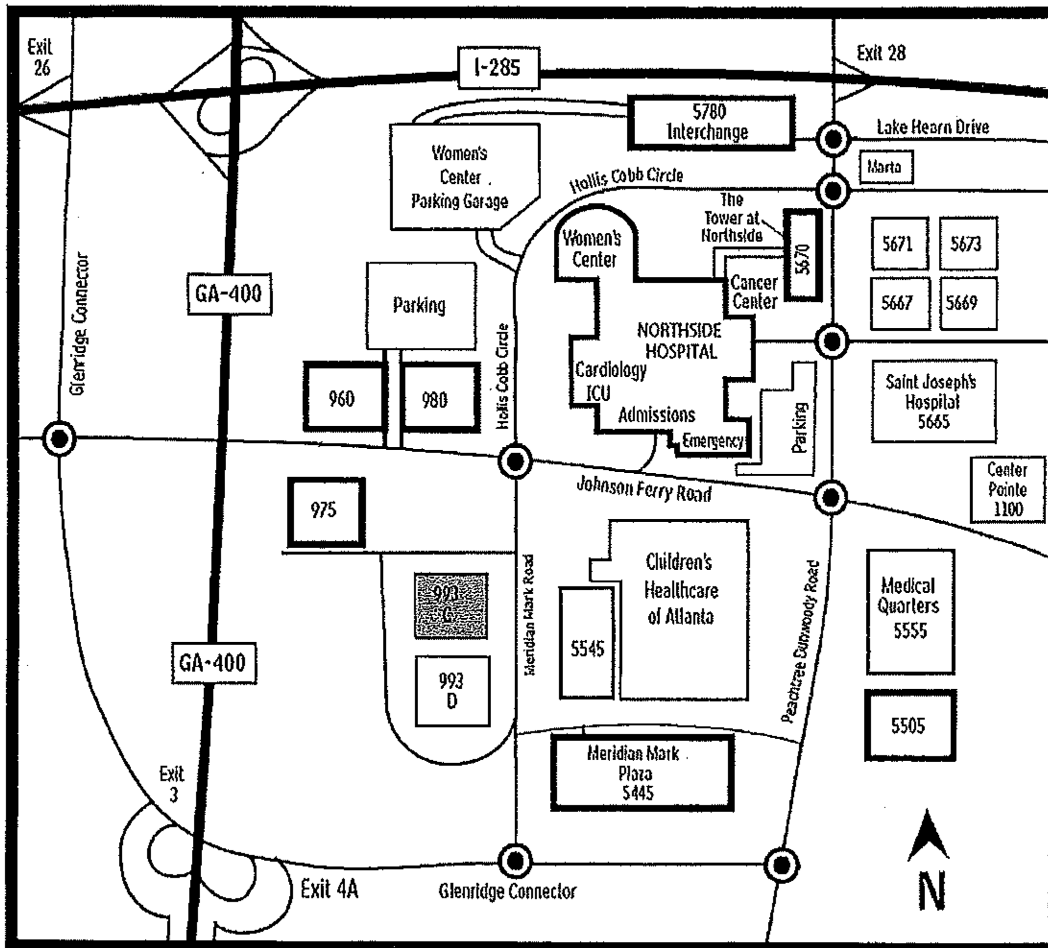
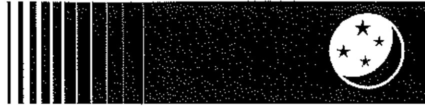
SLEEP DISORDERS CENTER
of Georgia
A Northside Network Provider
We don't rest until you do

OFFICE LOCATION
993-C Johnson Ferry Road, Suite 300, Atlanta, GA 30342
(404) 257-0080



DIRECTIONS FOR PARKING

When you turn off Meridian Mark, Building C will be on your left.
Pull up to the parking booth and take a ticket from the machine.
Turn right into the parking garage and park your vehicle.
As you enter building C, take the elevator to the third floor.
We are located in suite 300 directly across from the elevator



Sleep Disorders Center of Georgia

A Practice of Northside Hospital

Review of Medical Conditions and Medications (Including Supplements)

Please place an X beside each condition you have and list the medication you take for it.

Condition	X	Medication / Dosage / Times per day	Medication / Dosage / Times per day
Acid Reflux			
Anxiety			
Arthritis (Type ______________)			
Asthma			
Back Pain			
COPD			
Depression			
Diabetes: Type I Type II (circle)			
Erectile Dysfunction			
Glaucoma			
Coronary Artery Disease			
Heart Arrhythmia (Type__________)			
Congestive Heart Failure			
High Blood Pressure			
High Cholesterol			
Heart Valve Dysfunction			
Previous Heart Attack or Stroke			
HIV Positive			
Kidney Disease (Stage _________)			
Memory Loss			
Migraines			
Rhinitis / Sinusitis			
Scoliosis			
Are you on Oxygen?			
Other : ____________________			
Other : ____________________			
Other : ____________________			
Other : ____________________			

MEDICAL CONDITIONS MEDICATION FORM

Sleep Disorders Center
of Georgia

SLEEP EVALUATION(S)

1. Have you previously been evaluated in a sleep clinic? ☐ Yes ☐ No
2. Have you had a sleep study? ☐ Yes ☐ No
3. What was your diagnosis: ______________________________

If you previously had a sleep study(studies) please bring a copy(s) of the study and the doctor's note from the appointment ordering the study with you to your appointment. Records can be faxed to our office at 404 257-0592 prior to your appointment.

4. Have you had surgery for snoring or sleep apnea? ☐ Yes ☐ No
   If yes, list type, dates, and location ______________________________
5. If you are currently using a CPAP machine, please bring it and your mask with you to your appointment.

SLEEP EVALUATION(S)

Trouble sleeping at night How many months/years? ______________________________
Snoring How many months/years? ______________________________
Unwanted behaviors during sleep Explain: ______________________________
Other: Explain ______________________________

Please check all of the following statements that are true about your sleep:

BREATHING

☐ I have been told that I stop breathing while I sleep
☐ I wake up at night choking, smothering or gasping for air
☐ I have been told that I snore
   ☐ mildly, occasionally ☐ frequently, moderately ☐ constantly, severely
☐ I have been told that I snore only when sleeping on my back
☐ I have been awakened by my own snoring
☐ My bedpartner is bothered significantly by my snoring

DAYTIME SLEEPINESS

☐ I have had "blackouts" or periods when I am unable to remember what just happened
☐ I have fallen asleep while driving or feel my driving is affected by sleepiness
☐ I have had an auto accident as a result of falling asleep while driving
☐ I fall asleep easily in quiet situations
☐ I perform poorly in school or work because of sleepiness
☐ I have had injuries as the result of sleepiness
☐ I have had sudden muscle weakness in response to emotions such as laughter, anger or surprise
☐ I have had an inability to move while falling asleep or when waking up
☐ I have had hallucinations or vivid dreamlike images or sounds when falling asleep or waking up

SLEEP HABITS

☐ I usually watch TV or read in bed prior to sleep
☐ I have thoughts that start racing through my mind when I try to fall asleep
☐ I often drink alcohol prior to bedtime
☐ I wake up early in the morning, and I am still tired but unable to return to sleep
☐ I cannot sleep on my back
☐ I need elevation of the head of my bed
☐ I share a bed with someone
☐ I frequently have trouble with insomnia
☐ My job requires frequent travel
☐ I can only sleep on my back
☐ I sleep alone
☐ I am a shift worker on rotating shifts

SLEEP HISTORY QUESTIONNAIRE

Name: ______________________________ DOB: ______________

	Work days (weekday)	Off days (weekends)
Typical bedtime:	________ am/pm	________ am/pm
Typical amount of time it takes to fall asleep:	________	________
Typical numbers of awakenings per night:	________	________
Typical wake up time:	________ am/pm	________ am/pm
Total amount of sleep per night:	________ hours	________ hours
Number of naps per day/duration:	________	________

Usual Work Days: ______________ Usual Work hours: ______________

SLEEP HABITS

☐ I have uncomfortable feelings in my legs and/or arms when I lie down at night
☐ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
☐ I have a hard time falling asleep because of my leg movements
☐ Leg restlessness delays my sleep ☐ often ☐ occasionally ☐ rarely
☐ I have been told that I kick or jerk my legs and/or arms frequently during sleep
☐ I frequently talk in my sleep
☐ I have walked in my sleep as an adult

RESTLESSNESS/PARASOMNIA CONTINUED

☐ I grind my teeth in my sleep
☐ I use a guard to protect my teeth from grinding
☐ I have acted out dreams physically while asleep
☐ I have injured myself or others with movement during the night

FAMILY HISTORY

Has an immediate blood relative had any of the following? ☐ Sleep Apnea ☐ Restless legs ☐ Narcolepsy

HABITS

Do you smoke or have you smoked? ☐ Yes, currently ☐ no never ☐ Previously pack(s) per day ________
If previously: When did you quit ________ How many years did you smoke ________

Do you drink alcohol? ☐ Yes ☐ No
If yes what type? ☐ Beer ☐ Wine ☐ liquor
Frequency? ________ drinks per ☐ Day ☐ Week ☐ Month

Do you drink caffeinated beverages during the day ☐ Yes ☐ No
# of cups/bottles/cans/oz. per day ____________

Do you use recreational drugs? ☐ Yes ☐ No

List all Hospitalizations and surgeries (list the dates as well) you have had. Please be thorough and include surgeries to remove adenoids or tonsils or any hospitalizations for head injuries, seizures, or heart conditions:

____

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____

Are there any other aspects of your sleep problem which you feel have not been adequately covered in this questionnaire?

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____

Signature: ______________________________ **Date/Time:** ______________

SLEEP HISTORY QUESTIONNAIRE

NH0670

NORTHSIDE HOSPITAL

SLEEP DISORDERS CENTER

ADDRESSOGRAPH

AFFIX PATIENT LABELS OVER THIS BOX

BAR CODE MUST FALL BETWEEN THESE LINES

Patient Name: ______________________________

Gender (circle one): Male Female Age: __________

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 decide how you would react to these situations. Use the following scale to choose the most appropriate number for each one.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	**CHANCE OF DOZING** (circle one)			
Sitting and reading.	0	1	2	3
Watching TV.	0	1	2	3
Sitting, inactive in a public place (e.g., theater or 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 to 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

TOTAL SCORE: __________ **AVERAGE AMOUNT OF SLEEP PER NIGHT:** __________

SIGN HERE: Completed by: ____________________ Date/Time: ____________________

Reviewed by: ____________________ Date/Time: ____________________