Comprehensive Sleep Center

22-18 Broadway, Suite 103 • Fair Lawn, NJ 07410 • 201-773-8185 • Fax 201-773-8187 • Comprehensivesleepcenter.com

DATE: _____

Last Name:_____ **First Name:**_____ **MI:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

SS#:_____ **DOB:**_____ **Employer:**_____

Home Phone: _____**Cell Phone:**_____**May we leave messages at home?** _____

Work Phone:_____ **Employer:** _____

Emergency Contact:_____ **Phone #:**_____ **Relation:**_____

Sex: M F **Marital Status:** S M W D O **Spouse's Name:**_____

Race: African American, Asian, Native Hawaiian, Hispanic, White, Other: _____

Language: English, Spanish, Other:_____

Referred By:_____

Primary Care Physician:_____**Primary Care Physician Phone #:**_____

Primary Care Physician Address:_____

Pharmacy Name:_____ **Pharmacy Number:**_____

INSURANCE INFORMATION:

Primary Insurance:_____ **ID#:**_____

Group#:_____**Provider Phone #**_____

Insured Name:_____ **DOB:**_____ **Relation to Patient:**_____

Secondary Insurance:_____ **ID#:**_____

Group#:_____

INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize Heart and Vascular Associates d/b/a Comprehensive Sleep Center to apply for benefits for covered services by them or by their order. I request that payment from any insurance company be made directly to Heart and Vascular Associates (or to the party who accepts assignment). I authorize the release of any medical information necessary to process this claim. I certify that the information I have reported with regards to any insurance coverage is correct. I permit a copy of the authorization to be used in place of the original This authorization may be revoked by either me or my insurance company at any time in writing.

Signature:_____ **Date:**_____

Health History Questionnaire

Comprehensive Sleep Center

All the information that you provide in this questionnaire is strictly confidential and will become part of your medical record.

Medical History (Check all that apply)

Condition	
Heart Failure	☐
Heart Disease	☐
Atrial Fibrillation	☐
Hypertension	☐
Pulmonary Hypertension	☐
Lung Disease	☐
Diabetes	☐
Stroke	☐
Polycythemia	☐
Sleep Apnea	☐

Measurements

	Current	5 Years Ago
Height		
Weight		
Collar Size		

List any surgeries that you have had: (additional information should be placed at the bottom of the next page)

Surgery	Date:

List any other hospitalizations that you have had: (extra lines available at bottom of page)

Hospitalization	Date:

List all medicines and supplements that you are currently taking:

Name of Drug	Strength	Frequency Taken	Date Started

Drug Allergies

Name of Drug	Reaction You Had

Health Habits

Exercise:	☐ Sedentary (no exercise) ☐ Mild exercise (climb stairs, frequent walk, golf) ☐ Occasional vigorous exercise (less than 4 times per week for 30 min.) ☐ Regular vigorous exercise (more than 4 times per week for 30 min.)
Caffeine:	☐ Any of the Following: ☐ Soda: Cups per day ___ ☐ Tea: Cups per day ___ ☐ Coffee: Cups per day ___ ☐ None

---

Family Health History (1st Degree Family Members Only)

Family Member:	Problem:	Age at Death (if applicable):

Please feel free to inform us about any other health issues here.

_____

_____

_____

_____

_____

Sleep History Questionnaire

Comprehensive Sleep Center

In your own words, describe your sleep problem:

_____

_____

1. WHAT TIME DO YOU USUALLY GO TO BED? _____

2. WHAT TIME DO YOU USUALLY WAKE UP? _____

3. HOW LONG DOES IT TAKE YOU TO FALL ASLEEP? _____

4. WHAT TIME DO YOU GET OUT OF BED? _____

5. DO YOU TAKE NAPS? ____NO ____YES *IF YES – HOW LONG AND WHAT TIME? _____*

6. HAVE YOU EVER HAD A SLEEP STUDY BEFORE? ____NO ____YES *IF YES – WHAT YEAR? _____*

7. HAVE YOU EVER USED CPAP OR BiPAP BEFORE? ____NO ____YES

	NO	*YES*
DO YOU WAKE UP FREQUENTLY DURING THE NIGHT?		
HAVE YOU EVER BEEN TOLD YOU SNORE?		
DO YOU WAKE UP GASPING OR FEELING LIKE YOU CANNOT BREATHE?		
DO YOU WAKE UP WITH A HEADACHE?		
DO YOU EVER WAKE UP WITH A SOUR/BITTER TASTE IN YOUR MOUTH?		
HAS ANYONE TOLD YOU THAT YOU STOP BREATHING IN YOUR SLEEP?		
DO YOU OFTEN FEEL TIRED, DISORIENTED, OR FOGGY IN THE MORNING OR THROUGHOUT THE DAY?		
DO YOU TOSS AND TURN AT NIGHT?		
DO YOU GET A NERVOUS/RESTLESS FEELING IN YOUR LEGS THAT IS HELPED BY WALKING OR MOVING YOUR LEGS?		
DO YOU SEE THINGS OR HEAR THING THAT ARE NOT THERE BEFORE FALLING ASLEEP?		
DO YOU EVER WAKE UP UNABLE TO MOVE AT ALL?		
DO YOU EVER FEEL WEAKNESS IN YOUR KNEES, NECK, OR ARMS WHEN EMOTIONAL?		
DOES YOUR SPEECH BECOME SLURRED WHEN YOU ARE TIRED OR EMOTIONAL?		
DID YOU EVER HAVE ABNORMAL BEHAVIORS DURING SLEEP (screaming, kicking, moving)?		
DO YOU WAKE UP TO URINATE MORE THAN ONCE?		
DO YOU FALL ASLEEP AT INAPPROPRIATE TIMES?		

Comprehensive Sleep Center
22-18 Broadway, Suite 103
Fair Lawn, NJ 07410
201.773.8185 Phone
201.773.8187 Fax

Epworth Sleepiness Scale

Height -
Weight -

PATIENT NAME:	**DATE:**
SEX: ☐ Male ☐ Female	**DATE of BIRTH:**

Please Circle (Y) for Yes or (N) for No for the following questions:

Do you snore? **Y** **N**	Do you wake up often in the night? **Y** **N**	Do you suffer from morning headaches? **Y** **N**	Has anyone noted that you stop breathing while sleeping? **Y** **N**

Please use the key below to circle the number for each dozing situation listed to the right. Thank you.

Key

0 = would ***NEVER*** doze
1 = ***SLIGHT*** chance of dozing
2 = ***MODERATE*** chance of dozing
3 = ***HIGH*** chance of dozing

DOZING SITUATION	CHANCE OF DOZING (Use key)			
Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting, inactive in a public place (i.e. theater, 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 with 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**

Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score.

For each question, please put a CHECK next to the number that best describes your answer.

Please rate the CURRENT (1.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED / DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ your total score

Comprehensive Sleep Center

22-18 Broadway Suite 103 • Fair Lawn, NJ 07410 • 201-773-8185 • Fax 201-773-8187 • Comprehensivesleepcenter.com

Thank you for choosing Comprehensive Sleep Center for your sleep study. You have been scheduled for a sleep study on _____at 9:00 PM.

Our address is 22-18 Broadway, Suite 103 Fair Lawn, NJ 07410. Please park on the side of the building in our off street, lighted parking lot. The main doors to the Broadway Medical Building will be open. **If you are being dropped off by a relative or medical transportation, it is imperative you advise them your pick up time is no later than 6:30 am the next morning.**

General Information

The study for which you have been scheduled will include measures of brain activity, muscle activity, breathing, and heart rate. Depending on the nature of your study, other measures also may be obtained. All of the tests performed are painless, and all of the recording devices that are used are placed only on the surface of the skin. Small electrodes will be applied to the surface of your scalp, temples, chin and lower legs for recording sleep patterns. Air flow, heart rate, chest movement, and oxygen levels will also be monitored. Rare individuals with sensitive skin may experience minor skin irritation from the paste and or cleansing solution used to apply and remove the electrodes. Please inform the technician the night of your study if you have any allergic reactions to adhesives like those found in medical tape.

To facilitate the application of the sensors and to obtain optimum readings we request that each patient shower and wash their hair prior to arrival at the sleep center. We also request that no lotions, oils or make-up be applied to the skin prior to the study as it might impede data collection.

Each study results in as much as 1000 pages of information, which must be individually analyzed. The full report generally will be available within one week of your sleep study. You may call following the study and we will report the results to you, if they are available, or we will tell you when they should be ready. A full report will also be sent to your referring physician. All studies are scanned initially for any abnormalities needing immediate attention, and in this case, we will contact your referring physician.

Please bring the following items with you.

1. Picture ID and health insurance card(s).
2. An overnight bag with any toiletries you will need and something to wear to sleep in. We recommend 2-piece pajamas, shorts and a t-shirt, or sweat pants, bring something comfortable.
3. A list of any medications you are currently taking and any medications you will need for that night and the following morning. This would include any non-prescription medications as well as none are available at the sleep center.

4. **This paperwork filled out completely**. If you have trouble with these forms we will be happy to help you with them when you arrive for your study. If you forget this paperwork you will be asked to fill out another set.

Financial/Office Policy

Please read carefully your responsibility to our center:

1. **Patients with Medicare** who do not have a secondary insurance will be responsible for their 20%. This amount will be billed.
2. **Secondary Insurance.** We will be happy to file your secondary insurance for you.
3. **No Show Fee**: A bedroom and the services of a highly skilled sleep technologist have been reserved for you for the night of your sleep study. If you are unable to keep your appointment, please contact us at 201-773-8185 at least 24 hours in advance to reschedule your sleep study**. A No Show Fee of $350 will be assessed otherwise**. This charge is necessary due to costs incurred of having staff present especially for you that night and the fee will not be billed to your insurance. We want to treat you with the utmost care and keeping your scheduled appointments will allow us to do this in a most timely fashion. If you know you are going to be late in arriving on the night of your study, please call the sleep center at 201-773-8185 and leave a message for the sleep technologist.
4. **Change of information**: If you have any changes in your insurance coverage it is your responsibility to let us know immediately.
5. **Insurance denials/holds**: We will contact your insurance provider to pre-certify you as well follow up with you with any additional information. If you have any questions or concerns, in regards to this process or your study in general, please do not hesitate to contact the sleep center at 201-773-8185.
6. **Leave valuables at home**: Comprehensive Sleep Center does not assume liability for personal items of value. You will be provided a locked cabinet in your room where you can secure personal items.