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Director

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Associate Director

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Nurse Practitioner

CENTER *for* SLEEP MEDICINE

Chestnut Hill Hospital
8835 Germantown Avenue
Philadelphia, PA 19118
Phone (267) 339-6462
Fax (215) 248-0696

1500 Lansdowne Ave
Darby, PA. 19023
Phone (610) 237-4592
Fax (610) 237-4542

Thank you for scheduling an evaluation at our Center. Our practitioners aim to provide a comprehensive analysis of your sleep problem and help you sleep and feel better. The questionnaire that follows is helpful to us for your visit, please complete it and bring it with you. If you sleep with someone, we would encourage you to discuss the first two pages with them as they may be able to provide useful information about your sleep.

Although we bill all insurance plans, your charges may not be totally paid by your particular plan. You may be required to pay a co-pay, a deductible, and/or co-insurance payments. We recommend you contact your insurance in advance of your appointment to become familiar with your insurance coverage. At the bottom of this page, we list common procedure codes that we use; your insurance company will be able to let you know what your coverage is for these services.

If you have a CPAP/BiPAP machine, records from previous sleep studies, or recent copies of blood work, please bring this to your first visit.

A few of our policies:

- We require all patients to pay their co-pay at the time of the visit. We accept credit card and personal check (at this time we cannot accept cash payments)
- If your insurance requires a referral (such as Keystone Health Plan East, Cigna/Healthspring, and others) please be certain to have your primary care doctor submit the referral prior to your visit.
- If you are not able to keep your appointment, please contact us at least 2 days prior to cancel the visit.

OFFICE VISITS	INSURANCE CODE
Initial Evaluation	99244, 99245, 99204 or 99205

PROCEDURES	
Home Sleep Test	G0399
Polysomnogram (in center sleep test)	95810
Polysomnogram with CPAP	95811
Multiple Sleep Latency Test	95805

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PATIENT QUESTIONNAIRE

NAME _____ DATE OF BIRTH_____

Briefly describe your sleep problems or reason you were referred:

_____
_____
_____

Current medications taken for sleep:

_____ _____ _____
_____ _____ _____

Medications for sleep taken in the past:

_____ _____ _____
_____ _____ _____

For questions below, please circle all answers that apply and fill in blanks.

Do you have caffeine within 2-3 hours of bedtime:?	yes	no	occasionally
Do you smoke a cigarette within 2-3 hours of bedtime:?	yes	no	occasionally
Do you drink alcohol within 2-3 hours of bedtime:?	yes	no	occasionally
Do you exercise within 2-3 hours of bedtime:?	yes	no	occasionally
Do you share a bed with someone?	yes	no	sometimes
Is your bedroom dark and quiet for sleep?	yes	no	sometimes

How do you feel as bedtime approaches?

Sleepy Calm/Looking forward to sleep Not sleepy Anxious or stressed Worried about sleep

What do you do after you get into bed?

Try to fall asleep immediately Watch television Television stays on most or all of the night Read
Listen to Music/Radio/Podcast Use computer Talk on phone Play on phone/iPad/tablet

How do you sleep away from home? Better Same Worse

Which of the following disturb your sleep:

None Pet(s) children spouse/bedpartner family headache heartburn
lower back pain upper back pain neck pain joint pain

When are your work hours?- Days Evenings Overnights Rotating Shifts /Varies
Weekends Retired Disabled Other _____

Usual time into bed: work days_____ off days _____
Usual time you wake up: work days_____ off days_____
Usual hours of sleep per night: work days_____ off days_____

How long does it usually take you to fall asleep? _____minutes _____hours
Number of nights per week you take more than 30 minutes to fall asleep: _____
Number of awakenings per night: 0 1 2 3 4 5 6 7 other_____
Out of bed during awakenings: yes no sometimes
Activities during awakenings: bathroom look at time eat drink read watch TV smoke
Use phone/tablet worry get mad get frustrated other_____
Number of nights per week with an awakening longer than 30 minutes: _____

Rested after sleep: yes no sometimes
Sleepy during the day: yes no sometimes
Drowsy driving: yes no sometimes only with long distance driving only at night
Unintentional dozing: none 1 to 3 times a month 1 to 3 times per week
4 to 6 times per week 1 to 3 times every day
Number of deliberate naps per week _____

Which of these are true while sleeping: snoring snoring disturbs others snoring worse on back
gasping for air awakenings with gasping or choking awakenings with shortness of breath
breathe through mouth dry mouth observed breathing pauses NONE

Do you have uncomfortable feelings in your legs while inactive? Yes No
If yes, feelings: Cause an urge to move decrease or stop with movement interfere with sleep
Discomfort occurs: in bed while sitting and relaxing in the evening
after sitting for a long time in the afternoon anytime inactive

Do you have jerking leg movements: Yes No
Do you have observed leg movements while sleeping: Yes No

Have you ever:
Had sudden bouts of muscle weakness caused by laughter or strong emotion? Yes No
Felt paralyzed (unable to move) while falling asleep or waking up? Yes No
Felt as if you were dreaming while falling asleep or waking up? Yes No

Which of these are true for you:
talking during sleep sleepwalking yelling out or screaming during sleep
acting out dreams violent behaviors during sleep injury to self or other due to sleep behaviors
night terrors during childhood sleepwalking during childhood none

PAST MEDICAL HISTORY

Check Yes or Now for Any Medical Problems You Have Now or in the Past

Disorder	Yes	No	When
High Blood Pressure			
Heart Attack (MI)			
CHF (congestive heart failure)			
Atrial Fibrillation			
High Cholesterol			
Sinusitis			
Allergies/Hayfever			
Asthma			
COPD			
Other Lung Disease			
Acid Reflux (GERD)			
Liver Disease			
Head Trauma/Injury			
Fibromyalgia			
Arthritis			
Back or Spine Problems			
Orthopedic Problems			
AIDS/HIV			
Anemia			
Iron Deficiency/ Low Iron Levels			
Kidney Disease			
Diabetes			
Cancer			
Hyperthyroidism			
Hypothyroidism			
Migraine Headaches			
Parkinson's Disease			
Stroke			
Epilepsy/Seizures			
Other Neurological Problems			
Anxiety Disorder			
Depression			
Mental Illness			

Please list any other health problems not mentioned above: _____
_____

SURGICAL HISTORY

Have You ever had the following surgical procedures? If so, please write when it was done

Procedure	YES	NO	WHEN
Tonsillectomy & Adenoidectomy			
ENT/Sinus Surgery			
Septoplasty			
Gastric Bypass or Gastric Sleeve			
Heart Surgery			
Other Abdominal Surgery			
Spine Surgery			
Back Surgery			
Thyroid Surgery			
Other			
Other			

ALLERGIES TO MEDICINE

Please list all allergies to medication you have and the reaction it caused (Example- Penicillin- rash)

ALLERGIES TO THE ENVIRONMENT/FOOD/ OTHER

Please list all allergies to the environment, food, or other causes you have.

Household Dust Pollen Cats Dogs Ragweed Latex Surgical Tape Shellfish
Other: _____
_____

MEDICATIONS

Please list all prescription medications, over-the-counter medications, and supplements you are currently taking and the doses (Example- Prozac 20 mg a day)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

Please circle answers and fill in blanks below

Occupation: _____

Education: school grade completed: 4 5 6 7 8 9 10 11 12

completed some college graduated college post graduate

Marital Status: married single divorced separated widowed domestic partner

Other household members: Live alone Live with other(s)

Number of children: 0 1 2 3 4 5 6 7 8 9 10

Caffeine intake: none occasional moderate heavy

Alcohol intake: none occasional moderate heavy

Smoking status: never former current daily current some days

If you smoke, how long does 1 pack of cigarettes last you? _____

Tobacco-years of use: _____ date quit_____

Illicit drugs: never past current

Diet: regular vegetarian vegan gluten free specific

diabetic cardiac carbohydrate

Exercise level: none occasionally moderate heavy

General Stress Level: low medium high

FAMILY HISTORY

Check any disorder known for these family members

Disorder	Mother	Father	Sister	Brother	Grandmother Mother/Father Side	Grandfather Mother/Father side
High Blood Pressure						
Heart Disease						
Obesity						
Diabetes						
Sleep apnea						
Restless legs syndrome						
Insomnia						
Snoring						

REVIEW OF SYSTEMS

Do you CURRENTLY have any of the symptoms below? Please circle yes or no for <u>all</u> items.

Fatigue	Yes	No	Palpitation	Yes	No	Excessive Thirst	Yes	No
Recent Weight Gain	Yes	No	Difficulty Breathing Lying Flat	Yes	No	Excessive Sweating	Yes	No
Recent Weight Loss	Yes	No	Difficulty Breathing with Exertion	Yes	No	Headaches	Yes	No
Stuffy Nose	Yes	No	Leg/Ankle Swelling	Yes	No	Memory Loss	Yes	No
Runny Nose	Yes	No	Nausea	Yes	No	Depression	Yes	No
Post Nasal Drip	Yes	No	Constipation	Yes	No	Anxiety/Nervousness	Yes	No
Nosebleeds	Yes	No	Heartburn	Yes	No	Irritability	Yes	No
Sinus Pain	Yes	No	Frequent Nighttime Urination	Yes	No	Difficulty Concentrating	Yes	No
Allergy Symptoms	Yes	No	Incontinence	Yes	No			
Dry Mouth	Yes	No	Back Pain	Yes	No			
Sore Throat	Yes	No	Neck Pain	Yes	No	For Women:		
Hoarseness	Yes	No	Join Pain	Yes	No	Regular Periods	Yes	No
Wheezing	Yes	No	Joint Stiffness	Yes	No	Menopause?	Yes	No
Coughing	Yes	No	Rashes	Yes	No			
Shortness of Breath	Yes	No	Dry Skin	Yes	No			

THE EPWORTH SLEEPINESS SCALE

Use the following scale to rate your chance of dozing off or falling asleep (not just feeling tired) in the following situations during recent times. If you haven't done the activity recently, try to rate how you think it would affect you.

0= no chance 1= slight chance 2= moderate chance 3= high chance

Sitting and reading _____
Watching television _____
Sitting inactive in a public place (theater or meeting for example) _____
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 _____