

Registered  
Polysomnographic  
Technologist on Staff

Specializing in Sleep Studies (Lab or Home)

Respiratory  
Therapist  
on Staff



Dr. Sever Surdulescu, Medical Director (Lake Norman Pulmonary & Critical Care Spec.)

Board Certified in Sleep Medicine

[www.piedmontsleepcenter.com](http://www.piedmontsleepcenter.com)

**H** 1022 3<sup>rd</sup> Avenue Dr. NW  
Hickory, NC 28601  
Phone: (828) 322-3111  
Fax: (828) 322-3160

302 Mulberry St. SW  
Lenoir, NC 28645  
(across from Caldwell Memorial)  
Phone: (828) 322-3111  
Fax: (828) 322-3160

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NAME \_\_\_\_\_  
APPT. DATE \_\_\_\_\_  
ARRIVAL \_\_\_\_\_  
WAKE-UP \_\_\_\_\_

**INSTRUCTIONS FOR ALL-NIGHT SLEEP STUDIES:**

1. PLEASE RING **DOOR BELL** WHEN YOU ARRIVE.
2. PLEASE HAVE **CLEAN HAIR, NO LOTION, NO MAKEUP.**
3. PLEASE BRING A **LIST** OF PRESCRIBED MEDS THAT YOU ARE TAKING. TAKE ALL OF YOUR PRESCRIBED MEDS AS NORMAL. DO NOT TAKE ANY "OVER THE COUNTER" DRUGS, ESPECIALLY ALLERGY OR COLD REMEDIES. YOU MAY TAKE TYLENOL OR ADVIL.
4. PLEASE BRING AN **UPDATED INSURANCE CARD.**
5. IF YOU HAVE A COPAY, PLEASE BRING CASH OR CHECK. (PLEASE MAKE CHECKS PAYABLE TO: LAKE NORMAL SLEEP CENTER).
6. **NO ALCOHOL OR CAFFEINE.**
7. **DO NOT NAP.**
8. **WEAR PAJAMAS, OR SHORTS AND A T-SHIRT.** YOU MAY BRING YOUR OWN PILLOW.
9. FRIENDS OR FAMILY MAY **NOT** REMAIN IN LAB DURING STUDY.
10. PLEASE LET US KNOW BEFOREHAND IF YOU NEED SPECIAL ASSISTANCE.
11. DO NOT BRING A TV OR RADIO. CELL PHONES NEED TO BE TURNED **OFF** UPON ARRIVAL.
12. IF YOU USE A **CPAP** MACHINE AT HOME, PLEASE BRING YOUR **MASK.**
13. IF YOU ARE ON **OXYGEN**, PLEASE LET US KNOW AND BRING A **CANNULA.**

**\*PLEASE UNDERSTAND THAT WE CAN NOT GIVE YOU ANY INFORMATION REGARDING YOUR SLEEP STUDY RESULTS.\***

**If you are unable to keep your appointment, please let our office know within 48 HOURS so we can reschedule you. We only have 2 patients per night, and count on each one to show up to their scheduled appointment. If you are a no-show, you will not be rescheduled.**

**\*Insurance Benefits are estimates only and not a guarantee of payment.**

You are responsible for providing the correct insurance information. Please let us know if the information is correct and if you change policies.

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### **DIRECTIONS TO OUR HICKORY CENTER:**

#### **EASY TO FIND // CONVENIENTLY LOCATED OFF HWY. 321**

**10-30 minutes from Lenoir, Morganton, Statesville, Gastonia, Lincolnton, Cherryville, Blowing Rock, Boone, Taylorsville, North Wilkesboro, Denver, Newton/Conover**

From Hwy. 127 take 3<sup>rd</sup> Ave. NE and turn onto 3<sup>rd</sup> Ave. NW. Go through 6 stoplights (1 mile) and Piedmont Sleep Center will be on the right (next to Plum Pretty Consignment).

From Hwy. 321 South, after you cross the bridge into Catawba County, turn left at the light beside of the Nissan Dealership onto Old Lenoir Rd. Travel 1 ½ miles and Piedmont Sleep Center will be on the left.

From Hwy. 321 North, after you pass Lowe's Foods, turn right at the next stoplight beside of Arby's. Travel on Old Lenoir Rd. for 1 ½ miles and Piedmont Sleep Center will be on the left.

From I-40 East and West, take exit #123, Lenoir/Blowing Rock/Boone. Take 321 North for 2 ½ miles. Turn right onto Old Lenoir Rd. Travel 1 ½ miles and Piedmont Sleep Center will be on the left.

### **DIRECTIONS TO OUR LENOIR CENTER:**

From Taylorsville, once you come into Lenoir, turn left onto NC-18. Travel 0.7 miles and turn right onto Mulberry St SW. Travel 0.4 miles and you will find us across from Caldwell Memorial Hospital.

From Boone, take 321 South towards Lenoir for 17.3 miles. Turn right onto 321 Alt/N Main St. and travel 0.9 miles. Turn slightly left onto 321 Alt S/N Main St. and travel 1 mile. Turn left on College Ave SW and then turn right onto Mulberry St SW. Travel 0.2 miles and you will find us across from Caldwell Memorial Hospital.

From Jefferson, take Valley Blvd until it turns into 321 South. Travel for 17.3 miles. Turn right onto 321 Alt/N Main St. and travel 0.9 miles. Turn slightly left onto 321 Alt S/N Main St. and travel 1 mile. Turn left on College Ave SW and then turn right onto Mulberry St SW. Travel 0.2 miles and you will find us across from Caldwell Memorial Hospital.

From Wilkesboro, start out going west on W Park Dr toward US-421 BR. Turn left onto US-421 BR W and travel for 1.2 miles. Turn left onto US-421 S/NC-16 S/WATSON BRAME EXPY and travel for 1.5 miles. Merge onto NC-16 S/NC-18 S via EXIT 286A toward Taylorsville/Lenoir and travel 3.2 miles. Turn right onto NC-18 and travel 24.4 miles. Turn left onto Morganton Blvd SW/US-64/NC-18 BYP and travel 0.7 miles. Turn right onto Mulberry St SW and travel 0.2 miles. You will find us across from Caldwell Memorial Hospital.

#### **For Patients Only**

(Hickory) Direct Number (828) 322-3111

(Lenoir) Direct Number (828) 754-9621

**PATIENT INFORMATION**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Soc. Sec.# \_\_\_\_\_

Marital Status:

City, State, Zip \_\_\_\_\_

\_\_\_\_ Married \_\_\_\_ Single \_\_\_\_ Divorced

Phone \_\_\_\_\_

(Please check one.)

\_\_\_\_ Home \_\_\_\_ Work \_\_\_\_ Other (Please check one.)

**PATIENT EMPLOYMENT INFORMATION**

Employer \_\_\_\_\_

Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

**RESPONSIBLE PARTY**

*(If the patient is the responsible party, please skip to the next section, "Insurance Information")*

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Soc. Sec.# \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Employer \_\_\_\_\_

Phone \_\_\_\_\_

Employer Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Policy Holder: \_\_\_\_\_ Patient  
\_\_\_\_\_ Responsible Party  
\_\_\_\_\_ Other (Name and Date of Birth) \_\_\_\_\_

Name of Insurance \_\_\_\_\_

Ins. ID# or Policy# \_\_\_\_\_

Ins. Group# \_\_\_\_\_

Ins. Phone # \_\_\_\_\_

Patient Relationship to insured \_\_\_\_\_

*I hereby authorize Lake Norman Pulmonary & Critical Care Specialists to release any information acquired in the course of my treatment to the insurance company. I understand that Lake Norman Pulmonary will file my insurance as a courtesy. However, I am ultimately responsible for all medical fees relating to my care. Should my insurance deny for such reasons as: deductible or non-covered service, I understand that I will be responsible for my bill. This authorization is valid until revoked in writing.*

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

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**L**

**PATIENT HISTORY**

Patient Name \_\_\_\_\_

Date \_\_\_\_\_ Ref. Number \_\_\_\_\_

Referring MD \_\_\_\_\_

**Please circle any of the following that apply to you:**

1. PARKINSONS DISEASE
2. HYPERTENSION/HIGH BLOOD PRESSURE
3. HEART PROBLEMS
4. PACE MAKER
5. STROKE
6. DIABETIC
7. HEPATITIS
8. HIV/AIDS
9. TB
10. RENAL PROBLEMS
11. SHORTNESS OF BREATH
12. CONGESTIVE FAILURE
13. OXYGEN
14. COPD
15. BLOOD THINNING MEDICATION
16. SEIZURES
17. OTHER \_\_\_\_\_

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Name \_\_\_\_\_

Referring Physician \_\_\_\_\_

Date \_\_\_\_\_

Ref. # \_\_\_\_\_

**EPWORTH SLEEPINESS SCALE**

Please complete the following. Rate how likely it would be that you would fall asleep during these situations.

**CHANCE OF DOZING (0-3)**

**0 = never doze**

**1 = slight chance of dozing**

**2 = moderate chance of dozing**

**3 = high chance of dozing**

Sitting and reading \_\_\_\_\_

Watching TV \_\_\_\_\_

Sitting in a public place (movie, meeting) \_\_\_\_\_

As a passenger in a car for 1 hour \_\_\_\_\_

Lying down to rest in the afternoon \_\_\_\_\_

Sitting and talking to someone \_\_\_\_\_

Sitting quietly after lunch (without alcohol) \_\_\_\_\_

In a car while stopped in traffic \_\_\_\_\_

**TOTAL** \_\_\_\_\_

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**SLEEP DISORDER QUESTIONNAIRE**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE- HOME: \_\_\_\_\_ CELL: \_\_\_\_\_ WORK: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SS# \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ USUAL WEIGHT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ AGE OF SPOUSE: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ DATE LAST SEEN: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ DATE LAST SEEN: \_\_\_\_\_

1. Please describe your sleep problem in the space below (include when it started and describe any changes in the condition within the last year):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you previously had any evaluations, sleep studies, or treatment for your sleep problem?

\_\_\_\_\_  
\_\_\_\_\_

3. List any past or present health problems and treatments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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4. Please list all prescription and non-prescription medications (include dosage). If you have a separate list of medications, please write "see attached list".

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5. Do you have any allergies? \_\_\_\_\_  
Allergic to latex? \_\_\_\_\_  
Sinus problems? \_\_\_\_\_  
Nasal congestion at night? \_\_\_\_\_

6. Do you have any chronic breathing/lung problems? Please describe:

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7. Do you use oxygen at home? \_\_\_\_\_ What flow rate? \_\_\_\_\_  
Are you a- Nonsmoker? \_\_\_\_\_ Smoker? \_\_\_\_\_ Former Smoker? \_\_\_\_\_  
(If you are a smoker or former smoker, please indicate:)  
Age you started smoking: \_\_\_\_\_  
Age you stopped smoking: \_\_\_\_\_  
Average amount smoked each day: \_\_\_\_\_

8. Do you ever awaken with a gasping or choking sensation? If yes, how long does it last? What relieves it?

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9. Do you ever awaken feeling short of breath? If yes, how long does it last? What relieves it?

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10. Do you ever awaken with headaches in the morning?

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11. Do you ever awaken with a burning sensation in your chest or throat, such as heartburn? \_\_\_\_\_

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12. Do you ever have a restless feeling in your legs when you lie down or difficulty getting them comfortable? \_\_\_\_\_

13. Does anyone complain that you kick your legs at night or move frequently, or seem restless? \_\_\_\_\_

14. Do you snore? \_\_\_\_\_  
Which word best describes your snoring?  
Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_

15. Are you excessively sleepy during the daytime? \_\_\_\_\_

On a scale from 1 to 10 (with 10 being the most sleepy and 1 being wide awake), how sleepy are you in these situations?

Upon awakening \_\_\_\_\_

Later in the morning \_\_\_\_\_

In the afternoon \_\_\_\_\_

In the evening \_\_\_\_\_

16. Do you ever fall asleep at inappropriate times, such as when you're driving or talking? Please describe: \_\_\_\_\_

17. Do you fall asleep easily during quiet activities (reading, or watching TV)? \_\_\_\_\_

18. Do you fall asleep at work? \_\_\_\_\_ How often? \_\_\_\_\_

19. What is your usual bedtime? \_\_\_\_\_  
How long does it take you to fall asleep? \_\_\_\_\_

20. After you fall asleep do you awaken during the night? \_\_\_\_\_  
If yes, please describe how often: \_\_\_\_\_  
What awakens you? \_\_\_\_\_  
How long are you awake before you fall back asleep? \_\_\_\_\_

21. What is your usual wake-up time? \_\_\_\_\_  
Do you awaken to an alarm, spontaneously, or does someone awaken you? \_\_\_\_\_



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22. What is your average amount of sleep per night? \_\_\_\_\_

23. Is your sleep on weekends different from your sleep during the week? Please describe: \_\_\_\_\_

24. Do you nap? \_\_\_\_\_ If yes, list the time of day, weekends or weekdays, and duration of naps: \_\_\_\_\_

25. What is your usual sleeping position? \_\_\_\_\_

26. Do you drink alcohol? \_\_\_\_\_ If yes, please list the amount and how often you drink it: \_\_\_\_\_

27. List the amount of caffeine you have per day (including coffee, tea, soft drinks, chocolate): \_\_\_\_\_

28. Please note any additional comments you think are relevant to your sleep problem: \_\_\_\_\_

Thank you.