SLEEP DISORDER CENTER

502 East Pine Ave Crestview, FL 32539
111 Bailey Drive Suite 2 Niceville, FL 32578
8734 Ortega Park Drive Navarre, FL 32566
151 Mary Esther Blvd, Suite 203 Mary Esther, FL 32569
(850) 689-5496 ● (850) 243-4456 ● (850) 279-4442 ● (850) 936-4717 ● Fax: (850) 689-5497

Patient Instructions for Sleep Study

Arrive at the Center on 5-17-12 at 9:30 **P.M**. Please do not arrive early. **24 hours notice is required if you are unable to keep your appointment, or a $100. Inconvenience fee will be billed to you!** Please fill out the attached questionnaire and bring it with you to your appointment. There will be paperwork to be completed before and after your study.

FOR YOUR SAFETY THE DOORS WILL BE LOCKED. PLEASE KNOCK AND HAVE YOUR ID READY, THE TECHNICIAN WILL LET YOU IN.

☐ **Ft. Walton Beach Location**: Santa Rosa Executive Plaza, **151 Mary Esther Blvd., Suite 203** (850) 243-4456. **Directions**: From the Santa Rosa Mall, go towards Hwy 98. The Santa Rosa Executive Plaza is to your immediate left, just past the traffic signal at Hollywood Blvd., across from Krystal. The office complex is beige stucco with tan Spanish tile roofs and brown doors. Enter the Plaza main entrance and turn right. Continue to the end, turn left, and go to the back of the complex. Turn right and you will find us in the last unit on the left. Maps and driving directions are available for printing @ www.sdcfwb.com.

☐ **Crestview Location:** 502 East Pine Avenue, Crestview (850) 689-5496. **Directions:** From the intersection of Hwy 85 and Hwy 90, go north 2 blocks. Turn right (*beside car wash*) onto Webb Street. If you pass KFC you have gone too far. Our brick building is to your left, at the corner of Pine and Webb, just before you get to the stop sign. Maps and driving directions are available for printing @ www.sdcfwb.com.

☐ **Niceville Location:** 111 Bailey Drive, Suite 2, Niceville, FL 32578 On highway 20 directly across from K-Mart sign is Bailey Drive, turn on Bailey Drive and go 1 block. The center is located on the left with the blue roof. Maps and driving directions are available for printing @ www.sdcfwb.com.

☐ **Navarre Location Directions:** Coming from Mary Esther; Go west on HWY 98 to Ortega Park Drive and turn right. Go straight for 200 feet and turn left into parking lot. The Sleep Lab is the unit on the left end. From Pensacola; Go east on HWY 98 1 block past Pullam Street and turn left the driveway between Days Inn & Suites and Taco Bell. The driveway goes around the back of Taco Bell and curves to the right. Turn right on Ortega Park Drive and then left into the parking lot. Maps and driving directions are available for printing @ www.sdcfwb.com.

1. Your estimated out-of-pocket expense $0.00. This amount is required at the time of the study. Any additional expense is contingent upon payment by your insurance company. The business office can be reached during the day from 9 am-4pm Monday – Friday. We accept cash, check, MasterCard and Visa. **If paying cash, bring exact change**.
2. Please arrive tired and ready for bed. Eat dinner before arriving. Please shave, shower and shampoo before arriving. Do not use any lotion, powder, makeup, hair Products, etc.…. on face or body. Bring something you find comfortable to sleep in (*pajamas, or tee shirt/shorts*). You may bring anything from home that will make you feel more comfortable (*pillow, blanket, etc*.). Our pillows are covered with plastic covers for your protection. You will be video and audio recorded during the test.
3. Cell phones, DVD players, radios, electronic game players, etc. are not permitted. **If you bring a cell phone it must be turned off upon arrival.**
4. **No** caffeine after noon on the day of the study. **No** naps the day of the study. There are no food restrictions. Continue to take any medications that your doctor has prescribed, unless otherwise instructed.
5. Please notify us **in advance** of any special needs or requirements during your stay with us (*Example: walking upstairs, oxygen use, food requirements, etc*.). We can make arrangements for oxygen use.
6. We do not dispense or prescribe any sleep aids (*medications*). If you feel you may need a sleep aid, it is your responsibility to get a prescription from your doctor in advance of your study and have taken it for at least one night prior to arriving for your study. If you do use a sleep aid you may need to make arrangements for someone to drive you home.
7. Your results will be faxed or mailed to your physician in approximately two weeks

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SLEEP DISORDER QUESTIONNAIRE

Please complete this form in its entirety and bring with you to your appointment

This questionnaire is regarding your sleep habits and medical history. Please answer each question and explain when asked

Name____ Date_________________

Address ____

City / State / Zip Code ____

Home Phone ____________Work ____________Cell ____________ Emergency Contact ________________

Date of Birth ______________________ Age ____________ Height _____________ Weight ___________

Social Security ____________________________Marital Status ___________ Sex ____________ Race ______

Employer _________________________________ Occupation __________________________________

Referring Physician ____ Phone ________________________

Address of Referring Physician ____

Family Physician (if different from Referring Physician) ___________________________________

Address ___________________________________ Phone_______________ Date last seen _____________

Additional Physician(s) you would like the Interpretation sent to: ______________________________

Address: ____

Medicare: Are you covered under both Medicare Part A and B? _______Our billing is done through **Medicare Part B only**

Primary Insurance Carrier Name _______________________________________ Phone _________________

Primary Insurance Carrier Address ____

ID # ____________________ Group # _______________ Sponsor: __________________ ID#___________________

Secondary Insurance Carrier Name __________________________________ Phone _____________________

Secondary Insurance Carrier Address ____

ID # ____________________ Group # _______________ Sponsor: __________________ ID#___________________

1. Have you ever been diagnosed with a sleep disorder? Yes ☐, No ☐ If so, please list where diagnosis was made and when. ______________________________

2. Have you ever had a surgical procedure to eliminate snoring or sleep apnea? Yes ☐, No ☐

   If so, what type of surgical procedure was done ______________________________

   What was the surgical procedure done to correct? ______________________________

   Where was the procedure performed? ______________________ When? ______________

   Was the surgical procedure effective? ______________________________

3. Are you now or have you ever-used CPAP (Continuous Positive Airway Pressure) Yes ☐, No ☐

   If yes, are you still using CPAP? ________ What is your pressure? _________If no, why? ______________

   ____

4. Have you ever been diagnosed with breathing problems (COPD, Chronic Bronchitis, Asthma, etc)? ____________

   If so, are you on oxygen therapy? Yes ☐, No ☐ If yes, do you use oxygen all the time or just at night? ___

   ____

5. Have you ever been diagnosed with any heart problems or have had a heart attack? Yes ☐, No ☐

   If yes, please explain: ______________________________

6. Do you snore? Yes ☐, No ☐ Does position affect your snoring? Yes ☐, No ☐

7. Have you ever been told that you stop breathing (apnea) when you sleep? Yes ☐, No ☐

8. Are you sleepy during the day? Yes ☐, No ☐ Are you tired during the day? Yes ☐, No ☐

9. Please **CHECK** all the statements that apply to you:

   ☐Night Sweats ☐Morning Headache ☐Morning Confusion ☐Sleep Talk

   ☐Teeth grinding ☐Loss of Libido (sexual drive) ☐Loose Urine while asleep ☐Sleep Walk

   ☐Restless Sleep ☐Leg/ Arm movements ☐Depression

10. Do you ever awaken with heartburn? Yes ☐, No ☐ Do you use antacids? Yes ☐, No ☐

11. Do you ever fall asleep at inopportune times such as: when driving? ☐ during a conversation ☐ at work ☐

    If yes please describe: ______________________________

12. Do you get sleepy during sedentary activities such as: watching TV ☐, reading ☐, using a computer ☐,

    other ______________________________

13. What is your usual bedtime on weekdays? ______________________ Weekends? ___________________________

14. What is your usual awakening time on weekdays? ________________ Weekends? __________________________

15. How long does it usually take for you to fall asleep? ____

16. Are you unable to move your body as you are falling asleep or waking up? _________________________________

    If yes, please explain: ____

17. The following statements refer to your sleep hygiene, please check as many as apply to you.

    Read in bed ☐ Watch TV in bed ☐ Eat in bed ☐ Write letters or checks in bed ☐

    Worry in bed ☐ Allow children to sleep with you ☐ Allow pets to sleep with you ☐

18. Are you a Cigarette or Cigar Smoker? Yes ☐, No ☐ Number of cigarettes smoked per day? ________________

    How many years have you smoked? ___________ If you answered no, have you ever smoked? ________________

    When did you quit? __________________

19. Do you consume alcoholic beverages? Yes ☐,No ☐ If yes, how many alcoholic beverages do you consume per:

    day______ or week ______ or month______ or year_____? (Specify number; do not write occasionally or rarely)

20. Do you consume caffeinated beverages? Yes ☐, No ☐ If yes, how many beverages do you consume per:

    day______ or week ______ or month______ or year_____? (Specify number; do not write occasionally or rarely)

21. Please list any other medical problems: ____

    ____

22. Please list any **NON-Prescription** Medication (Vitamins, herbs, etc) that you take daily.

    Please also note how often you take them: ____

    ____

23. Please **print** the names of all prescription medication(s) you take. **Technician Check Box(s) when Verified**

    ____________________________☐ ____________________________☐ ____________________________☐

    ____________________________☐ ____________________________☐ ____________________________☐

    ____________________________☐ ____________________________☐ ____________________________☐

    (Use Back if More Space Is Needed)

24. Do you have any comments that you feel we need to know about you but did not ask?

    ____

    ____