NC 28546 – *Sleep Center*

We look forward to serving you! You have made the right choice!

Feeling Great!

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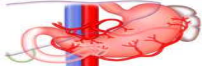

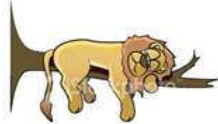





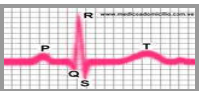
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* Screening Questions for Sleep Apnea = Prevent a Serious Medical Condition *

| | | |
|------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | Yes No | <p>I snore often, loudly, and stop breathing at night.</p> <ul style="list-style-type: none"> This critical problem may be sleep apnea which causes oxygen to decrease and places stress on vital organs – especially the heart / lungs / kidneys. Stroke, heart attack, and diabetes may result if sleep apnea is not corrected. Sleep Apnea is an epidemic unknowingly affecting tens of millions. |
|  | Yes No | <p>I wake up with nighttime heartburn or burning in my throat.</p> <ul style="list-style-type: none"> Nighttime acid reflux and regurgitation is aggravated by untreated sleep apnea. |
|  | Yes No | <p>I have headaches or pain when I awaken in the morning.</p> <ul style="list-style-type: none"> Decreased oxygen due to sleep apnea could be the cause of morning headaches. Frequent awakenings due to sleep apnea may result in muscle pain or aggravation of fibromyalgia, arthritis, and chronic fatigue syndrome. |
|  | Yes No | <p>I am sleepy and fatigued during the day.</p> <ul style="list-style-type: none"> Untreated sleep apnea causes sleep deprivation resulting in excessive daytime sleepiness, fatigue, less energy and depression. Some medications, sleeping pills, narcotics could worsen sleep apnea and result in death. Prior to surgery everyone should be screened for sleep apnea. Treatment improves outcome and recovery. |
|  | Yes No | <p>I am overweight and / or have problems with my diabetes.</p> <ul style="list-style-type: none"> CPAP treatment reduces blood glucose levels and improves insulin sensitivity. Sleep deprivation causes fluid retention and metabolic changes that interfere with weight reduction and increase cravings for salts and sweets. Large, short neck, unusual jaw position may cause sleep apnea. |
|  | Yes No | <p>I am irritable, anxious, and stressed out.</p> <ul style="list-style-type: none"> Depression and stress may be the result of sleep loss and increased cortisol levels. Impotence and decrease in sex drive may improve once CPAP treatment starts. |
|  | Yes No | <p>It is difficult for me to concentrate during the day.</p> <ul style="list-style-type: none"> Children and adults may exhibit poor concentration at school or work due to sleep loss. Enlarged tonsils or crowded airway may cause sleep apnea. Attention Deficit Disorder is affected by sleep loss due to untreated sleep apnea. |
|  | Yes No | <p>I wake up frequently at night.</p> <ul style="list-style-type: none"> Untreated sleep apnea may cause an individual to wake up hundred or more times during the night. This results in frequent urination, bedwetting, sleep loss, night sweats, and over-eating. |
|  | Yes No | <p>It is difficult for me to stay awake when I am driving.</p> <ul style="list-style-type: none"> People with sleep apnea are 6 times more likely to have a car crash. Treating all U.S. drivers suffering from sleep apnea would save billions in collision costs and save thousands of lives annually. Screening for all commercial drivers. |
|  | Yes No | <p>My high blood pressure is difficult to control.</p> <ul style="list-style-type: none"> Heart rhythm problems are noted in 50% - 75% of sleep apnea patients. 30% - 80% of patients with hypertension have sleep apnea. CPAP treatment improves daytime blood pressure and heart rate. Someone with untreated Sleep Apnea is up to 4 times more likely to have a stroke and 3 times more likely to be a candidate for heart disease. Sleep Apnea is one of the most deadly undiagnosed diseases in the world. |

Scores of 2 or greater indicate a need for further assessment and/or a sleep study. Leading-edge testing & patient centered care to diagnose & treat sleep apnea are offered at *Feeling Great!* Sleep Medical Center. Copyright Pending ©