ABOUT YOUR SLEEP STUDY

Scheduling

DATE: _______ TIME: _______
Sun Mon Tues Wed Thurs Fri Sat

Our sleep lab is located within our facility at 3155 E Southern Ave, Suite 104

CANCELLATION POLICY: IF YOU NEED TO CANCEL YOUR STUDY, PLEASE CALL WITHIN 24 HOURS TO AVOID A CANCELLATION/NO SHOW FEE OF $150.00

Please arrive at your scheduled appointment time so that the Technologist can review your paperwork and questionnaires with you prior to hooking you up for your sleep test. PLEASE RING THE BUZZER LOCATED OUTSIDE THE MAIN DOORS, TO THE RIGHT, ABOVE THE TRASH CAN. A technologist will let you in.

What should I bring with me?

- It is important to remember to bring any MEDICATIONS that you normally take.
- Please bring loose, comfortable pajamas, and slippers.
- Toothbrush and toothpaste, any toiletries, sleeping mask, ear plugs, etc.
- If you choose, you may bring any favorite pillow or blanket.

How do I prepare for my test?

To prepare for your sleep study and get the most out of your sleep please read the following instructions:

- Do not take any naps the day of your sleep study as naps may decrease the quality of your sleep that night.
- Do not drink caffeine on the day of your study.
- Bathe or shower and wash your hair before the test, as clean skin improves the application of the monitoring sensors. PLEASE SHAVE ANY FACIAL HAIR.
- Do not apply any lotions, hair conditioners, hair creams or tonics.
- Remove colored nail polish as the color may interfere with the oxygen sensors.

When do I leave in the morning?

You will spend the whole night in the sleep lab. In most cases we will awake you between 5:00 and 6:00 a.m. depending on when you started your test. After you have been unhooked, you may clean up and get ready for your day. If you need to be picked up, please have your ride here @ 5:30 a.m.

AFTER 5:00PM OR WEEKENDES, IF YOU NEED TO CANCEL YOUR SLEEP STUDY PLEASE CALL (480)659-6449.
Patient Sleep Questionnaire (To be completed by the patient before their study)

**Life and Work Habits**

1. Do you smoke or use other forms of tobacco?  
   - Yes [ ] No [ ]  
   If yes, what form? ___________________________  How much? ___________________________
2. Do you exercise?  
   - Yes [ ] No [ ]  
   If yes, how often?  
   - Seldom [ ] Often [ ] Daily [ ]
3. Describe your type of work and hours:  
   ____________________________________________
4. What is your primary sleep complaint?  
   ____________________________________________
5. What is the reason your physician recommended this sleep study?  
   ____________________________________________
6. Do you drink caffeinated beverages?  
   - Yes [ ] No [ ]  
   If yes, what caffeinated beverages do you drink and how much per day?  
   ____________________________________________
7. Do you drink alcoholic beverages?  
   - Yes [ ] No [ ]  
   If yes, what alcoholic beverages do you drink and how much per day? (beer, wine, mixed drinks):  
   ____________________________________________

**Problems Falling Asleep**

1. Do you have trouble relaxing and feeling ready to go to sleep?  
   - Yes [ ] No [ ]
2. Do you hear, see or feel things that may not be real as you are falling asleep?  
   - Yes [ ] No [ ]  
   For example hearing voices or feeling that someone is in the room.
3. Do you often have trouble falling asleep due to racing thoughts?  
   - Yes [ ] No [ ]
4. Do you often have trouble falling asleep because of pain or discomfort?  
   - Yes [ ] No [ ]  
   Elaborate when necessary:  
   ____________________________________________

**Sleep Hygiene**

1. Do you perform the following in bed? Check all that apply.  
   - None [ ] Read [ ] Have arguments in bed [ ] Eat [ ]
   - Watch TV [ ] Worry [ ] Write [ ]
2. When is your normal bed time (whether it is on the couch, on a recliner, in a bed, etc.)?  
   _____ 0 PM 0 AM
   When is your normal wake time?  
   _____ 0 PM 0 AM

**Patient Name:** ____________________________  **DOB:** ____________________________
### Sleep Habits

1. How long does it take you to fall asleep? ___ HOURS ___ MINUTES

2. How many hours on average do you sleep per night? ___ HOURS ___ MINUTES

3. Please check all of the positions you are unable to sleep in. □ BACK □ SIDE □ STOMACH
   Why? __________________________________________________________

4. Are you having trouble remembering misplaced items or events? □ YES □ NO

5. Have you ever had the sensation of weakness while you were laughing, angry or feeling sad? For example laughing very hard at a joke and feeling weak in your legs. □ YES □ NO

6. Do you usually feel sleepy anytime during the day? □ YES □ NO

7. Do you usually need a nap during the day? □ YES □ NO

7a. Do you usually find naps refreshing? □ YES □ NO
   Elaborate when necessary ____________________________________________________

### Problems During Sleep

1. Do you wake up during sleep and have trouble falling back to sleep? □ YES □ NO

2. Do you wake up too early and have trouble falling back to sleep? □ YES □ NO

3. Do you frequently check the clock? □ YES □ NO

4. Do you have difficulty sleeping due to discomfort in legs or arms? □ YES □ NO

5. Have you ever walked in your sleep? □ YES □ NO

6. Do you have nightmares? □ YES □ NO

7. Do you have a history of wetting the bed? □ YES □ NO
   If yes, when? □ CHILD □ ADULT

8. Do you grind your teeth? □ YES □ NO
   If yes, do you use a mouth device to prevent this? □ YES □ NO

9. Have you ever thrashed, thrown covers off or fallen out of bed? □ YES □ NO

10. Have you ever hit or kicked your bed partner, or injured yourself during sleep? □ YES □ NO

11. Have you ever awakened screaming? □ YES □ NO

12. Do you snore? □ YES □ NO

13. Has anyone ever said you stop breathing while sleeping? □ YES □ NO
### Patient Sleep Questionnaire (page 3 of 4)

#### Problems After Waking Up

1. Do you normally wake up with headaches?  
   - [ ] YES  
   - [ ] NO

2. Have you ever awakened confused or disoriented?  
   - [ ] YES  
   - [ ] NO

3. Have you ever awakened feeling like you are awake but you cannot move?  
   - [ ] YES  
   - [ ] NO

4. Do you feel tired when you wake up?  
   - [ ] YES  
   - [ ] NO

#### Daytime Sleepiness

Please check the following questions based on this scale:

<table>
<thead>
<tr>
<th>Activity</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (ex. Theater)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch (when you've had no alcohol)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In a car while stopped in traffic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Sleep Disturbances

My sleep is frequently disturbed by (check all that apply):

- [ ] None
- [ ] Sinus or cold symptoms
- [ ] Leg discomfort
- [ ] Choking or gasping for air
- [ ] Frightening dreams
- [ ] Need to urinate
- [ ] Indigestion
- [ ] Pain
- [ ] Hunger
- [ ] Bed partner
- [ ] Pets
- [ ] Asthma
- [ ] Cough
- [ ] Children
- [ ] Headaches
- [ ] Nausea
- [ ] Thirst
- [ ] Noise
- [ ] Stress
- [ ] Shortness of Breath

Please list any other symptoms that disturb your sleep not listed here:

__________________________________________________________________________
Patient Sleep Questionnaire (page 4 of 4)

Medical History

Please check all that apply:

- None
- Panic attacks
- GERD
- Seizures
- High blood pressure
- Depression
- Diabetes
- Stroke
- Nasal/Sinus problems
- Heart disease
- Thyroid disease
- Other nose or throat surgery
- Claustrophobia
- Lung disease
- Have you ever had surgery for Sleep Apnea?

Family Sleep Disorder History

Please list any diagnosed sleep disorders in your family. If you do not know the diagnosis, describe the symptoms.


Medications

Please list all prescribed medications you are currently taking. (Dosage not required.)


Please list all non-prescription medications you have taken in the last 48 hours before your sleep study. (Over-the-counter, herbal, homeopathic, etc.)


Sleep Disorder Awareness

How did you become aware that you might have a sleep disorder and may need a sleep study?

- Your Physician
- Media (radio, TV, newspaper, magazine)
- Website/internet
- Family/Friend