

Patient Instruction Sheet – Sleep Study

Your health care provider, _____, has requested your attendance for an overnight Sleep Study at ADVANCED SLEEP DISORDER CENTER, located at 1087 Town Center Drive, Orange City FL, on _____ at **8:30 P.M.**

****Please do not arrive before your appointment time unless previously arranged****

Please take the time to read the following instructions carefully. Complete the enclosed forms and bring them with you along with a list of all your medications on your appointment date.

Below are a few things that will better prepare you for your night with us:

1. Try to avoid caffeine (coffee, tea, cola, chocolate, etc) after 5:00PM and eat dinner prior to arrival.
2. Try not to nap on the day of your Sleep Study.
3. Pajamas, nightgown or shorts and a T-shirt are acceptable sleeping attire. Try to avoid satin, nylon and silk fabrics as well as pajamas with elastic around the ankles. Sleeping in undergarments only **is not** allowed. Please be advised that members of the opposite sex may be scheduled for the same night of your study. Please dress appropriately.
4. Personal toiletries such as toothpaste, toothbrush, etc. should be included in your overnight bag.
5. Wash and dry your hair on the day of your sleep test prior to coming to the lab. Please leave hair free of any product. No hairpieces of any type.
6. Do not wear make-up and limit application of moisturizer unless it is prescribed.
7. Remove nail polish and/or artificial nails from at least two fingers.
8. Try to get a normal night's sleep before the test. Unless instructed otherwise by your doctor, continue to take your regular medications.
9. If you are having a CPAP study, it is NOT necessary to bring yours. You may, however, bring your CPAP mask or nasal pillows.
10. Testing usually ends between **5:00AM and 5:30AM**. Please make arrangements for transportation pickup between **5:45 AM and 6:00 AM** if you do not drive yourself.
11. Due to testing requirements, **no one** is permitted to sleep in the bed with the patient. Family and friends are asked to make other arrangements. Should you have any special needs, please contact us prior to your sleep study so that we can make any necessary accommodations or arrangements.
12. Feel free to bring a book or a favorite pillow. Please note each room has a television should you wish to watch TV prior to going to sleep.
13. Please allow 2 - 3 weeks for sleep results to be finalized.

ADVANCED SLEEP DISORDER CENTER is staffed by highly trained healthcare professionals who are committed to making your experience as comfortable as possible. Please be advised that your technician may be of the opposite sex. If you have any questions, concerns or special requests, please contact us at (407) 936-1800 and a representative will gladly assist you.

Please note: Due to the in-depth study processes and appointment limitations, all No Show appointments are subject to a \$250 charge. If you are unable to keep your appointment, please call us to reschedule within 48 hours of your arrival time in order to avoid this charge. Thank you.

1087 Town Center Drive, Orange City FL 32763
(386) 917-0333 OR (407) 936-1800

Patient Signature

Patient Name (Printed)

ADVANCED SLEEP DISORDER CENTER

"Better Sleep, Better Health"

PATIENT NAME _____

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. You may find it useful to use your bed partners observations or comments.

1. Please describe your main sleep problem, in your own words, including when and how this began and what treatment you have received for this in the past.

2. How do you describe your sleep problem?

Check all that apply to you.

- Difficulty falling asleep.
 Wake up during the night
 Excessive daytime sleepiness
 Difficulty awakening

3. Has it been a continuous or an intermittent problem?

- Almost every night
 For periods of at least one week
 Irregularly
 Other _____

4. How long has this problem bothered you?

- Longer than two years
 One or two years
 Several months
 Within the last three months
 Within the last month

5. Do any other members of your family have sleep problems? Yes _____ No _____

If yes, list relationship _____

6. What treatment have you received for your sleep problem?

7. How many hours of sleep do you usually get per night? _____

8. At what time do you go to bed?

WEEKDAYS _____

WEEKENDS _____

9. At what time do you usually wake up?

WEEKDAYS _____

WEEKENDS _____

10. How long does it take for you to fall asleep?

11. If you awakened during the night (after you first fall asleep), which part(s) of your sleep period is it?

- Soon after falling asleep
 Middle of the night
 Early morning

12. How many times do you typically wake up at night? _____

13. If you wake up, in average, how long do you stay awake? _____

EPWORTH 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 times. Even if you have not done some of these things recently, imagine if you were given the opportunity. 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 of dozing

SITUATION

CHANCE OF DOZING

Sitting and reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting and talking to someone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
As a passenger on a car for an hour without a break	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting, inactive in a public place (e.g. a theater or meeting)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Watching TV	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting quietly after lunch (without alcohol)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
In the car while stopped for a few minutes in the traffic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Add the above values to determine your score _____

ADVANCED SLEEP DISORDER CENTER

"Better Sleep, Better Health"

PATIENT NAME _____

Please list all medications you are currently taking, including all sedatives, tranquilizers, sleeping pills and muscle relaxants, even if used infrequently.

	Name	Dose
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Please list all previous surgeries and/or hospitalizations

	Date	Type of Operation and/or Hospitalization	Location	Surgeon
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Has any of your immediate family had: (Please check)

	Yes	No	If yes, who		Yes	No	If yes, who
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____

Exposure History:

	Yes	No	If yes, please explain		Yes	No	If yes, please explain
Asbestos	<input type="checkbox"/>	<input type="checkbox"/>	_____	Animals/Pets	<input type="checkbox"/>	<input type="checkbox"/>	_____
Welding	<input type="checkbox"/>	<input type="checkbox"/>	_____	Soldering	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mining	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other inhalants	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever been given?

Pneumonia Vaccine	When _____	Where _____
Flu Vaccine	When _____	Where _____

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Please rate how often you:

	<u>Never</u>	<u>Rarely</u>	<u>Sometimes</u>	<u>Frequently</u>	<u>Constantly</u>
Awaken from sleep short of breath	<input type="checkbox"/>				
Awaken at night with heartburn, belching or cough or wheezing	<input type="checkbox"/>				
Snore	<input type="checkbox"/>				
Having breathing problems during the night					
Suddenly wake up gasping for breath during the night	<input type="checkbox"/>				
Snore loudly enough that others complain	<input type="checkbox"/>				
Feel unable to move (paralyzed) when waking up or falling asleep	<input type="checkbox"/>				
Fall asleep during the day	<input type="checkbox"/>				
Fall asleep involuntarily	<input type="checkbox"/>				
Fall asleep during physical activity	<input type="checkbox"/>				
Fall asleep while driving	<input type="checkbox"/>				
Fall asleep when laughing or crying	<input type="checkbox"/>				
Remember your dreams	<input type="checkbox"/>				
Have trouble with work or school because of sleepiness	<input type="checkbox"/>				
Notice your heart pounding or beating irregularly during the night	<input type="checkbox"/>				
Experience vivid dreams like scenes upon waking up or falling asleep	<input type="checkbox"/>				
Have nightmares	<input type="checkbox"/>				
Experience any type of leg pain during the night	<input type="checkbox"/>				
Kick during the night	<input type="checkbox"/>				
Grind teeth during sleep	<input type="checkbox"/>				
Notice that part of your body jerk during the night	<input type="checkbox"/>				
Have morning jaw pain	<input type="checkbox"/>				
Experience crawling and aching feelings in your legs	<input type="checkbox"/>				

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Do you have any of the following?

	Yes	No	If yes, please explain		Yes	No	If yes, please explain
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hay fever (allergies)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	_____	Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	_____

Recent lab work:

<u>Test</u>	<u>When</u>	<u>Where</u>	<u>Results if Known</u>
TB Skin Test	_____	_____	_____
Chest X-Rays	_____	_____	_____
Pulmonary Function Test (PFT)	_____	_____	_____

Please list any allergies: _____

Do you currently smoke? No ___ Yes ___ If yes, how many packs? _____

Have you ever smoked? No ___ Yes ___ How long (years)? _____ When did you quit? _____

Do you consume alcoholic beverages? No ___ Yes ___ If so, how much and how often? _____

Do you consume caffeine? No ___ Yes ___ If so, how much and how often? _____

Are you currently using a CPAP or BiPAP machine? No ___ Yes ___

Are you currently using supplemental oxygen? No ___ Yes ___

If yes, who is your current Home Healthcare Company? _____

Please indicate the current pressure of your CPAP / BiPAP _____

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Have you ever been diagnosed with any of the following or are you being treated or followed by a physician for:

	Yes	No	If yes, please explain		Yes	No	If yes, please explain
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____	Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Burn	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Previous Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
BiPolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pulmonary Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchiectasis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumothorax	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Pulmonary Emboli	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any other medical illnesses (not listed above) and date diagnosis

1. _____ Date _____

2. _____ Date _____

3. _____ Date _____

4. _____ Date _____