

# Baltimore Sleep and Wellness Center

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

- **If you arrive more than 10 minutes late for your scheduled appointment time, your appointment may be delayed, shortened, or have to be rescheduled. Some new patients may be required to view a short video prior to seeing the clinician.**

Dear New Patient:

We wish to make your visit pleasant, as well as efficient, and our courteous staff will assist you in every way possible. To be sure that your visit goes smoothly, please read thoroughly and follow the directions below. Call our appointment desk at (410) 284-3020 if you have any questions while completing this packet. If you have not already given your insurance information to our office, please call the appointment desk and provide this information.

1. Complete and sign all enclosed forms and bring them to your visit. It is **very important** that the questionnaire be completed **prior** to your visit. Failure to have a completed questionnaire could cause your visit to be shortened or cause it to have to be rescheduled. Also, be sure to bring your current insurance card for your medical benefits.
2. **If your insurance requires a referral, it is your responsibility to obtain this before your visit.** If we do not have the referral on the day of your appointment, you will be expected to pay all charges. If your insurance requires authorization prior to your sleep study, our office will potentially need to contact you to complete this process. If your visit will be covered by **workman's compensation**, we must have an authorization prior to visit.
3. In order to perform a thorough consultation, our doctors must have copies of any records you may have from any and all prior treatments and/or hospitalizations related to sleep disorders or the problem for which you are being seen. Check with prior caregivers for copies. Also, please make a list of all current medications as well as those taken in the past.
4. If you must cancel or reschedule your appointment, kindly give us a 24-hour notice in order to avoid a missed appointment charge of \$200. Frequent appointment cancellations may affect your treatment plan.
5. Payment in full is expected at time of service. For your convenience, we do accept MasterCard, Visa, AMEX Discover, Money Orders, Checks, or Cash. Co-pays must be paid at time service. There is a \$25.00 returned check charge.

6830 Hospital Drive Suite 106A  
Baltimore MD 21237  
Phone (410) 284-3020

*Baltimore Sleep and Wellness Center*  
**SLEEP HABITS QUESTIONNAIRE**

**Bring this form with you to your sleep consultation or  
sleep study!**

Please answer the following questions as completely as you can. Use the assistance of a bed partner or other observer of your sleep if possible. If the patient's and the observer's answers do not agree, include BOTH answers and indicate which answer is which. When "night" is mentioned, it means your longest, regular period of sleep. When "day" is mentioned, it means the rest of the time. All information is confidential and not accessible as part of your medical record without your consent.

This is an extensive and detailed questionnaire. It may take 30 to 60 minutes to complete. It is important to fill it out completely to ensure you get the proper evaluation and treatment.

Name \_\_\_\_\_ Date \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ SS# \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation and Employer \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ How Long? \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Your Weight One Year Ago \_\_\_\_\_ 5 Years Ago \_\_\_\_\_ 10 Years Ago \_\_\_\_\_

Referred By \_\_\_\_\_ Group Name \_\_\_\_\_

Office Phone \_\_\_\_\_ Specialty \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Group Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Please describe your sleep problem. If you don't think you have a sleep problem, please tell us why you have come to the Sleep Center for evaluation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1) What time do you usually go to bed? (Work nights) \_\_\_\_\_ (Other nights) \_\_\_\_\_

2) What time do you usually get up? (Work days) \_\_\_\_\_ (Other days) \_\_\_\_\_

3) Do you use an alarm clock to get up? No \_\_\_\_\_ Yes \_\_\_\_\_

4) Do you feel better with extra sleep? No \_\_\_\_\_ Yes \_\_\_\_\_

5) Do you have trouble falling asleep? No \_\_\_\_\_ Yes \_\_\_\_\_ How long does it take you to fall asleep? \_\_\_\_\_

If you do have trouble falling asleep, why do you think this is? \_\_\_\_\_  
\_\_\_\_\_

6) Do you have trouble staying asleep? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, why do you think this is?  
\_\_\_\_\_

7) If you wake up during the night, do you have trouble falling back asleep? No \_\_\_\_\_ Yes \_\_\_\_\_

8) Do you have fears or anxieties about having trouble sleeping? No \_\_\_\_\_ Yes \_\_\_\_\_

9) Does anything help you sleep at night? \_\_\_\_\_

10) Do you nap during the day? No \_\_\_\_\_ Yes \_\_\_\_\_

11) **Please rate how often you:**

	<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Frequently</b>	<b>Constantly</b>
Have vivid dream-like scenes upon awakening or going to sleep (dream while awake)	_____	_____	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____	_____	_____
Experience loss of muscle tone when extremely emotional	_____	_____	_____	_____	_____
Kick during the night	_____	_____	_____	_____	_____
Experience crawling and aching feelings in your legs	_____	_____	_____	_____	_____
Toss and turn while sleeping	_____	_____	_____	_____	_____
Urinate frequently at night	_____	_____	_____	_____	_____
Sweat excessively during the night	_____	_____	_____	_____	_____
Have difficulty waking up in the morning	_____	_____	_____	_____	_____
Awaken from sleep short of breath	_____	_____	_____	_____	_____
Awaken with dry mouth	_____	_____	_____	_____	_____
Awaken at night with heartburn, belching or with cough/wheezing	_____	_____	_____	_____	_____
Awaken at night with your heart pounding or beating irregularly	_____	_____	_____	_____	_____
Awaken with a headache	_____	_____	_____	_____	_____
Fall asleep while driving	_____	_____	_____	_____	_____
Have "sleep attacks" during the day	_____	_____	_____	_____	_____
Snore	_____	_____	_____	_____	_____

12) With 10 being the loudest, how would you rate your snoring on a scale from 1 to 10? \_\_\_\_\_

13) Do you relate your snoring to weight gain or any other medical conditions? No \_\_\_\_\_ Yes \_\_\_\_\_ What other conditions? \_\_\_\_\_

14) Do you experience fatigue, sleepiness, or decreased energy during the day? No \_\_\_\_\_ Yes \_\_\_\_\_

15) Is there anything that you think is important about your sleep that is not addressed above?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16) Have you ever been treated by a Psychiatrist, Psychologist, or other mental health professional?  
No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please indicate when you were treated and for what type of problem: \_\_\_\_\_  
\_\_\_\_\_

17) Are you in good health? No \_\_\_\_\_ Yes \_\_\_\_\_

Give details: \_\_\_\_\_

18) Please place a check mark next to any conditions you have ever had:

- |  |  |
|--|--|
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Heart attack                  |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Heartburn/ulcers              |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Heart disease/heart failure   |
| <input type="checkbox"/> Breathing trouble at night  | <input type="checkbox"/> Hiatal hernia                 |
| <input type="checkbox"/> Chronic pain                | <input type="checkbox"/> High blood pressure           |
| <input type="checkbox"/> Decreased sexual interest   | <input type="checkbox"/> Hyperactivity as a child      |
| <input type="checkbox"/> Dental problems             | <input type="checkbox"/> Kidney problems               |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Nose and throat problems      |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Panic attacks                 |
| <input type="checkbox"/> Drug or alcohol problems    | <input type="checkbox"/> Parkinson's disease           |
| <input type="checkbox"/> Emphysema                   | <input type="checkbox"/> Severe anxiety or nervousness |
| <input type="checkbox"/> Epilepsy or seizures        | <input type="checkbox"/> Sexual problems               |
| <input type="checkbox"/> Fibrositis                  | <input type="checkbox"/> Shortness of breath           |
| <input type="checkbox"/> Frequent headaches          | <input type="checkbox"/> Suicide attempts              |
| <input type="checkbox"/> Hallucinations or delusions | <input type="checkbox"/> Thyroid problems              |
| <input type="checkbox"/> Head injury or surgery      | <input type="checkbox"/> Wear dentures                 |

19) Do you have any medical problem not listed above? No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please list: \_\_\_\_\_

20) Please list any surgeries or hospitalizations: List the year, operation and reasons for any hospitalizations: \_\_\_\_\_

21) Do you take any medications (by prescription or over-the-counter)? No \_\_\_\_\_ Yes \_\_\_\_\_

Please list and give details:

<u>Name of Drug</u>	<u>Amount/dose</u>	<u>How often</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

22) Do you have any allergies to medication or latex? If so, please describe:

\_\_\_\_\_

23) Do you drink alcoholic beverages? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, on the average, how many alcoholic beverages do you drink:  
On weekends? \_\_\_\_\_ drinks per day On weekdays? \_\_\_\_\_ drinks per day

24) Do you smoke or use tobacco? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, what kind of tobacco? \_\_\_\_\_ How often? \_\_\_\_\_

25) Do you drink coffee or caffeinated beverages? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, how much? \_\_\_\_\_ cups/drinks per day

26) How late in the day do you drink caffeinated beverages? \_\_\_\_\_

27) List any medical conditions and/or illnesses that run in your family: \_\_\_\_\_

28) **Remarks:** If there are any other aspects of your sleep problem that you feel are important, please describe them in this space: \_\_\_\_\_

# THE MODIFIED EPWORTH SLEEPINESS SCALE

Please rate how likely you are to doze off or fall asleep in the following situations, in contrast to "just feeling tired." This refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to work out how they would affect you. 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

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (theater, meeting, etc.)	_____
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 the traffic	_____

## **THE MODIFIED EPWORTH SLEEPINESS SCALE FOR YOUR BEDPARTNER**

PATIENT NAME: \_\_\_\_\_

YOUR NAME (Bedpartner): \_\_\_\_\_

TODAY'S DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

TO THE PATIENT: Please have your BEDPARTNER complete this form and return it with the other forms.

TO THE BEDPARTNER: Please complete this form, giving us your observations of the patient's condition.

How likely is your bedpartner to doze off or fall asleep in the following situations, in contrast to "just feeling tired?" This refers to his/her usual way of life in recent times. Even if he/she has not done some of these activities recently, try to work out how they would affect your bedpartner. 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

<u>SITUATION</u>	<u>CHANCE OF DOZING</u>
Sitting and Reading	_____
Watching TV	_____
Sitting, inactive in a public place (theater, meeting, etc.)	_____
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 the traffic	_____

**THANK YOU FOR YOUR COOPERATION**

**BEDPARTNER'S (BP) QUESTIONNAIRE FOR**

# EXCESSIVE DAYTIME SLEEPINESS

To the Patient: Please have your BEDPARTNER (BP) complete this form.  
Return it with the other sleep forms.

To the Patient's Bedpartner: Please complete this form, giving us YOUR observations of the patient's condition.

Patient's Name: \_\_\_\_\_

Your Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

1) What is your BP's problem? (Describe in Detail):

\_\_\_\_\_  
\_\_\_\_\_

2) Does your BP snore? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, how long have you known your BP to snore (indicate months, years, etc.)? \_\_\_\_\_

3) Does he/she snore on his/her:

Back	No _____	or Moderately Loud _____	Very Loud _____
Sides	No _____	or Moderately Loud _____	Very Loud _____
Stomach	No _____	or Moderately Loud _____	Very Loud _____

4) Do you consistently sleep in the same bedroom? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, why? \_\_\_\_\_

5) How long have you slept in separate rooms (indicate months, years, etc.)? \_\_\_\_\_

6) Does your BP seem to stop breathing in his/her sleep? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how long has this occurred (indicate months, years, etc.)? \_\_\_\_\_

If yes, how long are the pauses in breathing? \_\_\_\_\_

If yes, does he/she gasp for air afterwards? Yes \_\_\_\_\_ No \_\_\_\_\_

7) Does your BP move around in bed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, does he/she toss and turn? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, are the movements small, regular, leg movements? Yes \_\_\_\_\_ No \_\_\_\_\_

8) Does your BP grind his/her teeth in their sleep? Yes \_\_\_\_\_ No \_\_\_\_\_

9) Is your BP sleepier than you most of the time? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, will he/she nap before bedtime? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how often? \_\_\_\_\_ days per week or \_\_\_\_\_ days per month

10) Will your BP fall asleep?:

In church Yes \_\_\_\_\_ No \_\_\_\_\_

While driving Yes \_\_\_\_\_ No \_\_\_\_\_

With company Yes \_\_\_\_\_ No \_\_\_\_\_