METROLINA MEDICAL ASSOCIATES SLEEP CENTER

Metrolina Medical Associates offers a full service ACHC accredited sleep center located at our office, for your convenience. We are committed to providing the best possible care to our patients. Our technical staff has extensive training in sleep technology and respiratory care.

There are four types of sleep studies. A PSG is a diagnostic study performed to determine if a patient has obstructive sleep apnea or other possible sleep disorders. A CPAP titration study is performed to determine the appropriate CPAP pressure needed to eliminate sleep disturbances. A combined study is occasionally performed where the PSG and CPAP study are both accomplished in one night. An MSLT is a daytime study consisting of a series of naps taken during the day to evaluate the patient's "natural sleepiness". You will be contacted the day before your sleep study to confirm your appointment.

Your appointment is scheduled on: _____arrive at 9:00 PM.

You should arrive at your appointed time above. We cannot accommodate patients before 9:00 PM. The hook-up procedure takes approximately 45 minutes to complete. If you miss your appointed time, a delay in your hook-up may occur. When you arrive a technician will greet you and direct you to your room. If you find that you cannot come to your appointment, please give the practice at least forty-eight (48) hours notice. Cancellations made with less than forty-eight (48) hours notice are charged a fee of $75.00. Failure to keep an appointment will result in a no show charge of $150.00.

We have a few instructions for you to follow on the day of your study. Follow these closely to help us get accurate information and to help you get a good night of sleep.

1. Bring Comfortable clothing/pajamas to sleep in
2. No hair extensions, weave, braids or hair pieces are allowed
3. Avoid taking naps if at all possible
4. Avoid caffeine after 12 noon (soda, tea, coffee, chocolate, etc.)
5. Hair should be clean. No oils, conditionals or treatments in hair.
6. Skin should be free of lotions and/or makeup
7. Take your usual medications unless otherwise directed by your physician
8. Remove all fingernail polish before arrival to the sleep center
9. Spouses and family members are welcome to stay for the hook up procedure, but are not allowed to stay overnight with the patient unless approved by the Medical Director.
10. Parents or guardians are required to stay overnight for patients under the age of eighteen.
11. Wake up time is 5:00 AM and discharge is 5:30 AM. Technicians cannot stay past 6:00 AM.

Should you need assistance finding the facility the night of your study, or have any other questions about your sleep study, please call 1-888-239-0616.

ACHC our accrediting body is available for any complaints or concerns regarding you sleep study, please call 1-855-937-2242. Thank you for choosing Metrolina Medical Associates for your sleep health.

You have been scheduled for a sleep study. This information is provided to acquaint you with the process. The sleep center is located at Metrolina Medical Associates, 2670 Mills Park Dr, Rock Hill, SC 29732. Upon your arrival at 9:00 p.m. please enter through the main Metrolina Medical Associates entrance (on the west side of the building facing India Hook road) and take the elevator to the second floor.

You will be sleeping in a comfortable private room. Our technologists will monitor you using cameras and sensors from their location in a separate room.

Our monitoring method uses closed-circuit video cameras that allow the technologists to actually see you while you sleep and record your sleep for our physicians to evaluate. These cameras are equipped to allow viewing in a dark room. You will be able to talk back and forth to the technologist using an intercom system between the control room and your room.

Also, during your study, we will be monitoring several other items such as brain wave, heart rate, breathing, eye movement and muscle activity. Several sensors are attached to your head and chest with adhesive materials to record this information.

Since you need to be alone during the study, we ask that family members leave after the hook up process.

There are a few things that we need from you, to provide us with the most accurate test results and to ensure your stay is as pleasant as possible. Enclosed you will find questionnaire forms to fill out. You should pay close attention to those questions as you complete the forms. Please bring the completed questionnaire with you and give it to the technician prior to your study.

We routinely confirm all sleep study appointments during the week of the study. However, it is very important that you notify the sleep center as soon as possible if you find that you will not be able to keep this appointment.

Please feel free to contact us if you have any questions or special needs.

SLEEP HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your sleep problem to help in the diagnosis and treatment of that problem. Your spouse or bedpartner may be able to help you answer these questions.

Some of the questions in this questionnaire are personal but need to be answered correctly to help in your diagnosis and treatment. All parts of this questionnaire will become part of your medical record and will be kept confidential.

PERSONAL INFORMATION

Name _____
Last First MI

Address _____
Street

_____
City State Zip Code

Study Date _____ SSN _____ Sex _____

Home (___)_____ Work (___)_____ Height _____ Weight _____

Birthdate ____/____/____ Age _____ Marital Status S M D W

Occupation _____

Referring physician name and phone number _____

SUMMARY OF YOUR SLEEP PROBLEM

1. In your own words, describe your sleep problem.

_____

_____

_____

_____

_____

SLEEP HISTORY/MEDICAL HISTORY QUESTIONNAIRE

Patient's Name: _____ Date _____

SLEEP SYMPTOMS

1.	Do you snore?	YES NO
	How long have you been snoring?	_____
	Is your snoring mild, moderate or loud?	_____
2.	Are you sleepy while awake?	YES NO
	How long have you been having this problem?	_____
3.	Do you wake up gasping or feeling unable to breathe?	YES NO
4.	Has your bed partner ever told you that you stop breathing during sleep?	YES NO
5.	Do you have a restless or creepy feeling in your legs?	YES NO
	Is it worse at rest and in the evenings?	*YES NO*
	Is it temporarily relieved by moving your legs?	*YES NO*
	Does this prevent you from sleeping?	*YES NO*
	How often do you experience this problem in a week?	_____
6.	Has your bed partner ever noticed leg movements or complained that you kick while you were sleeping?	YES NO
7.	Does your snoring or kicking prevent somebody from sleeping in the same bed with you?	YES NO
8.	Do you get up more than once a night to urinate?	YES NO
	If yes, how many times?	_____
9.	Do you ever find yourself somewhere and do not know how you got there?	YES NO
11.	Do you have vivid dreams shortly after falling asleep at night?	YES NO
12.	Do you ever feel that you cannot move after lying down or just after you awaken?	YES NO
13.	Do you waken feeling refreshed?	YES NO
14.	Do you waken with a headache?	YES NO
15.	Do you experience sudden weakness in your knees when emotionally excited such as laughing or crying?	YES NO
15.	Do you have a problem with sleepiness while driving?	YES NO

16. Have you ever had an automobile accident or near accidents related to sleepiness? ..... YES NO

How often? ..... ———

When was last time this happened? ..... ———

18. Have you ever had accidents at work related to sleepiness?..... YES NO

19. Do you awaken during the night and have trouble going back to sleep?..... YES NO

20. Does your job require working different shifts?..... YES NO

If yes, which shifts? ———

21. How do you sleep away from home (e.g., on vacation)? (Better, worse, or same)

22. Do you have trouble going to sleep? YES NO

23. Do you toss and turn in bed?..... YES NO

24. Do you have frequent awakenings during the night?..... YES NO

25. Do you awaken during the night and have trouble going back to sleep? ..... YES NO

26. Do you awaken at night with thoughts racing through your mind? ..... YES NO

27. Do you fall asleep more easily on the couch than in bed?..... YES NO

28. Do you feel frustrated or tense when seeing your bed or bed or bedroom? ..... YES NO

29. Do you have difficulty falling asleep or awaken frequently through the night because of pain? ..... YES NO

30. Do you awaken early in the morning and cannot go back to sleep? ..... YES NO

31. Have you felt depressed recently?..... YES NO

32. Are you easily awakened by noise or light?..... YES NO

33. Have you been having any marital conflict lately?..... YES NO

34. Do you have very much job stress?..... YES NO

34. Do you find it difficult to get out of bed in the morning?..... YES NO

35. Is your job or school performance affected by you sleep problem? ..... YES NO

36. Do you sleep talk?..... YES NO

37. Do you sleep walk? ..... YES NO

38. Do you eat when you wake up at night? ..... YES NO

Do you remember that in the morning? ..... YES NO

39. Have been told that you act your dreams? ..... YES NO

40. Have you ever hurt yourself or bed partner while asleep? ..... YES NO

41. Do you grind your teeth at night? ..... YES NO

42. Have you had any sleep problems as a child or teenager? ..... YES NO

If yes, please describe: .....

43. Has your weight changed?..... YES NO

If yes: Up or down?_____How much?_____Over how long?_____

44. While awake, do you experience short of breath or wheezing?..... YES NO

45. Have you ever been treated for snoring, sleep apnea, sleepiness or insomnia? ..... YES NO

46. Have you ever had a sleep study? ..... YES NO

If yes, where, when, what did it show?_____

_____

SLEEP HABITS

	Work Days	Weekends
a) What time do you go to bed?	_____ am/pm	_____ am/pm
b) What time do you get up?	_____ am/pm	_____ am/pm
c) On average, how many times do you wake-up during the night?	_____	_____
d) How long does it take you to fall asleep?	_____ min	_____ min
e) If awaken, How long does it take you to fall back to sleep	_____ min	_____ min
f) On average, how many hours of actual sleep do you get nightly?	_____ hrs	_____ hrs
g) What time do you go to work or school?	_____ am/pm	_____ am/pm
h) What time do you return home?	_____ am/pm	_____ am/pm

i) Naps:

Number of day time naps _____ *Duration* _____

Number of evening naps _____ *Duration* _____

j) Please list your activities in bed, (TV, reading, eating, computer, video games.)_____

k) Please list what you do if you wake up at night and can't go back to bed (TV, reading, eating, computer, video games.)._____

Are your sleep habits on the weekends similar to weekdays? ..... YES NO

MEDICAL HISTORY: Have ever been told by a doctor that you have:

YES		YES	
[ ]	Hypertension (high blood pressure)	[ ]	Depression or other psychiatric disorder
[ ]	Thyroid gland problems	[ ]	Irregular heart beat
[ ]	PTSD/panic attacks	[ ]	Heartburn/Reflux disease
[ ]	Epilepsy/seizures	[ ]	Emphysema or Chronic Bronchitis
[ ]	Heart attack	[ ]	Asthma
[ ]	Pain disorder	[ ]	Fibromyalgia
[ ]	Angina	[ ]	Sinusitis
[ ]	Stroke	[ ]	High cholesterol
[ ]	Diabetes	[ ]	Cancer

Please list any other medical problems here:

_____

_____

SURGICAL HISTORY Have you ever had:

YES		YES	
[ ]	Tonsillectomy (tonsils taken out)	[ ]	Hysterectomy
[ ]	History of trauma	[ ]	Cholecystectomy (gallbladder)
[ ]	Appendectomy	[ ]	other surgeries _____

Medication list

List medications (including the ones you can get without a prescription):

Name	Dose	Name	Dose

Do you ever use sleep pills, tranquilizers or sedatives? Yes No If yes, please list.

Name	Dose	Name	Dose

Allergies

Please list all drugs that you are allergic to and the type of reaction:

FAMILY HISTORY

Yes No Does anyone in your family snore or been diagnosed with sleep apnea, narcolepsy, insomnia or other sleep disorder? If yes, please specify:_____

Yes No Has anyone in your family been diagnosed with one of the disorders listed under the medical history above? If yes, please specify:_____

SOCIAL HISTORY

Habits

Do you smoke? Present Past Never

If present smoker: packs/day_____ years_____

If past-smoker: packs/day_____ years_____ when quit?_____

How much of the following do you use:

	CURRENT Weekdays	Weekend days
Coffee	_____	_____
Tea	_____	_____
Chocolate	_____	_____
Caffeinated soda (pop)	_____	_____
Alcohol	_____	_____
Recreational drugs	_____	_____

Please list with whom you live: _____

Occupation(s):

Past _____

Present _____

Review of System

Are you currently or regularly experience any of the following symptoms?
(Please check all that apply)

GENERAL

Fatigue	[ ] yes [ ] no
Fever	[ ] yes [ ] no
Loss of appetite	[ ] yes [ ] no
Weight gain	[ ] yes [ ] no
Weight loss	[ ] yes [ ] no

HEENT

Blurried vision	[ ] yes [ ] no
Nasal/seasonal allergies	[ ] yes [ ] no
Change in voice	[ ] yes [ ] no
Frequent nosebleed	[ ] yes [ ] no
Hearing loss	[ ] yes [ ] no
Sinus pain	[ ] yes [ ] no
Sore throat	[ ] yes [ ] no

CARDIOLOGY

Supine shortness of breath	[ ] yes [ ] no
Chest pain	[ ] yes [ ] no
Palpitations	[ ] yes [ ] no

RESPIRATORY

Wheezing	[ ] yes [ ] no
phlegm production	[ ] yes [ ] no
Cough	[ ] yes [ ] no
Shortness of breath	[ ] yes [ ] no

GASTROENTEROLOGY

Abdominal pain	[ ] yes [ ] no
Blood in stool	[ ] yes [ ] no
Constipation	[ ] yes [ ] no
Heartburn	[ ] yes [ ] no
Diarrhea	[ ] yes [ ] no

MUSCULOSKELETAL

Back pain	[ ] yes [ ] no
Joint pain	[ ] yes [ ] no

DERMATOLOGY

Suspicious moles	[ ] yes [ ] no
Change in color	[ ] yes [ ] no
Rash	[ ] yes [ ] no

ENDOCRINOLOGY

Cold intolerance	[ ] yes [ ] no
Excessive sweating	[ ] yes [ ] no
Excessive thirst	[ ] yes [ ] no
Heat intolerance	[ ] yes [ ] no

HEMATOLOGY/LYMPH

Easy bruising	[ ] yes [ ] no
Swollen glands	[ ] yes [ ] no

NEUROLOGY

Dizziness	[ ] yes [ ] no
Fainting spells	[ ] yes [ ] no
Headache	[ ] yes [ ] no
Memory loss	[ ] yes [ ] no
Seizures	[ ] yes [ ] no

PSYCHIATRIC

Anxiety	[ ] yes [ ] no
Depression	[ ] yes [ ] no
Hallucinations	[ ] yes [ ] no

UROLOGY

Blood in urine	[ ] yes [ ] no
Difficulty urinating	[ ] yes [ ] no
Urinary incontinence	[ ] yes [ ] no

Epworth Sleepiness Scale Page 2 of 2

Patient Name: _____

With the help of a bed partner please circle one of the following as it applies to a typical night.

Snoring	Nightly	Weekly	Rarely	Never
Observed pauses in breathing	Nightly	Weekly	Rarely	Never
Restless or interrupted sleep	Nightly	Weekly	Rarely	Never
Awakens short of breath, gasps or snorts	Nightly	Weekly	Rarely	Never
Difficulty falling asleep	Nightly	Weekly	Rarely	Never
Leg or body jerks	Nightly	Weekly	Rarely	Never
Teeth grinding	Nightly	Weekly	Rarely	Never
Vivid dreams	Nightly	Weekly	Rarely	Never
Headache during night or early morning	Nightly	Weekly	Rarely	Never
Acid indigestion	Nightly	Weekly	Rarely	Never
Night sweats	Nightly	Weekly	Rarely	Never
Heart palpitations	Nightly	Weekly	Rarely	Never
Night time urination	Nightly	Weekly	Rarely	Never
Not refreshed with AM wake up	Yes	No		
Dry mouth in AM wake up	Yes	No		
Sore jaw with morning wake up	Yes	No		

Metrolina Medical Associates

THE EPWORTH SLEEPINESS SCALE

Name:_____ Date:_____

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 times. 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

1 = ***Slight*** chance of dozing

2 = ***Moderate*** chance of dozing

3 = ***High*** chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. theater or school)	_____
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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total Score:	_____

1-6 Congratulations, you are getting enough sleep!

7-8 Your score is average

9 and up Seek the advice of a sleep specialist without delay