Blanchard Valley Sleep Disorders Center
419.427.2604 • Fax 419.427.2607 • 1909 South Main Street • Findlay, Ohio 45840

APPOINTMENT

Welcome,

We look forward to seeing you on appointment date:

_____@_____

A detailed sleep history is an essential part of a comprehensive Sleep evaluation. Thank you for filling out the sleep Questionnaire to the best of your ability.

Please bring to your appointment:

- Driver' license
- Insurance card(s)
- Completed Packet
- Other_____

Please call Blanchard Valley Hospital Registration at (419) 423-5304. This is necessary to ensure your information is updated for the Sleep Disorders Center.

- Dr. Daniel Sak's professional fee for office visits and sleep study Interpretations are processed through Blanchard Valley Hospital.
- Technical fees for office visits and sleep studies are billed through BVH as an outpatient hospital service.
- Please be aware it is your responsibility to contact your insurance provider to determine network coverage for physician professional fees and BVH services.

If you should need to reschedule, please call us at 419-427-2604.
Thank you for choosing Blanchard Valley Sleep Disorders Center.

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Medication List

Allergies/Reaction:_____

Medication (prescription, over-the-counter aspirin, vitamins, herbs, inhalers, aerosol treatments, oxygen)	**Dose** **mg, mcg, ml, units**	**Route** **Oral, nasal, inhalation, injection**	**Frequency** ____X daily, or as needed for _____	**OFFICE USE:** Document:√ if same, **New**, **DC** for discontinued Or last time taken for sleep study					
Staff Date/Time:				/	/	/	/	/	/

Medication list provided by:
- ❒ patient report
- ❒ meds brought in
- ❒ healthcare provider

- ❒ Gave copy of list to patient or care provider
- ❒ Patient declined copy of list

Staff Signature

Patient Signature:

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RELEASE OF PATIENT INFORMATION

List all of your current doctors with whom we should share your information to coordinate your medical care.

Primary Care Physician _____

Address _____

Phone (_____) _____-_____

Fax (_____) _____-_____

Physician _____

Address _____

Phone (_____) _____-_____

Fax (_____) _____-_____

I authorize Blanchard Valley Sleep Disorders Center to leave a message pertaining to my care (i.e. what department we are calling from, reminder for appointments, etc), by the following methods. I will assume responsibility to notify them if this information changes.

Home Telephone/Voicemail/Answering Machine (_____) _____ - _____ _____ *yes* _____ *no*

Work Telephone/Voicemail/Answering Machine (_____) _____ - _____ _____ *yes* _____ *no*

Cell Phone/Voicemail (_____) _____ - _____ _____ *yes* _____ *no*

Please list the names of any people you authorize to receive messages or information regarding your personal medical information.

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

X _____ _____
Patient Signature Date

THIS SPACE FOROFFICE USE ONLY

PSG	**Cert#**	**HST**	**Cert#**
CPAP	**Cert#**	**ROV**	**Cert#**
TV	**Cert#**	**ROV**	**Cert#**

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SLEEP DIARY

BEGIN LOG IN THE EVENING AS YOU PREPARE FOR BED							
	DAY 1	**DAY 2**	**DAY 3**	**DAY 4**	**DAY 5**	**DAY 6**	**DAY 7**
NAPS TAKEN							
CAFFIENE CONSUMED							
ALCOHOL CONSUMED							
NICOTINE USED							
MEDICATION TO INDUCE SLEEP							
IN THE MORNING COMPLETE DIARY AS IS POSSIBLE (WITHOUT UNDUE STRESS)							
BEDTIME (lights out)							
APPROXIMATE TIME It took to fall asleep							
Number of **AWAKENINGS**							
TIME SPENT **AWAKE DURING THE NIGHT**							
ALARM SET TIME							
# SNOOZE ALARM Activations							
WAKE UP TIME (Final wakeup time)							
ESTIMATED HOURS OF SLEEP							
WAKEUP REFRESHED	___ YES ___ NO	___ YES ___ NO	___ YES ___ NO	___ YES ___ NO	___ YES ___ NO	___ YES ___ NO	___ YES ___ NO

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SLEEP / WAKE Questionnaire

SEVEN DAY SLEEP DIARY – PLEASE FILL OUT BEFORE VISIT

Patient Name	
Date of Birth	
Reports to:	
Primary Care Physician	
Referring Physician	
Other Physician(s)	

Reason for Referral or Main Sleep Complaint:

_____

_____

_____

SLEEP / WAKE Schedule / Ease of Falling Asleep and Staying Asleep:

I begin my bedtime routine at:_____ AM/PM

I fall asleep in another room prior to retiring to the bedroom; (in front of the TV in the living room, etc):

____Yes _____No _____Sometimes

I am in bed at _____ AM/PM

I watch TV or read in bed prior to falling asleep: ____Yes ____No ____Sometimes

I turn out the lights and attempt to sleep at: _____ AM/PM

It takes me _____ minutes to fall asleep.

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SLEEP / WAKE Questionnaire

I wake up _____times during the night.

Reason for wakening: ___ Bathroom ___Thirst ___Hunger ___Pain ___Bed Partner

___ Children ___Other_____

Wake up Time: _____ I wake up naturally: ___Yes ___No

I use an Alarm: ___Yes ___No Alarm is set at: _____

Number of times the snooze alarm is activated: _____

I am out of bed at:_____ I wake up refreshed: ___Yes ___No

I nap during waking hours: ___Never ___Sometimes ___Daily

Sleep Environment and Sleep Hygiene

My **Sleep Room** during hours of sleep: is comfortable and is suitable to my personal needs:

___Yes ___No ___ Could be better

My **Bed**: is comfortable and suits my sleep style: ___Yes ___No….Could be better

There are pets in my room: ___Yes ___No

There are children in my room: ___Yes ___No

I share my room with a spouse or bed partner: ___Yes ___No

My **Spouse/bed partner:** Rests comfortably and does **not** disturb my sleep:

___Yes ___No ___N/A

Either due to my schedule or by choice I may be engaged in activities right up to bedtime (work, study, mail, bill paying, entertainment, physical activity): ___Yes ___No

Before retiring to bed, I have a routine that permits me to “unwind” and prepare for sleep:

___Yes ___No

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I require specific relaxation techniques to accomplish sleep: ___Yes ___No
(reading, meditation, music, prayer, scripture reading, sexual activity, food, beverage, etc)

I require medication to fall asleep: ___Yes ___No _____

If I wake up during the night, I am able to get back to sleep easily: ___Yes ___No
After I wake up, I may get up and _____

Sleep related symptoms

I have experienced or my spouse/family/friends have witnessed:

- ❑ Snoring
  - My ___restlessness ___snoring ___disruptive sleep disturbs my spouse/bed partner: ___Yes ___No ___N/A
  - My Spouse/bed partner and I: Occasionally sleep separately due to sleep related issues e.g. snoring, restless legs, disruptive sleep etc: ___Yes ___No __ N/A
    Explain:_____
- ❑ Stop breathing episodes or pausing; fluctuation in snoring or breathing
- ❑ Sweating at night
- ❑ Waking up gasping for air or short of breath
- ❑ Waking up coughing
- ❑ Waking up with heartburn or a sour taste in the back of my mouth
- ❑ Waking up with a dry mouth
- ❑ Waking up with a headache

My ability to fall asleep and stay asleep may at times be affected by:

- ❑ Pain
- ❑ Restless legs

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Sleep related symptoms continued

My ability to fall asleep and stay asleep may at times be affected by:

- ❑ Indigestion/heartburn
- ❑ Hunger
- ❑ Need to use the bathroom (nocturia)
- ❑ Irritable bowel symptoms

- ❑ Worry
- ❑ Anxiety
- ❑ Sadness
- ❑ Work schedule or work related issues
- ❑ Family

I have experienced or been told that:

- ❑ I sleep talk – without recollection
- ❑ I sleep walk – without remembering what I did
- ❑ I sleep eat – without remembering - perhaps finding evidence of such the next morning
- ❑ I appear to have awakened but am confused - not remembering the apparent awakening the next morning
- ❑ I experience night terrors without recollection the next morning
- ❑ I make rocking or rolling movements in my sleep and am unaware of my restlessness
- ❑ I dream
- ❑ My dreams are vivid, disturbing and are like “nightmares”
- ❑ I have acted out dreams or am very active during my dreams disturbing my spouse/bed partner which prompts them to wake me up
- ❑ I have experienced a seizure during sleep

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The Epworth Sleepiness Scale

How Sleepy Are You?

Please score the following situations based on the following number assignments:

- **0 = No Chance of dozing**
- **1 = Chance of dozing Slight**
- **2 = Chance of dozing Moderate**
- **3 = Chance of dozing High**

Situation Chance of Dozing	PATIENT'S RESPONSE	FAMILY'S RESPONSE
Sitting and reading		
Watching TV		
Sitting inactive in a public place (e.g., 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 a lunch **without alcohol**		
In a car, while stopped for a few minutes in traffic		
TOTAL		

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SLEEP / WAKE Questionnaire

Daytime / Wake-time symptoms

Sleepiness:

- ❑ I have been involved in a motor vehicle accident **due to sleepiness**
- ❑ I have experienced a “near-miss” while driving **due to sleepiness**
- ❑ I have fallen asleep or closed by eyes while waiting at an intersection
- ❑ I have driven a distance and not recalled the details of the drive

- ❑ I have experienced a persistence of dream like images while awakening
- ❑ I have experienced a feeling of paralysis (inability to move) upon awakening
- ❑ I have experienced sudden muscle weakness with excitement

Other Sleep Issues you wish to bring to the physician’s attention:

Physician Signature_____Date ___/___/___ Time ___:___

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SLEEP CENTER MEDICAL HISTORY QUESTIONNAIRE

NAME OF PATIENT: _____

DATE OF BIRTH: _____

MEDICAL HISTORY (Please check all that apply and add additional history that pertains to you now or in the past)

- ❑ Seasonal Allergies
- ❑ Sinusitis
- ❑ Blindness
- ❑ Hearing Loss

- ❑ Hypertension
- ❑ Hypercholesterolemia
- ❑ Coronary Artery Disease
- ❑ Myocardial Infarction (Heart Attack)
- ❑ Atrial Fibrillation
- ❑ Atrial Flutter
- ❑ Ventricular Tachycardia
- ❑ Congestive Heart Failure
- ❑ Heart Valve Disease
- ❑ PAD-Peripheral Artery Disease

- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Chronic Bronchitis
- ❑ Pulmonary Hypertension
- ❑ Pulmonary Fibrosis
- ❑ Respiratory Failure requiring Oxygen Therapy

- ❑ Arthritis
- ❑ Degenerative Disc Disease
- ❑ Chronic Back Syndrome
- ❑ Muscle Disease

- ❑ Heart Burn (GERD)
- ❑ Peptic Ulcer Disease
- ❑ Irritable Bowel Syndrome
- ❑ Colitis
- ❑ Gastrointestinal Bleeding

- ❑ Chronic Urinary Tract Infections
- ❑ Kidney Stones
- ❑ Benign Prostatic Hypertrophy
- ❑ Interstitial Cystitis
- ❑ Chronic Renal Failure

- ❑ Migraine Headaches
- ❑ Seizure Disorder
- ❑ Neuropathy
- ❑ Stroke
- ❑ TIA
- ❑ Parkinson's Disease
- ❑ Familial (Benign) Tremor
- ❑ Multiple Sclerosis
- ❑ Myasthenia Gravis
- ❑ Muscular Dystrophy
- ❑ Childhood Polio
- ❑ ALS
- ❑ Guillian-Barre Syndrome
- ❑ Cerebral Palsy

- ❑ Chronic Pain
- ❑ Cancer

- ❑ Thyroid Disease
- ❑ Diabetes Mellitus

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SLEEP CENTER MEDICAL HISTORY QUESTIONNAIRE

- ❑ Insomnia
- ❑ Obstructive Sleep Apnea
- ❑ Narcolepsy
- ❑ Restless Leg Syndrome
- ❑ REM Behavior Disorder
- ❑ Night time eating Disorder
- ❑ Depression
- ❑ Anxiety Disorder
- ❑ Bipolar Mood Disorder
- ❑ ADD
- ❑ ADHD
- ❑ Dyslexia
- ❑ Learning Disability

Other Medical History: _____

_____

_____

SURGICAL HISTORY

Recent	Past	Surgery

FAMILY HISTORY (Check any that apply)

	Heart Disease		Obstructive Sleep Apnea
	Hypertension		Bed wetting
	Diabetes Mellitus		Narcolepsy
	Thyroid Disease		Insomnia
	Lung Disease		Depression
	Colitis		Anxiety
	Kidney Disease		Tuberculosis
	Cancer		Genetic Disease

MEDICATIONS: (SEE LIST)

ALLERGIES: NONE: ❑: _____

_____

_____

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SLEEP CENTER MEDICAL HISTORY QUESTIONNAIRE

OCCUPATION: _____

Alcohol: NONE: _____ RARE: _____ SOCIAL/WEEKEND: _____ DAILY: _____
"NIGHTCAP": _____ I may use alcohol to help induce sleep: _____

Tobacco: NONE: _____ QUIT: _____ CIGARETTES: _____Packs per day_____# years:_____
CIGARS: _____ CHEW:_____ VAPOR:_____

Caffeine: NONE: _____ COFFEE: _____ TEA:_____ SODA:_____ TABLETS:_____

Exercise: Times per week:_____ Time of Day: AM_____ / PM_____ NONE:_____

REVIEW OF SYSTEM:

General

- ❑ Weight ___Gain, ___Loss
- ❑ Recurring Fever or Chills
- ❑ Fatigue – without clear reason
- ❑ Night Sweats
- ❑ **NONE**

Eyes

- ❑ Corrective Lenses
- ❑ Recent Change in Vision
- ❑ Under the care of an Eye Doctor
- ❑ **NONE**

Ears

- ❑ Hearing Loss
- ❑ Ringing in Ears
- ❑ Hearing Aids
- ❑ Ear Pain
- ❑ **NONE**

Nose/Sinuses

- ❑ Chronic Nasal Congestion
- ❑ Chronic Nasal Drainage
- ❑ Loss of Smell
- ❑ Bleeding from Nose
- ❑ Chronic Sinusitis
- ❑ **NONE**

Throat

- ❑ Recurrent sore throats or Tonsillitis
- ❑ Difficulty Swallowing
- ❑ Coughing after swallowing
- ❑ Vocal Hoarseness
- ❑ **NONE**

Cardiovascular

- ❑ Chest Pain
- ❑ Palpitations
- ❑ History of Heart Murmur
- ❑ Leg or ankle swelling (edema)
- ❑ Pain in legs with walking
- ❑ Cold Hands or Feet
- ❑ **NONE**

Respiratory

- ❑ Shortness of Breath
- ❑ Cough
- ❑ Wheezing
- ❑ Sputum Production
- ❑ Coughing Up Blood
- ❑ **NONE**

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SLEEP CENTER MEDICAL HISTORY QUESTIONNAIRE

Gastrointestinal

Appetite: Good____ Fair____ Poor_____

- ❑ Gastroesophageal Reflux (GERD)
- ❑ Wake up Hungry at Night
- ❑ Get up at Night to Eat
- ❑ Change in Bowel Habits
- ❑ Blood in Bowel Movements
- ❑ **NONE**

Genitourinary

- ❑ Get up at Night to Urinate
- ❑ Urgent Urination
- ❑ Painful Urination
- ❑ Blood in Urination
- ❑ Less than perfect Bladder control
- ❑ **NONE**

Musculoskeletal

- ❑ Joint pain, stiffness or swelling
- ❑ Muscle pain
- ❑ Chronic back pain
- ❑ Require an appliance (cane/walker/wheelchair/scooter)
- ❑ **NONE**

Neurologic

- ❑ Recurring Headaches
- ❑ History of Seizure
- ❑ Numbness, Tingling
- ❑ Chronic Pain
- ❑ Restless Legs
- ❑ Tremors
- ❑ Muscle Weakness
- ❑ **NONE**

Skin

- ❑ Chronic Rash
- ❑ Itchy Dry Skin
- ❑ Suspicious Lesions
- ❑ History of Cellulitis
- ❑ **NONE**

Endocrine

- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Coarse Hair with Dry Skin
- ❑ Increase Thirst
- ❑ Excessive Urination
- ❑ **NONE**

Psychiatric

- ❑ Depression
- ❑ Anxiety
- ❑ Less than perfect Memory
- ❑ Thoughts of suicide
- ❑ Fear – people, places, circumstances
- ❑ **NONE**

Hematologic/Lymphatic

- ❑ Bruising
- ❑ Anemia or Iron Deficiency
- ❑ Enlarged Lymph Nodes
- ❑ **NONE**

Immunologic

- ❑ Poorly healing wound
- ❑ Recurrent or persistent Infection
- ❑ HIV Exposure
- ❑ History of Hepatitis B or C
- ❑ **NONE**

DATE _____/_____/_____

_____

Patient Signature

_____

Provider Signature

Date: ____/____/____ Time: _____/_____