



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, Suite104 85204

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. Please note that if you arrive before your scheduled time, the building might be vacant until the appointment time.**

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, toothpaste, etc.
- If you choose, you may bring any favorite pillow or blanket.
- **If you are using CPAP, having your own CPAP mask is encouraged.**

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.
- Do not apply any lotions, hair conditioners, hair creams or tonics.

When do I leave in the morning?

You will spend the whole night in the sleep lab. In most cases we will awaken 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 @ 5:30a.m.

AFTER 5:00PM or WEEKENDS, IF YOU NEED TO CANCEL YOUR SLEEP STUDY PLEASE CALL (480)659-6449.



Sleep History Questionnaire

Name:	Gender:	DOB:	
Primary Insurance:	Secondary Insurance:		
Primary Care Physician:	Height:	Weight:	Date:

MEDICAL HISTORY

High Blood Pressure	YES	NO
Heart Disease	YES	NO
Lung Disease (Asthma, Bronchitis, Emphysema)	YES	NO
Productive Cough	YES	NO
Sinus Problems	YES	NO
Smoker? How many cigarettes/day? _____	YES	NO
Unexplained Weight Gain	YES	NO

What is your occupation? _____

List any other medical problems: _____

Current Medications:

Do you have allergies? (Please list) _____

Do you have drug allergies? (Please list) _____

Alcohol Consumption: (Please circle) Daily Weekly Rarely Socially None

Caffeine Consumption: _____ drinks/day

How much weight have you lost _____ or gained _____ in the last year?

EXCESSIVE DAYTIME SLEEPINESS AND NARCOLEPSY

Do you get sleepy during the day?	YES	NO
Do you have trouble staying awake during the day?	YES	NO
Have you ever fallen asleep unwillingly at an inappropriate time/place? (talking, eating, driving)	YES	NO
Do you get persistent, uncontrollable sleep attacks?	YES	NO
Do you catch yourself doing activities automatically? (performing routine activities without remembering)	YES	NO
Do you get hypnagogic hallucinations? (Vivid hallucinations while falling asleep)	YES	NO
Do you get sleep paralysis? (inability to move while partially awake)	YES	NO

SLEEP PATTERN

How would you describe your night sleep? (Fragmented, un-refreshing, restless, etc) _____

Do you feel rested in the morning when you wake up? _____

What are your normal sleep hours? _____

How often do you take naps? (never, rarely, usually, daily) _____

Have you ever been told you snore in your sleep? _____

Is your snoring heard from outside the bedroom? _____

Have you ever been told that you stop breathing in your sleep? _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g a theater or a 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 a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
TOTAL	_____			

SLEEP SYMPTOMS

Do you have a bed partner?	YES	NO
If yes, does your sleep upset or affect your partner?	YES	NO
Are you a violent sleeper? (Thrash around, throw off sheets?)	YES	NO
Do you grind your teeth at night?	YES	NO
Do you awaken with headaches in the morning?	YES	NO
Do you awaken with chest pain?	YES	NO
Do you awaken with shortness of breath?	YES	NO
Do you experience fogginess or in coordination upon waking?	YES	NO
Do you or a family member have history with sleep disorder?	YES	NO
Have you ever had a sleep study done before?	YES	NO
Have you ever used CPAP before?	YES	NO
Are you currently on supplemental Oxygen?	YES	NO