East Valley Center for Pulmonary & Sleep Disorders

Pre-Test Questionnaire

Date:_____ Hospital # _____

(Please Print)

Name:_____Sex:_____Age:_____Date of Birth:_____

Height:_____ft.____in.

Weight:_____lbs Gain? Loss? of_____lbs over_____

Chief Complaints

What problem(s) brings you to sleep disorders center? (circle all that apply)

sleepy / fall asleep during the day	urge to move legs in daytime	sleep walking
excessive or loud snoring	difficulty falling asleep	bed wetting
choking in sleep	waking up during the night	nightmares
legs jerk / kick at night	waking up too early in morning	acting out dreams
legs uncomfortable at night	paralysis on waking/falling asleep	cataplexy

How long time has this occurred?_____

How many nights per week, on average, are you disturbed by poor sleep?

Sleep Habits: Please answer the following questions.

What time do you usually go to bed?	in weekdays: in weekends:
What time do you usually wake up?	in weekdays: in weekends:
How many hours of sleep do you usually get each night?	
How long does it usually take you to fall asleep?	
On average, how many times do you wake up at night?	
When was the last time you drank coffee or tea?	
When was the last time you drank alcohol?	
Did you take a nap today? If yes, for how long?	__NO __YES for minutes
Have you taken sleeping pills in the last two weeks?	__NO __YES

Sleep Habits (Continued): Please answer the following questions.

If yes, what sleep pill did you take and how much?	
Did you have an overnight sleep study before? If yes, where did you have it?	__NO __YES
When was your most recent overnight sleep study?	
Are you currently using a CPAP or biPAP? If yes, for how long and at what pressure setting?	__NO __YES

Previous and Current Medical Problems and Illness

Year	Disease or Illness	Place Hospitalized

Previous Surgeries

Year	Reason for Operations	Place Hospitalized

Have you had blood transfusions: YES NO If Yes, Dates:_____

Have you ever had? (Circle all that apply)

AIDS Or HIV	Heart Murmur	Radiation / Chemotherapy
Anxiety	Heart Attack: Year_____	Rheumatic Fever
Asthma	Hepatitis	Seizure / Epilepsy
Bladder Infection	Herpes	Sexually Transmitted Disease
Cancer	High Blood Pleasure	Sinus Trouble
Chronic Lung Disease	Kidney Infection	Skin Cancer
Colon Polyps	Kidney Stone	Stroke
Dental Trouble	Migraine Or Other Headaches	Syphilis
Depression	Nose Broken	Thyroid Trouble
Deviated Nasal Septum	Phlebitis Or Blood Clots	Tuberculosis
Diabetes: Years____	Pneumonia	Ulcer
Gonorrhea	Polio	Others

Sleepiness Scale

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 time. Even if you have not done some of these things recently, try to work out how they would have affected you. 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 if dozing

Situation	Never	Slight	Mod	High
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive, in a public place(e.g. a theater)	0	1	2	3
As a passenger in a car for an hour without break	0	1	2	3
Lying down to ret in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
Total Score				

_____ _____

Patient Signature Technologist Signature

Date:_____ Date:_____

Allergies/Drug Allergies/Reaction

_____

1._____ 4._____

2._____ 5._____

3._____ 6._____

Home Medication/Dietary Supplements/OTCO/Herbal Order

Medication	Dose	Route	Frequency	Last Dose	Continue in Sleep lab		Continue after discharge	
					YES	NO	YES	NO
Comments:								

_____ _____

Tech Signature Faxed By:

_____ _____

Date Date/Time

Audio / Visual Authorization

Name:_____ Client#:_____

The undersigned does hereby authorize the Sleep Institute, its agents or employees, any attending physicians, or other persons to photograph, making moving sound pictures, videotapes, or audiotapes of

_____
(Patient's name)

while under the care of the Sleep Institute. The Institute and its agents or employees, attending physicians, or other person may use the negatives, prints, videotapes or audiotapes prepared therefrom for such purposes and in such manner as may be deemed useful or necessary, including: research, teaching, or publication, or other purpose, for, medical profession.

Signed:_____

Date:_____

Witness:_____

Legal Guardian:_____