



Welcome to the Sleep Disorders Center at Kettering Medical Center. We would like to ask that you fill out the following information before you arrive to the sleep clinic on your scheduled appointment. The sleep clinic is now located in the basement of the hospital. **Please call at least 24 hours in advance to cancel any appointment. You may be charged a \$20.00 fee for a no call/ no show office visit.** This will allow other patients the opportunity to be seen a little sooner.

Please be sure that you have all the appropriate information with you upon arrival to the clinic. We prefer that you come with your spouse if at all possible.

1. Please give as much detail as possible on the information sheets.
2. Please have your family physician give you or fax any labs that you may have had especially any thyroid tests.
3. Please have your insurance cards with you. Also if your insurance needs a referral you must have yours faxed to the sleep clinic before your appointment. Fax # 937-395-8821.
4. Your co-payment will be due at the time of service. (we prefer cash or check)
5. If you had a sleep study outside Kettering Hospital please call and have them send us a copy

Please note that if your **insurance policy** requires a deductible to be met for outpatient services performed at a hospital, it could apply to your visit at our Sleep Lab. If this presents a problem, please call our office at 439-3600.

We are looking forward to seeing you at your appointment.

Questions regarding your date of appointment please call the sleep clinic at 937-395-8805.

Pulmonary Medicine of Dayton, Inc.
Patient Information

Please print clearly

Patient Name: _____ Birthdate: _____ Age: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Marital Status: Single _____ Married _____ Widowed _____ Divorced _____
Occupation: _____ Employed By: _____
Work phone number: () _____ Social Security # _____

Spouse's Name: _____ Birthdate: _____
Occupation: _____ Employed By: _____
Work Phone Number: () _____ Social Security #: _____

Primary insurance: _____ Policyholder Name: _____
Insurance ID#: _____ Group#: _____
Second insurance: _____ Policyholder Name: _____
Insurance ID#: _____ Group#: _____ Plan#: _____

Primary Physician: _____
Address: _____ Phone: _____
Person to Contact in an Emergency: _____
Relationship: _____ Phone: _____

Assignment of Benefits

I hereby assign all medical and or surgical benefits, to include Major Medical Benefits to which I am entitled including Medicare, private insurance and any other health plan to: **Pulmonary Medicine of Dayton, Inc.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance. I here by authorize said assignee to release medical information to secure the payment. I also understand the any CO-PAYMENT is due in full at the time of service, and if I am unable to pay it at that time, a service charge of \$20 will added to my bill.**

SIGNED: _____ **DATE:** _____

Kettering Memorial Hospital

Dr. Mariano Iberico

Dr. Hemant Shah

Today's Date _____

Name _____

Referring physician: _____ Tel # _____

Family physician: _____ Tel # _____

Age: _____ Height: _____ Weight: _____

Main reasons you are coming for this visit: _____

USUAL SLEEPING HABITS

How many hours of sleep do you get _____ Night _____ Day _____

Usual time you go to bed _____

Usual time you fall asleep _____

Number of times you wake up _____ To do what? _____

Time you get out of bed _____ with/without an alarm clock

When you wake up do you still feel tired/groggy? _____

Do you wake up frequently with a headache?

Any unusual dreams? If so describe _____

Do you snore? _____ (Y/N) Heavy/Light _____

Does it wake your partner? _____ (Y/N)

Does your partner sleep in separate rooms due to your snoring? _____

On weekends/days off do you sleep longer? (Y/N) (how many hours?) _____

Do you take naps during the day? (describe) _____

Are they Restful? _____

As you are going to bed, do your legs have a creepy, crawly feeling? _____

Describe it further:

If so, does the discomfort get (circle one) BETTER/WORSE when you do fall asleep?

Does the feeling get (circle one) BETTER/WORSE with moving the legs?

Is it worse during the (circle one) evening/night OR during the daytime?

Do you have uncontrollable urges to fall asleep in the daytime? _____

Do you fall to the ground or pass out if you laugh/cry/get emotional? _____

Do your muscles feel weak when you are laughing or excited? _____

At night: any unusual activities? _____

While asleep do you: Talk? _____ Walk? _____ Eat? _____

Do you ever injure yourself? _____ Others ? _____

Do you: Grind your teeth? _____ Wet your Bed? _____

Wake up coughing? _____ Wheeze? _____ Have Chest Pain? _____

Kettering Sleep Lab
Dr. Mariano Iberico, M.D
Dr. Hemant Shah

Name: _____
Today's Date: _____

DAYTIME SLEEPINESS

In the daytime, do you feel sleepy? _____
Do you fall asleep while (circle all that apply) driving? _____
Doing your job? _____
While eating? _____
Have you ever had any accidents or near accidents related to sleep issues?
Describe what happened _____

PAST HISTORY:

Currently, have you been diagnosed with the following:

- | | |
|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Gastroesophageal reflux (GERD) |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Emphysema / Asthma / COPD | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Other (describe) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Thyroid disorder | |

SURGERIES (with dates):

ALLERGIES (and describe what happens)

CURRENT MEDICATIONS:

(Please list all medications you are taking, prescription and over-the-counter).
Any medicines in particular for sleeping/ OR to keep you up?

Medications	Dosage	#of tablets	How many times a Day

Kettering Sleep Lab
Dr. Mariano Iberico, M.D.
Dr. Hemant Shah, M.D.

Name: _____
Date: _____

FAMILY HISTORY of sleep related problems:

MOTHER? _____ BROTHER? _____
FATHER? _____ SISTER? _____

Habits:

Did you ever smoke? (Y/N) _____
of packs/day? _____ for how long? _____
Date of your last cigarette _____
Alcohol: (type) _____ Amount _____
Any other drugs? _____
Coffee: Y/N _____ Number of cups/per day _____ caffeinated /decaf
Cola/Pop (name) _____ Number of cans/bottles a day _____

OCCUPATION:

Type of work _____
Usual work hours _____
How many miles (aprox.) do you drive to and from work per day? _____
Any use of dangerous equipment or machinery? (Describe) _____

Please circle any of the following that you have recently experienced.
 If there is anything else please put it in the blank boxes.

Constitution:	Weight Loss	Fatigue	Weight Gain			
Cardiovascular:	Chest Pain	Palpitations	Swelling (edema)	Murmurs		
Ears, Nose, and Throat	Heartburn or Reflux	Deviated Nasal Septum	Nasal Obstruction	Hoarseness or Sore Throat	Dentures	
Hematology/Lymph:	Easy Bruising	Bleeding Tendency	Enlarged Lymph Nodes	Anemia		
Neurology:	Headaches	Seizures	Head Injury	Dementia/ Forgetfulness	Unsteady Gait / Walking Problems	
Skin:	Rash	Itching	Dry Skin			
Musculoskeletal:	Muscle Wasting	Tremors	Weakness	Back Pain		
Psychiatric:	Feeling Anxious	Feeling Depressed	Feeling Sad			
Gastronintestinal:	Heartburn	Trouble Swallowing				
Endocrine:	Excessive Thirst	Excessive Urination				
Genitourinary:	Frequent Urination	Loss of Bladder control	Difficult Urination	Renal Failure	Dialysis	

Park in the MAIN Garage Underground in front of the MAIN hospital (MAIN Driveway Entrance)

Do not park in the Garage by the Emergency Room

(You will get a parking pass once you left the Sleep Lab)

Take the steps / Elevators to the **GROUND FLOOR**

You will pass the Cafeteria and more Elevators you will see a

(Sleep Lab sign)

Turn Left down the long hallway

Go until you reach the 2nd Sleep Lab sign

TURN RIGHT

The Sleep Lab is on your Left

