Welcome to the Sleep Disorders Center at Kettering and Sycamore Medical Centers.

Please complete the enclosed information forms before you arrive to the sleep clinic for your scheduled appointment. The sleep clinic is located in the basement of both Kettering and Sycamore hospitals. Please call (937) 395-8805 at least 24 hours in advance to cancel any appointment. You may be charged a $20.00 fee for a no call / no show office visit.

Please bring all necessary information with you for your clinic appointment. It is suggested that you are accompanied by a spouse or bed partner if at all possible.

1. Please call 395-8880 to pre-register for your appointment.
2. Please give as much detail as possible on the information sheets.
3. Please request test results from your family physician or fax any lab results particularly thyroid test results.
4. Please have your insurance cards with you. If your insurance carrier requires a referral for this visit, please request the referral information to be faxed to the sleep clinic before your appointment.

   Sleep Disorder Center fax number: (937) 395-8821

5. Co-payments are due at the time of service. Cash, check, Visa, MasterCard, or Discover is accepted.
6. If you had a previous sleep study outside the Kettering Health Network, please call to request a copy of the study results to be sent to the Sleep Lab at fax number: (937) 395-8821.

Please check with your insurance carrier regarding deductible requirements for outpatient services performed at a hospital. This visit will be billed as an outpatient service within a facility by Pulmonary & Medicine of Dayton. A facility fee will be charged separately by the hospital.

We look forward to seeing you at your appointment. For questions regarding the date of your appointment, please call the Kettering Sleep Clinic at (937) 395-8805 or Sycamore Sleep Clinic at (937) 384-4820.
PATIENT INFORMATION

PLEASE PRINT CLEARLY

PATIENT NAME:________________________ BIRTHDATE:__________AGE:______SEX:______

ADDRESS:____________________________ CITY:_____________STATE:_______ZIP:________

PHONE:(___)____________MARITAL STATUS:___SINGLE ___MARRIED ___WIDOWED ___DIVORCED

OCCUPATION:____________________________ EMPLOYED BY:________________

WORK PHONE NUMBER:(___)____________ SOCIAL SECURITY NO:________________

CELL PHONE NUMBER:(___)____________ E-MAIL ADDRESS:________________

SPOUSE’S NAME:________________________ BIRTHDATE:________________

OCCUPATION:____________________________ EMPLOYED BY:________________

WORK PHONE NUMBER:(___)____________ SOCIAL SECURITY NUMBER:________________

PRIMARY INSURANCE:___________________ POLICYHOLDER NAME:________________

INSURANCE ID #:________________________ GROUP #:____________ PLAN #:____________

SECOND INSURANCE:___________________ POLICYHOLDER NAME:________________

INSURANCE ID #:________________________ GROUP #:____________ PLAN #:____________

REF. / FAMILY PHYSICIAN:________________

ADDRESS:____________________________ PHONE:(___)____________

PERSON TO CONTACT IN AN EMERGENCY:________________

RELATIONSHIP:________________________ PHONE:(___)____________

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: PULMONARY MEDICINE OF DAYTON, INC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure the payment.

SIGNED:________________________________ DATE:________________

POS# Reorder # 1000517
Name: ____________________
DOB: __________

Referring Physician: ____________________ Tel # ____________________
Family Physician: ____________________ Tel # ____________________
Age: _________ Height: _______ Weight: _______

Main reasons you are coming for this visit: _____________________________________________________________

USUAL SLEEPING HABITS:
How many hours of sleep do you get ___________ Night ____________ Day ____________
Usual time you go to bed__________
Usual time you fall asleep__________
Number of times you wake up__________ To do what? ______________
Time you get out of bed__________ with/without an alarm clock
When you wake up do you still feel tired/groggy? ________
Do you wake up frequently with a headache? _______
Any unusual dreams? If so, describe _____________________________________________________________
Do you snore? ________ (Y/N) Heavy/Light __________
Does it wake your partner? ________ (Y/N)
Does your partner sleep in separate rooms due to your snoring? _________
On weekends/days off do you sleep longer? (Y/N) ______________ (How many hours?) ______
Do you take naps during the day: (describe) _______________________________________________________
Are they Restful __________ (Y/N)?
As you are going to bed, do your legs have a creepy, crawly feeling? ________
Describe it further: __________________________________________________
If so, does the discomfort get (circle one) BETTER/WORSE when you do fall asleep?
Does the feeling get (circle one) BETTER/WORSE with moving the legs?
Is it worse during the (circle one) evening/night OR during the daytime?
Do you have uncontrollable urges to fall asleep in the daytime? _________
Do you fall to the ground or pass out if you laugh/cry/get emotional? ______________
Do your muscles feel weak when you are laughing or excited? ______________
At night: any unusual activities? ______________
While asleep do you Talk ______ Walk _________ Eat ________
Do you ever injure yourself? __________________ Others? ______________
Grind your teeth ______________ Wet your Bed _________________
Wake up coughing ______________ Wheezing ______________ Chest Pain ______________
**DAYTIME SLEEPINESS:**

In the daytime, do you feel sleepy? __________

Do you fall asleep while (circle all that apply):
- Driving __________
- Doing my job __________
- Eating __________

Have you ever had any accidents or near accidents related to sleep issues? __________

If so, describe what happened. ____________________________________________________

**PAST HISTORY:**

Currently I have been diagnosed with the following:

- Hypertension
- Heart attack
- Stroke
- Emphysema / Asthma / COPD
- Depression / Anxiety
- Diabetes
- Thyroid disorder
- Hiatal Hernia
- Gastroesophageal reflux (GERD)
- Peptic Ulcer Disease
- Irritable Bowel Syndrome
- Other (describe)
- Irregular heart beat

**SURGERIES (with dates):**

________________________________________

________________________________________

**ALLERGIES (and describe what happens):**

________________________________________

________________________________________

________________________________________

**CURRENT MEDICATIONS:**

(Please list all medications you are taking, prescription and over-the-counter).

Any medicines in particular for sleeping OR to keep you up?

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>DOSAGE</th>
<th># OF TABLETS</th>
<th>HOW MANY TIMES A DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Kettering Health Network
Dr. Mariano Iberico
Dr. Hemant Shah
Dr. Median Ali

Name: ____________________
DOB: __________

FAMILY HISTORY of sleep related problems:

MOTHER: __________________ BROTHER: __________________
FATHER: ___________________ SISTER: _______________

Habits:
Did you ever smoke? (Y/N)____
Number of packs/day_______________ For how long? _____________
Date of your last cigarette_____________
Alcohol: (type) _______ Amount _________
Any other drugs? _______________
Coffee: Y/N _______________ Number of cups per day ________ caffeinated/decaf
Cola/Pop (name) _____________ Number of cans/bottles a day_________________

OCCUPATION:
Type of work _____________________
Usual work hours _______________
Approx. driving distance _________ miles per day to and from
Any use of dangerous equipment or machinery? (Describe) ___________________
Please circle any of the following that you have recently experienced.
If there is anything else please put it in the blank boxes.

<table>
<thead>
<tr>
<th>Constitution:</th>
<th>Weight Loss</th>
<th>Fatigue</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular:</td>
<td>Chest Pain</td>
<td>Palpitations</td>
<td>Swelling (edema)</td>
</tr>
<tr>
<td>Ears, Nose, and Throat</td>
<td>Heartburn or Reflux</td>
<td>Deviated Nasal Septum</td>
<td>Nasal Obstruction</td>
</tr>
<tr>
<td>Hematology/Lymph:</td>
<td>Easy Bruising</td>
<td>Bleeding Tendency</td>
<td>Enlarged Lymph Nodes</td>
</tr>
<tr>
<td>Neurology:</td>
<td>Headaches</td>
<td>Seizures</td>
<td>Head Injury</td>
</tr>
<tr>
<td>Skin:</td>
<td>Rash</td>
<td>Itching</td>
<td>Dry Skin</td>
</tr>
<tr>
<td>Musculoskeletal:</td>
<td>Muscle Wasting</td>
<td>Tremors</td>
<td>Weakness</td>
</tr>
<tr>
<td>Psychiatric:</td>
<td>Feeling Anxious</td>
<td>Feeling Depressed</td>
<td>Feeling Sad</td>
</tr>
<tr>
<td>Gastronintestinal:</td>
<td>Heartburn</td>
<td>Trouble Swallowing</td>
<td></td>
</tr>
<tr>
<td>Endocrine:</td>
<td>Excessive Thirst</td>
<td>Excessive Urination</td>
<td></td>
</tr>
<tr>
<td>Genitourinary:</td>
<td>Frequent Urination</td>
<td>Loss of Bladder control</td>
<td>Difficult Urination</td>
</tr>
</tbody>
</table>
DATE: ____________________

NAME: _______________________________

**EPWORTH SLEEPINESS SCALE**

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

_____ Sitting and reading  
_____ Watching television  
_____ Sitting inactive in a public place, for example, a theater or meeting  
_____ A passenger in a car for an hour without a break  
_____ Lying down to rest in the afternoon  
_____ Sitting and talking to someone  
_____ Sitting quietly after lunch (when you have had no alcohol)  
_____ In a car, while stopped in traffic
Thank you for the opportunity to participate in your medical care and treatment.