Erlanger North
Sleep Disorders Center
423.778.3316

DO NOT OMIT ANY REQUESTED INFORMATION

PATIENT FULL NAME: _____ **DOB** _____

Email Address: _____ Age _____ SS #_____

Street Address_____City/State/Zip_____

Phone Numbers: Home (____)_____Cell (_____)_____ Work (_____)_____

Preferred number for reminder: _____ **Phone or Text (please circle preferred method)**

Employer_____Occupation_____ **Full Time / Part time**

Please circle: Male / Female **Race:** _____ **Please Circle**: Single / Married / Widowed / Divorced

SPOUSE / GUARDIAN

Name_____Age_____DOB_____SS #_____

Phone Numbers: Home (____)_____Cell (_____)_____ Work (_____)_____

Employer_____Occupation_____

EMERGENCY CONTACT

Name_____ Phone (____)_____ Relation _____

INSURANCE

PRIMARY INSURANCE _____ **Group #**_____ **ID #**_____

Insured's Name_____ DOB_____ SS #_____

SECONDARY INSURANCE _____ **Group #**_____ **ID #**_____

Insured's Name_____ DOB_____ SS **#**_____

Primary Care Physician_____ **Phone (_____)**_____

Referred By_____ **Phone (_____)**_____

PHARMACY

Name_____ Phone (_____)_____

It is the policy of this office to keep all medical records confidential. There may be occasions when you need this information released to another office/person. Please answer the following questions and authorize us to give your confidential information in these situations:

1. May we leave your medical information, including test results, on an answering machine, or give it to another person, such as a spouse, adult child or caregiver? YES _____ NO _____

Name(s) and relationship to patient: _____

2. May we give pertinent information to your primary care doctor, the doctor who referred you here, or a doctor we refer you to? YES _____ NO _____

3. May we leave detailed appointment reminders or voice / texts messages to call us back on your answering machine at home, work, or cell phone, or with whoever answers the phone? YES _____ NO _____

Patient Signature _____ **Date** _____

PRESENT ILLNESS:

Have you had a sleep study before? [ ] YES [ ] NO If yes, when and where was it? _____

******If your previous study was done in another sleep lab, please bring the copy of the study result to the visit. ******

What is the Primary reason for this examination? _____

_____

When did the symptoms start? _____

Medical Equipment

Do you use any medical equipment? [ ] YES [ ] NO

What is the name of your equipment company? _____

Are you on oxygen? _____ If so, how much? _____

Are you on CPAP or BiPAP? [ ] YES [ ] NO

What are you settings? _____

SLEEP HISTORY:

Do you have or has anyone noticed that you have the following symptoms?

[ ] Snore	[ ] Stop breathing while sleeping	[ ] Wake up gasping for air
[ ] Have restless sleep	[ ] Have morning headaches	[ ] Episodes of confusion
[ ] Talk in sleep	[ ] Take medication for sleep	[ ] Have vivid dreams
[ ] Walk in sleep	[ ] Leg kicking in sleep	[ ] Have nighttime wheezing
[ ] Have creeping or crawling in legs	[ ] Feel like you have to move you legs	[ ] Frequent nightmares
[ ] Acting out during sleep	[ ] Grinding teeth during sleep	[ ] Night sweats

Have you ever felt weak in your muscles when laughing, surprised, angry, or any other emotions? [ ] YES [ ] NO

Have you ever seen or heard things that aren't there while falling asleep or while waking up from sleep? [ ] YES [ ] NO

Have you ever felt like you cannot move while falling asleep or while waking from sleep? [ ] YES [ ] NO

Other: _____

What is your typical Sleep Schedule on **work days?**

Bedtime: _____ Rise time: _____ How long to fall asleep: _____

What is your typical Sleep Schedule on **off days?**

Bedtime: _____ Rise time: _____ How long to fall asleep: _____

Do you routinely sleep with children or pets in your bed? [ ] YES [ ] NO _____

In the past, how many hours did you sleep, per night, on average? _____

Do you work shifts or irregular hours? [ ] YES [ ] NO Explain: _____

How many times do you wake up during the night? _____ For restroom visits? _____

Is your nighttime sleep refreshing? [ ] YES [ ] NO

Do you take naps? [ ] YES [ ] NO How long are they? _____ What time do you nap? _____

MEDICAL HISTORY

Check if you have a history of [ ] Stroke or "TIA" [ ] High blood pressure [ ] Diabetes [ ] Seizures [ ] Parkinson's Disease [ ] Neuromuscular diseases [ ] Other neurological disorders [ ] Drug or Alcohol Addiction [ ] Heart Disease [ ] Kidney Disease [ ] Lung Disease [ ] Thyroid Problem [ ] Deviated nasal septum [ ] Depression [ ] Anxiety [ ] Asthma

Other past or current medical problems: _____

_____

Review of Symptoms: Please check box if you have had any of the following in the past few weeks.

Check here if all negative. [ ]

Psychiatric:	**Genitourinary:**	**Gastrointestinal:**
[ ] Depression	**[ ] Frequent urination at night**	**[ ] Heartburn**
[ ] Anxiety		**[ ] Reflux**
ENT:	**Respiratory:**	**Musculoskeletal:**
[ ] Sinus congestion @ night	**[ ] Coughing or wheezing**	**[ ] Back pain**

[ ] Positive pregnancy test, if applicable

Other: _____

SOCIAL HISTORY

[ ] Married [ ] Single [ ] Divorced (Year _____) [ ] Widowed (Year _____)
Present occupation _____
Do you use tobacco? [ ] Yes [ ] No How many years _____ [ ] Have quit / Date _____
(Circle) Cigarettes / Cigars / Pipe / Chew Daily amount _____ Do you want to quit? Yes / No
Do you drink alcohol? [ ] Yes [ ] No Daily amount _____
Do you drink 2 hours or less before going to sleep? [ ] Yes [ ] No
Do you drink caffeinated drinks (coffee, tea, soda)? [ ] Yes [ ] No If so, how many cups per day? _____
Do you use prescription medication or over-the-counter medications to help get to sleep? [ ] Yes [ ] No
If yes, what do you use: _____

Is there someone in the family with sleep apnea, narcolepsy or an illness similar to the one for which you are seeing the doctor today?
_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent time. 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.

0 = would "never doze" **2 = "moderate" chance of dozing**
1 = "slight" chance of dozing **3 = "high" chance of dozing**

CHANCE OF DOZING / SLEEPING **(Please circle the most appropriate number)**	**SITUATION**
0 1 2 3	**Sitting and reading**
0 1 2 3	**Watching T.V.**
0 1 2 3	**Sitting, inactive in a public place (theatre or meeting)**
0 1 2 3	**As a passenger in a car 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**
TOTAL: _____	**(Add each number up and give a total out of 24)**

Erlanger Sleep Center

628 Morrison Springs Road
Suite 300
Chattanooga, TN 37415
423.778.3316

Thank you for choosing Erlanger North Sleep Center for your healthcare needs. Arrangements have been made for you to see:

Paul Bates, PA-C ***Tareck Kadrie, M.D.***

for an initial consultation. After you see the physician an appointment will be made for you to come in for a sleep study, if it is deemed necessary. **Please complete these forms and bring them with you for your appointment. **Please *DO NOT* mail these forms to us, bring them with you to your appointment. ****

Please bring a list of all medications, Insurance Cards and photo ID to your appointment. Your Co-pay is due at the time of visit.

You may be subject to a $25 cancellation/no show fee if you cancel/reschedule your appointment with less than 24 hours notice or no show your appointment. Please call our office @ *423-778-3316* to cancel or reschedule your appointment. Our office hours are Monday-Thursday 8:30 a.m. – 4:00 p.m. and Friday 8:30 a.m. -12 noon. We are closed daily from 12:00 -1:00 p.m. for lunch.

YOUR APPOINTMENT HAS BEEN SCHEDULED FOR:

_____ AT _____ **a.m. / p.m.**

Thank you in advance for completing these forms and we look forward to meeting you in the near future.

Sincerely,

Erlanger Sleep Center

Directions to the Sleep Center:

Turn off of Morrison Springs Road onto Tom Weathers Drive (the road runs beside the hospital before the main entrance). Our parking area is on the right side of the road across from the pool.