To: New Patient

From: Dr. Iberico, Dr. Shah, and Dr. Ali
Kettering Health Network Sleep Disorders Center

Welcome to the Sleep Disorders Center at Kettering and Sycamore Medical Centers.

Please complete the enclosed information forms before you arrive to the sleep clinic for your scheduled appointment. The sleep clinic is located in the basement of both Kettering and Sycamore hospitals. **Please call (937) 395-8805 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.**

Please bring all necessary information with you for your clinic appointment. *It is suggested that you are accompanied by a spouse or bed partner if at all possible.*

1. **Please call 395-8880 to pre-register for your appointment.**
2. Please give as much detail as possible on the information sheets.
3. Please request test results from your family physician or fax any lab results particularly thyroid test results.
4. Please have your insurance cards with you. If your insurance carrier requires a referral for this visit, please request the referral information to be faxed to the sleep clinic before your appointment.
   Sleep Disorder Center fax number: (937) 395-8821
5. Co-payments are due at the time of service. Cash, check, Visa, MasterCard, or Discover is accepted.
6. If you had a previous sleep study outside the Kettering Health Network, please call to request a copy of the study results to be sent to the Sleep Lab at fax number: (937) 395-8821.

Please check with your insurance carrier regarding deductible requirements for outpatient services performed at a hospital. This visit will be billed as an outpatient service within a facility by Pulmonary & Medicine of Dayton. A facility fee will be charged separately by the hospital.

We look forward to seeing you at your appointment. For questions regarding the date of your appointment, please call the Kettering Sleep Clinic at **(937) 395-8805** or Sycamore Sleep Clinic at **(937) 384-4820**.

PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE: ____________________

PATIENT NAME: ____________________ BIRTHDATE: __________ AGE: ______ SEX: ______

ADDRESS: ____________________ CITY: __________ STATE: ______ ZIP: ________

PHONE: (   ) ______________ MARITAL STATUS: ___ SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED

OCCUPATION: ____________________ EMPLOYED BY: ____________________

WORK PHONE NUMBER: (   ) ______________ SOCIAL SECURITY NO: ____________________

CELL PHONE NUMBER: (   ) ______________ E-MAIL ADDRESS: ____________________

SPOUSE'S NAME: ____________________ BIRTHDATE: ____________________

OCCUPATION: ____________________ EMPLOYED BY: ____________________

WORK PHONE NUMBER: (   ) ______________ SOCIAL SECURITY NUMBER: ____________________

PRIMARY INSURANCE: ____________________ POLICYHOLDER NAME: ____________________

INSURANCE ID #: ____________________ GROUP #: __________ PLAN #: __________

SECOND INSURANCE: ____________________ POLICYHOLDER NAME: ____________________

INSURANCE ID #: ____________________ GROUP #: __________ PLAN #: __________

REF. / FAMILY 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 hereby authorize said assignee to release medical information to secure the payment.**

SIGNED: ______________________________ DATE: ____________________

Kettering Health Network
Dr. Mariano Iberico
Dr. Hemant Shah
Dr. Median Ali

Name: ______________________
DOB: _________

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 ___________(Y/N)?
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? _______________
Grind your teeth________________ Wet your Bed______________
Wake up coughing___________ Wheezing ____________ Chest Pain_____________

Kettering Health Network
Dr. Mariano Iberico
Dr. Hemant Shah
Dr. Median Ali

Name: ______________________
DOB: _________

DAYTIME SLEEPINESS:

In the daytime, do you feel sleepy? ___________
Do you fall asleep while (circle all that apply):

- Driving __________
- Doing my job____________
- Eating ______________

Have you ever had any accidents or near accidents related to sleep issues? _________
If so, describe what happened. ____

PAST HISTORY:

Currently I have been diagnosed with the following

____ Hypertension
____ Heart attack
____ Stroke
____ Emphysema / Asthma / COPD
____ Depression/Anxiety
____ Diabetes
____ Thyroid disorder
_____ Hiatal Hernia
_____ Gastroesophageal reflux (GERD)
_____ Peptic Ulcer Disease
_____ Irritable Bowel Syndrome
_____ Other (describe)
_____Irregular heart beat

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 Health Network
Dr. Mariano Iberico
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Name: ______________________
DOB: _________

______________ ________ ______________ _________________________

***FAMILY HISTORY of sleep related problems*:**

MOTHER: __________________ BROTHER: ___________________
FATHER: ___________________ SISTER: ______________________

Habits:

Did you ever smoke? (Y/N)______
Number 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 ______________
Approx. driving distance _________ miles per day to and from
Any use of dangerous equipment or machinery? (Describe) __________________________

Kettering Health Network
Dr. Mariano Iberico
Dr. Hemant Shah
Dr. Median Ali

Name: ______________________
DOB: _________

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	

DATE: ___________________

NAME: ______________________________

EPWORTH SLEEPINESS SCALE

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

_____ Sitting and reading

_____ Watching television

_____ Sitting inactive in a public place, for example, a theater or meeting

_____ A passenger in a car for an hour without a break

_____ Lying down to rest in the afternoon

_____ Sitting and talking to someone

_____ Sitting quietly after lunch (when you have had no alcohol)

_____ In a car, while stopped in traffic

SYCAMORE HOSPITAL SLEEP DISORDERS CENTER
4000 Miamisburg Centerville Rd.
Miamisburg, OH 45342
Phone (937) 384-4820 Fax (937) 384-4826

DIRECTIONS FROM THE NORTH:
I-75 South to Exit #44
Right (west) on OH 725/Miamisburg Centerville Rd.
(towards Miamisburg)
One mile to Sycamore Hospital on the Left

DIRECTIONS FROM THE SOUTH:
I-75 North to Exit #44
Left (west) on OH 725/Miamisburg Centerville Rd.
(towards Miamisburg)
One mile to Sycamore Hospital on the Left

UPON ARRIVAL AT SYCAMORE HOSPITAL:
Park in parking lot in front of the hospital.

Enter in the Main Entrance.
Take main elevators, located across from Gift Shop to Ground Floor.
Turn left off elevators.
Turn left again into long corridor.
Sleep Disorders Lab is located on the Left.
Doorway on Left.

KETTERING HOSPITAL SLEEP DISORDERS CENTER
3535 Southern Blvd
Kettering, OH 45429
Phone (937) 395-8805 Fax (937) 395-8821

DIRECTIONS FROM NORTH DAYTON:
I-675 South to Exit #10
I-75 South to Exit #50B
Right (west) on Dorothy Ln.
Left (south) on Springboro Rd / OH-741
Left (south) on Southern Blvd.
Left (east) on West Dorothy Ln
Kettering Hospital on the Right

DIRECTIONS FROM THE SOUTH:
I-75 North to Exit #47
Merge on to South Dixie Hwy
Right (east) on Stroop Rd.
Left (north) on Southern Blvd.
Kettering Hospital on the Left.

UPON ARRIVAL AT KETTERING HOSPITAL:
Park in the MAIN Garage Underground in front of the MAIN hospital

(You will get a parking pass when you leave the Sleep Lab)
Take the steps / Elevator to the **Ground Floor**
Pass the Cafeteria and more Elevators.
At Sleep Lab sign, turn Left down the long hallway.
Proceed until you reach the 2nd Sleep Lab sign.
Turn Right. The Sleep Lab is located on the Left.

Thank you for the opportunity to participate in your medical care and treatment.