East Valley
Center for Pulmonary & Sleep Disorders

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 my 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.

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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	s _____

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 wakening?	○ 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