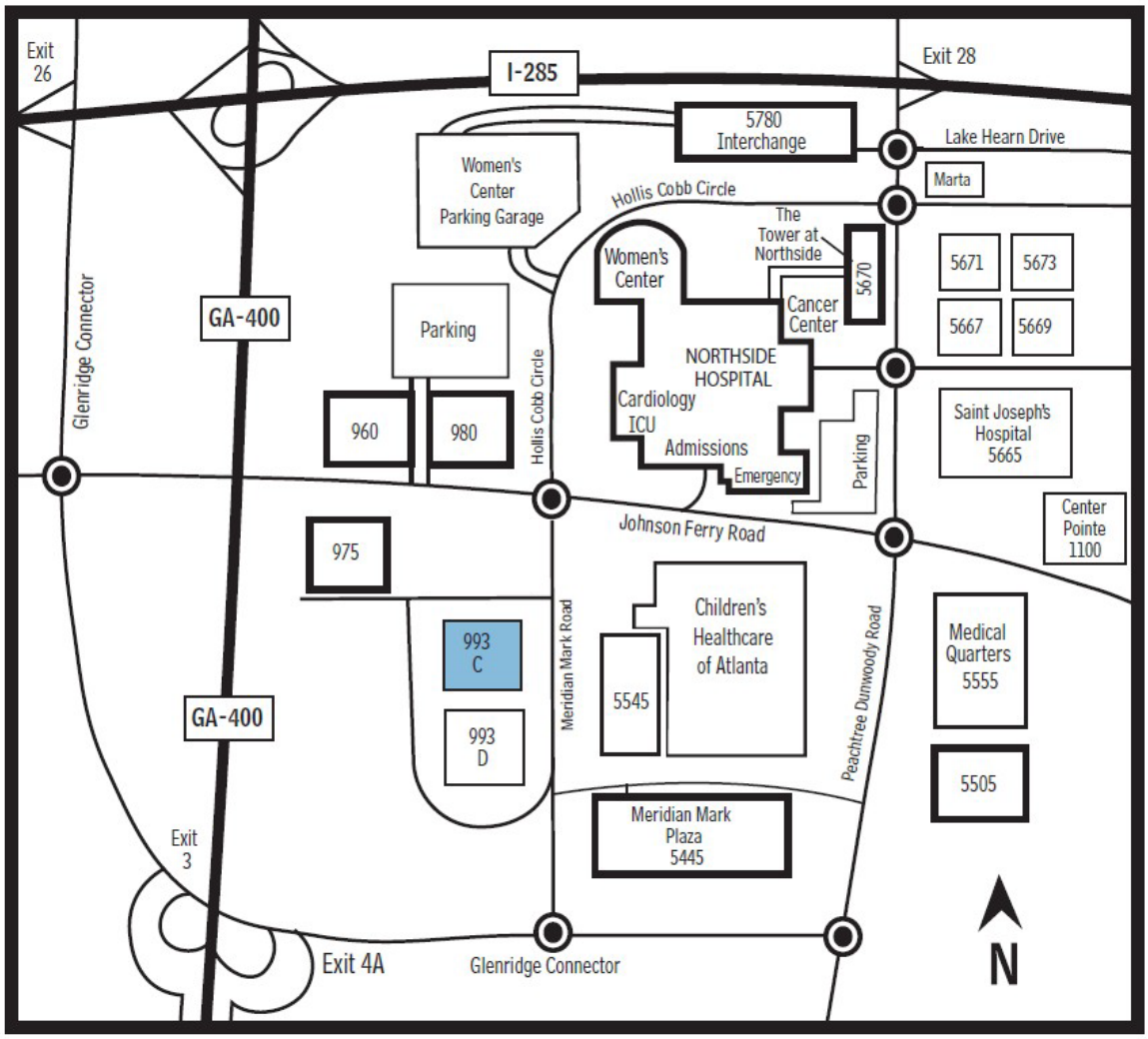
SLEEP DISORDERS CENTER
of Georgia

We don't rest until you do

OFFICE LOCATION

993-C Johnson Ferry Road, Suite 301, Atlanta, GA 30342
(404) 257-0080



**********DIRECTIONS FOR PARKING********** **********

When you turn off Meridian Mark, building C will be on your left.
Pull up to the parking booth and take a ticket from the machine.
Turn right into the parking garage and park your vehicle.
As you enter Building C, take the elevator to the third floor.
Exit the elevator and go around the corner to the right.
We are located in **suite 301.**

Abul Matin, MD, PhD
993-C Johnson Ferry Road, Suite 301, Atlanta, GA 30342 ★ SleepCenterGA.com ★ P: (404) 257-0080 ★ F: (404) 257-0592

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A Practice of Northside Hospital

Review of Medical Conditions and Medications (Including Supplements)

Please place an X beside each condition you have and list the medication you take for it.

Condition	X	Medication / Dosage / Times per day	Medication / Dosage / Times per day
Acid Reflux			
Anxiety			
Arthritis (Type _____)			
Asthma			
Back Pain			
Chronic Fatigue Syndrome			
COPD			
Cystic Fibrosis			
Depression			
Diabetes Type I Type II (circle)			
Erectile Dysfunction			
Fibromyalgia			
Glaucoma			
Heart Related:			
Coronary Artery Disease			
Arrhythmia (Type _____)			
CABG			
Congestive Heart Failure			
High Blood Pressure			
High Cholesterol			
Heart Valve Dysfunction			
Previous Heart Attack or Stroke			
Hepatitis Positive B C (Circle)			
HIV Positive			
Kidney Disease (Stage _____)			
Memory Loss			
Migraines			
Rhinitis			
Scoliosis			
Sinusitis			
Thyroid Hypo / Hyper (circle)			
Are you on Oxygen?			
Other : _____			
Other : _____			
Other : _____			
Other : _____			

Reorder #48749 PP0694 (SDCG)
Piedmont Graphics 01/31/19

SLEEP DISORDERS CENTER
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In an attempt to gather information for the Centers for Medicare and Medicaid Services we are asking our established patients to complete this form. Please note that if you are not comfortable with any of the questions you have the option of checking "prefer not to answer".

RACE

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Prefer not to answer

MARITAL STATUS

- ☐ Domestic Partner
- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Other
- ☐ Prefer not to answer

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Prefer not to answer

LANGUAGE

- ☐ English
- ☐ French
- ☐ German
- ☐ Japanese
- ☐ Mandarin
- ☐ Russian
- ☐ Spanish
- ☐ Other
- ☐ Prefer not to answer

SOCIAL HISTORY

EMPLOYMENT STATUS

- ☐ Employed
- ☐ Full time student
- ☐ Part time student
- ☐ Retired
- ☐ Unemployed
- ☐ Prefer not to answer

TOBACCO HISTORY

- ☐ Current every day smoker
- ☐ Current some days smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Currently uses smokeless tobacco
- ☐ Prefer not to answer

Food Allergy: _____

Drug Allergy: _____

Envt Allergy: _____

Patient's Name: _____ **Patient's DOB:** _____

Please print

Reorder #34901 PP0439 (SDCG)
Piedmont Graphics 08/17/17

PATIENT DEMOGRAPHICS

SLEEP DISORDERS CENTER
of Georgia

The purpose of this questionnaire is to determine the nature of your sleep problem. It is very important to be as accurate as possible in answering the questions. Your bed partner may be able to assist you.

Please write your name at the top of each page

This information will become part of your medical record and will remain confidential

GENERAL INFORMATION

Date questionnaire completed: _____ Email address: _____

Name _____
Last First MI

Address: _____
street

_____
City State Zip Code

Date of Birth: _____ Age: _____ Sex: _____ Marital status: _____

Height: _____ Weight: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Physician: _____ Phone: _____

SUMMARY OF YOUR SLEEP PROBLEM:
Describe your sleep problem(s) in your own words:

_____

_____

_____

_____

Describe how and when this problem began:

_____

_____

_____

_____

SLEEP HISTORY QUESTIONNAIRE

Name: _____ Date:_____

SUMMARY OF YOUR SLEEP PROBLEM:

Describe any treatments you have received for your problem:

_____

_____

_____

_____

Has this been a continuous or intermittent problem?

- ☐ intermittent, occasional problem
- ☐ frequent problem
- ☐ continuous, almost every night

How long has your sleep problem(s) bothered you?

- ☐ 1 to 2 years
- ☐ longer than 2 years
- ☐ several months
- ☐ within the last 3 months
- ☐ within the last month

List all hospitalizations and surgeries (list the dates as well) you have had. Please be thorough and include surgeries to remove adenoids or tonsils, or hospitalizations for head injuries, seizures or heart conditions.

_____

_____

_____

_____

Do you have a family history of snoring or other sleep disorders? ☐ Yes ☐ No

If yes, please describe _____

_____

_____

Are you unable to sleep in a flat position due to shortness of breath?	☐ Yes	☐ No
Have you ever sustained a brain concussion, head injury or serious blow to the head?	☐ Yes	☐ No
Do you have spells or seizures?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Have you experienced weight gain/loss in the last year?	☐ Yes	☐ No
If "yes" approximately how many pounds have you gained/lost? _____ lbs		
Has your shirt collar size increased recently?	☐ Yes	☐ No
If "yes" approximately how many inches?_____		

List any allergies:_____

_____

Please place a check mark beside the Yes or No questions.

Circle one of the following where applicable

N: No R: Rarely O: Occasionally F: Frequently A: Always Y: Yes

Name: _____ Date:_____

Do you smoke? ☐ Yes ☐ No

If yes, how many packs per day? _____

How long have you smoked? _____

Are you a former smoker? ☐ Yes ☐ No

If "yes" how much did you smoke? _____ packs a day

How long did you smoke? _____ years

When did you quit smoking? _____

Do you drink alcohol? *This includes beer, wine & liquor* ☐ Yes ☐ No

Estimate the number of drinks you have per workday _____

Estimate the number of drinks you have on days off _____

Do you drink alcohol after 6:00 pm? N R O F A

Do you consume caffeinated drinks? ☐ Yes ☐ No

Estimate the number of drinks you have per workday _____

Estimate the number of drinks you have on days off _____

Do you drink caffeine after 6:00 pm N R O F A

MALES - Have you experienced difficulties with sexual functioning? N R O F A

FEMALES - Does your sleep problem vary according to the stage of your menstrual cycle? ☐ Yes ☐ No

FEMALES - Have you gone through menopause or had a hysterectomy? ☐ Yes ☐ No

YOUR SLEEP HABITS

How many hours of sleep do you usually get per night? _____

What time do you usually go to bed on workdays? _____

What time do you usually go to bed on days off? _____

What time do you usually wake up? _____

How long does it take you to fall asleep? _____

How many times do you typically wake up at night? _____

If you wake up, on average how long do you stay awake? _____

Which shift do you work? ☐ day ☐ evening ☐ night

How often do you rotate shifts? N R O F A

Does your job require overnight travel? N R O F A

Are you able to fall asleep and awaken on a day to day, week to week basis according to your desired schedule? N R O F A

Do you nap during the day or evening? List any allergies: N R O F A

Circle one of the following where applicable

N: No R: Rarely O: Occasionally F: Frequently A: Always Y: Yes

Name: _____ Date:_____

THE QUALITY OF YOUR SLEEP

Do you feel refreshed after a typical night's sleep?	N	R	O	F	A
Do you feel sleepy during the day even when you have slept all night?	N	R	O	F	A
Do you feel refreshed after a short nap?	N	R	O	F	A
Do you get sleepy while driving?	N	R	O	F	A
Have you had an accident or near-accident when driving due to excessive sleepiness?	N	R	O	F	A
Do you fall asleep when you want to stay awake (movies, theater, church or watching TV)?	N	R	O	F	A
Are you able to fight off the excessive sleepiness?	N	R	O	F	A
Do you have memory or concentration problems?	N	R	O	F	A
Do you experience vivid dream like scenes upon awakening or falling asleep?	N	R	O	F	A
When you are angry or laugh, do you ever feel week, as though you might fall?	N	R	O	F	A
Are you ever unable to move or speak upon falling asleep or awakening?	N	R	O	F	A
Do you have trouble falling asleep when you first go to bed?	N	R	O	F	A
When you try to fall asleep does your mind race with many thoughts?	N	R	O	F	A
When you try to fall asleep do you worry about whether or not you will be able to sleep?	N	R	O	F	A
When you try to fall asleep do you feel pain?	N	R	O	F	A
Does pain ever wake you up, disrupt your sleep or keep you from going back to sleep?	N	R	O	F	A
Are you a light sleeper, easily awakened?	N	R	O	F	A
Is your sleep disturbed because of your bed partner or others in your household?	N	R	O	F	A
Do you snore?	N	R	O	F	A
Does your snoring stop for brief periods during the night (as seen by others)?	N	R	O	F	A
Does your breathing sometimes stop during sleep (as seen by others)?	N	R	O	F	A
Is your bed partner disturbed by your snoring?	N	R	O	F	A
Do you wake up choking or gasping for breath?	N	R	O	F	A
Do you have night sweats?	N	R	O	F	A
Do you have heartburn at night?	N	R	O	F	A
Do you have a bitter bile taste in the back of your throat when you wake up? (not morning breath)	N	R	O	F	A
Do you have nasal/sinus congestion at night?	N	R	O	F	A
Do you have morning headaches?	N	R	O	F	A
Are you a restless sleeper, tossing and turning at night?	N	R	O	F	A

Circle one of the following where applicable

N: No R: Rarely O: Occasionally F: Frequently A: Always Y: Yes

Name: _____ Date:_____

Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	N	R	O	F	A
Do you experience any type of leg or back pain during the night?	N	R	O	F	A
Do you wake up with sore or aching muscles or joints (including leg or back pain)?	N	R	O	F	A
Do you grind or clench your teeth during sleep?	N	R	O	F	A
Did you walk or talk in your sleep as a child or adolescent?	N	R	O	F	A
Do you walk or talk in your sleep now?	N	R	O	F	A
Do you have frightening dreams or nightmares?	N	R	O	F	A
Do your dreams or nightmares awaken you?	N	R	O	F	A
Do you wet your bed?	N	R	O	F	A

OTHER COMMENTS:

Are there any other aspects of your sleep problem which you feel have not been adequately covered on this questionnaire? If so, please describe below:

_____

_____

_____

_____

REVIEWED BY: _____
Physician signature

DATE: _____

NH0670

ADDRESSOGRAPH

NORTHSIDE HOSPITAL

SLEEP DISORDERS CENTER

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Patient Name: _____

Gender (circle one): Male Female Age: _____

How likely are you 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 things recently, try to decide how you would react to these situations. Use the following scale to choose the most appropriate number for each one.

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

SITUATION	**CHANCE OF DOZING** (circle one)			
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting, inactive in a public place (e.g., theater 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.	0	1	2	3

TOTAL SCORE: _____ **AVERAGE AMOUNT OF SLEEP PER NIGHT:** _____

SIGN HERE: Completed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

EPWORTH SLEEPINESS SCALE