Very Important Information

Sleep Disorders Center at IU Health North Hospital

- **Plan to arrive at the sleep center at the time specified in the enclosed letter.**
- **Complete the forms** in this packet and bring them with you the night of your study.
- If you need to take any medications before bedtime, bring them with you (including basic medications like aspirin or Tylenol). **Medications CANNOT be provided to you by the sleep center staff.**
- Have your hair clean and dry the day of your test.
- Do not wear makeup or use any products in your hair. Do not apply any heavy creams or lotions to your skin because they alter the quality of your test.
- Bring something to sleep in that is 2-piece and loose fitting.
- Bring your insurance card and a photo id (driver's license).
- Go about your normal day; this includes performing all your usual activities and taking all of your usual medications.
- Try to **avoid**:
  - Naps unless they are a usual part of your day. If you do nap, make it slightly shorter than usual.
  - Excessive amounts of caffeine, more than normal (coffee, tea or cola beverages).
- If you have special needs and you have not already advised your scheduler, call 317.688.2955 prior to your appointment (Mon – Fri, between the hours of 8 am – 5:30 pm).
- If you have not yet spoken to the pre-registration department, call the number listed on the letter at the front of this packet for pre-registration.

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Common Questions Regarding Sleep Testing

Sleep Disorders Center at IU Health North Hospital

What symptoms might lead my doctor to suspect I have a sleep disorder?
Some symptoms include excessive daytime sleepiness, fatigue, depression, insomnia, hypertension, morning headaches, poor concentration and memory loss. Perhaps your bed partner has complaints of loud snoring/snorting, teeth grinding, active leg/body movements during sleep and many others.

What is a sleep test?
The technician assigned to you will apply various monitors to your head, chest, legs, finger, nose, mouth and throat. These specialized devices will record the details of your sleep and tell the doctor about the quality of sleep you are getting, as well as things like oxygen level, heart rhythm, breathing pattern and various other things occurring while you sleep.

How long does this test take?
In order to obtain an accurate account of all the complicated functions of sleep, you are expected to stay for six to eight hours the night of your test. It will take the technician approximately 45 minutes to apply the recording devices and approximately 15 minutes to calibrate the devices to you. During the calibration, you will follow verbal commands given by the technician.

What if I need something or have to go to the restroom in the middle of the night?
Once you are connected to the testing equipment, you can move freely in bed. If you need to leave the bed for any reason, state your request out loud and a technician will be there promptly to assist you.

What is CPAP? What does CPAP do?
CPAP stands for Continuous Positive Airway Pressure. It is a small bedside unit that has tubing and a small mask that is placed gently over your nose and delivers air into your airway. It merely assists your body in breathing while allowing you to rest so that the breathing irregularity does not keep you from sleeping properly. If the technician observes a breathing problem during your study, he/she may awaken you to continue the test with one of these devices.

Will there be TV and DVD available in the room?
Each room has a TV and a DVD player; however, at some point in the evening the technician will ask that you attempt to fall asleep without the TV on for clinical reasons.

Will I be able to have a family member stay with me?
No, we do not have additional rooms for family to stay. If a caregiver is required, the caregiver is to stay in the room monitoring the patient.

PLEASE DO NOT ARRIVE MORE THAN 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

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SLEEP DISORDERS CENTER

PATIENT INFORMATION
(Page 1 of 1)

FOR OFFICE USE ONLY:

Sleep MD: _____

Date: _____ Sex: **Male** **Female**

Name: _____
Last First MI

Address: _____ c/o _____
Street Address City State Zip

Home Phone: (____)_____ Work: (____)_____ Other: (____)_____

Date of Birth: _____ Cell: (____)_____

Primary Care Doctor: _____ Phone: (____)_____

Address: _____
Street Address City State Zip

Patient's Employer: _____

Address: _____
Street Address City State Zip

Patient's Spouse: _____
Last First MI

Spouse's Employer: _____ Phone: (____)_____

Address: _____
Street Address City State Zip

EMERGENCY CONTACT NOT RESIDING WITH PATIENT:

Name: _____
Last First MI

Address: _____
Street Address City State Zip

Home Phone: (____)_____ Work Phone: (____)_____

☐ Spiritual/Cultural implications that impact care

Spiritual Resource: _____ Phone: (____)_____

INSURANCE INFORMATION BELOW MUST BE FILLED OUT COMPLETELY

Primary Insurance: _____ Phone: (____)_____

Subscriber's Name: _____ SS#: _____ DOB: _____

Insurance Address: _____

Policy/ID#: _____ Group/Acct#: _____ Effective Date: _____

Secondary Insurance: _____ Phone: (____)_____

Subscriber's Name: _____ SS#: _____ DOB: _____

Insurance Address: _____

Policy/ID#: _____ Group/Acct#: _____ Effective Date: _____

DOES YOUR INSURANCE REQUIRE HOSPITAL PRECERTIFICATION: ☐ **Yes** ☐ **No**

PARENT/GUARDIAN INFORMATION: *(complete if patient is a child/minor)*

Parent/Guardian Name: _____

Address: _____ Home Phone: (____)_____

Employer: _____ Other Phone: (____)_____

Work Address: _____

Pt. Name_____ DOB_____

Sleep/Medical History Form

Sleep Disorders Center at IU Health North Hospital

PATIENT INFORMATION

Height _____ Weight _____

A) CHIEF COMPLAINT – Please describe your sleep/wake problem and how long it has been present.

_____

_____

B) TYPICAL SLEEP TIMES:	Weekdays	Weekends
Go to bed:	_____	_____
Get out of bed:	_____	_____
Naps during the day:	_____	_____
Time spent asleep:	_____	_____

How many times do you awaken from sleep each night on average? _____

What do you think causes this or what do you notice at that moment? _____

C) PAST MEDICAL HISTORY - List any significant health problems in the following areas.

	Type of Problem	Dates
Allergies to medications	_____	_____
Head or nervous system or stroke	_____	_____
Eyes, ears, nose, throat or mouth	_____	_____
Upper airway allergies	_____	_____
Breathing (lungs)	_____	_____
Heart, circulation or blood pressure	_____	_____
Stomach, digestive	_____	_____
Kidney diseases	_____	_____
Anxiety or depression	_____	_____
Other medical problems (diabetes, thyroid disorder)	_____	_____
Arthritis	_____	_____

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Pt. Name_____ DOB_____

Sleep/Medical History Form

Sleep Disorders Center at IU Health North Hospital

D) PAIN

Origin _____Onset _____

Location _____Quality (i.e. burning, dull ache)_____

Intensity Level: 0 1 2 3 4 5 6 7 8 9 10 Frequency/Duration _____

Aggravating/Relieving Factors _____

Pain Management History _____

Present Pain Management Regimen and Effectiveness _____

Other (Specify)_____

List all prescriptions and non-prescription medicines. Use space below if necessary.

1. _____ Dose _____ times/day _____
2. _____ Dose _____ times/day _____
3. _____ Dose _____ times/day _____
4. _____ Dose _____ times/day _____
5. _____ Dose _____ times/day _____
6. _____ Dose _____ times/day _____
7. _____ Dose _____ times/day _____

Please list all medicines that you are allergic to: _____

_____

_____

_____

_____

(Use this blank space to provide additional information; please continue to complete the following pages.)

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Pt. Name_____ DOB_____

Sleep/Medical History Form

Sleep Disorders Center at IU Health North Hospital

The following list includes possible complaints or problems associated with sleep at night. Please circle the number for each complaint/problem listed. Use the following scale:

0 = never
1 = rarely (once or twice in your life)
2 = sometimes (once or twice each year)
3 = often (once or twice each month)
4 = very often (once or twice each week)
5 = always (every night)

0 1 2 3 4 5	snoring disturbs others
0 1 2 3 4 5	gasp or wake up from sleep choking
0 1 2 3 4 5	stop breathing for short periods
0 1 2 3 4 5	feel paralyzed when falling asleep or waking up
0 1 2 3 4 5	have near hallucinations or dreamlike images when falling asleep or just waking up
0 1 2 3 4 5	have leg cramps at night
0 1 2 3 4 5	uncomfortable, crawling sensation in legs that is relieved by moving or walking
0 1 2 3 4 5	jerk your arms or legs at night
0 1 2 3 4 5	sleep restlessly
0 1 2 3 4 5	have aches or pains at night. Please describe:_____
0 1 2 3 4 5	have problems falling asleep or staying asleep
0 1 2 3 4 5	lie awake feeling depressed, worried or anxious
0 1 2 3 4 5	grind your teeth at night
0 1 2 3 4 5	frightening dreams or nightmares
0 1 2 3 4 5	walk in sleep
0 1 2 3 4 5	talk in sleep
0 1 2 3 4 5	sleep often disturbed by your bed partner
0 1 2 3 4 5	sleep often disturbed by noise or pets
0 1 2 3 4 5	smoke at night
0 1 2 3 4 5	eat in bed at night
0 1 2 3 4 5	watch TV in bed
0 1 2 3 4 5	wake up with nausea or heartburn
0 1 2 3 4 5	wake up with chest pain

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Pt. Name_____ DOB_____

Sleep/Medical History Form

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4 = very often (once or twice each week)
5 = always (every night)

0 1 2 3 4 5	feel unrefreshed in the morning after sleep
0 1 2 3 4 5	find it hard to wake up in the morning
0 1 2 3 4 5	wake up with headaches
0 1 2 3 4 5	irritable
0 1 2 3 4 5	unable to concentrate
0 1 2 3 4 5	poor memory during the day
0 1 2 3 4 5	yawn frequently during the daytime
0 1 2 3 4 5	feel drowsy or sleepy during the day
0 1 2 3 4 5	daytime sleepiness interferes with normal activities
0 1 2 3 4 5	daytime fatigue
0 1 2 3 4 5	have hallucinations or dream-like mental images during the day
0 1 2 3 4 5	have attacks of sudden physical weakness or paralysis when laughing, angry or in other emotional situations
0 1 2 3 4 5	have daytime sleep complaints that seem to go in cycles or only appear at certain times (example: only in the evenings; every 10 days; when you sleep away from home)

E) FAMILY SLEEP HISTORY – Do any of your relatives have a sleep disorder? Yes No

Circle all that apply: mother, father, brother, sister, son, daughter

Circle the type of sleep disorder: sleep apnea, narcolepsy, restless legs, insomnia

F) SOCIAL HISTORY – Please complete the following general information.

Circle whichever applies: live and sleep alone, someone sleeps in a room close by, have a roommate, married

What is your occupation _____

Cups of caffeinated coffee/day _____ Number of caffeinated drinks/day _____

Number of cigarettes, cigars or pipe-fulls of tobacco _____ /day

Number of years smoking _____

Number of alcoholic drinks per week _____

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Pt. Name_____ DOB_____

Sleep/Medical History Form

Sleep Disorders Center at IU Health North Hospital

G) REVIEW OF SYSTEMS - Please check those issues that apply to you.

YES NO

Ear, nose, mouth, throat:
- ___ ___ Frequent sore throat
- ___ ___ Hay fever/allergies
- ___ ___ Sinus trouble
- ___ ___ Tonsillectomy
- ___ ___ TMJ Syndrome

Respiratory symptoms:
- ___ ___ Shortness of breath w/ exertion
- ___ ___ Asthma/Emphysema
- ___ ___ Chronic cough

Cardiovascular symptoms:
- ___ ___ Recurrent chest pain
- ___ ___ Palpitations or arrhythmia
- ___ ___ High Blood Pressure
- ___ ___ History of MI/ heart attack
- ___ ___ Congestive Heart Failure (CHF)

YES NO

Gastrointestinal symptoms:
- ___ ___ Heartburn/GERD
- ___ ___ Mononucleosis or liver disease

Kidney problems:
- ___ ___ Known kidney disease
- ___ ___ Kidney stones
- ___ ___ Prostate problems

Psychiatric issues:
- ___ ___ Depression
- ___ ___ Chronic anxiety
- ___ ___ Panic attacks

Neurological problems:
- ___ ___ Stroke or TIA
- ___ ___ Seizure
- ___ ___ Neuropathy
- ___ ___ Major head injury

YES NO

Musculoskeletal problems:
- ___ ___ Neck or back problems
- ___ ___ Arthritis

Endocrine or gland problems:
- ___ ___ Thyroid disorder
- ___ ___ Heat or cold intolerance
- ___ ___ Diabetes

Constitutional symptoms or issues:
- ___ ___ Poor appetite
- ___ ___ Weight gain over past two years
- _____ (How much weight?)

Other:
_____

If there are other physicians you would like to receive a copy of the test results, please list their names, phone numbers and addresses here:

H) FALLS ASSESSMENT

Have you fallen 3 or more times in the last 3 months? YES NO

If you answered yes to the question above, please answer the questions below.

Were there any injuries resulting from the falls? YES NO

Was an MD informed? YES NO

Name of MD_____ Date informed_____

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Epworth Sleepiness Scale

Sleep Disorders Center at IU Health North Hospital

NAME: _____ Age: _____

Sex: ❒ M ❒ F Today's Date: _____

Please indicate the likelihood that you would fall asleep in the following situation. The 0–3 scale refers to your usual way of life in recent times. 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	_____
Watching television	_____
Sitting, inactive in a public place (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	_____

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Sleep Log

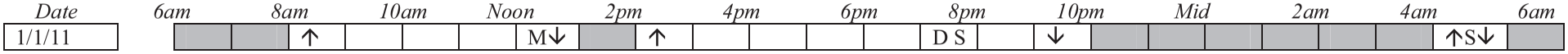
Sleep Disorders Center at IU Health North Hospital

Name _____

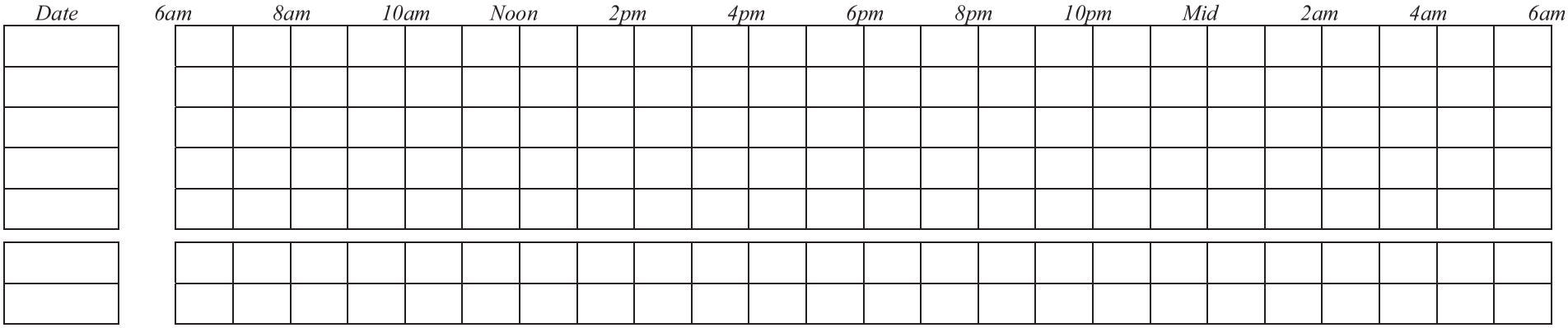
Instructions: (Please bring these logs in for your appointment or mail them to the clinic.)

1. Leave the times you are awake BLANK.
2. SHADE, crosshatch or color the times when you sleep.
3. ARROW DOWN whenever you lie down to sleep.
4. ARROW UPWARD when you awaken (include naps).
5. "M" for meals, "S" for snacks, and "D" for drinks with alcohol.
6. Include notes below each week or on the back.

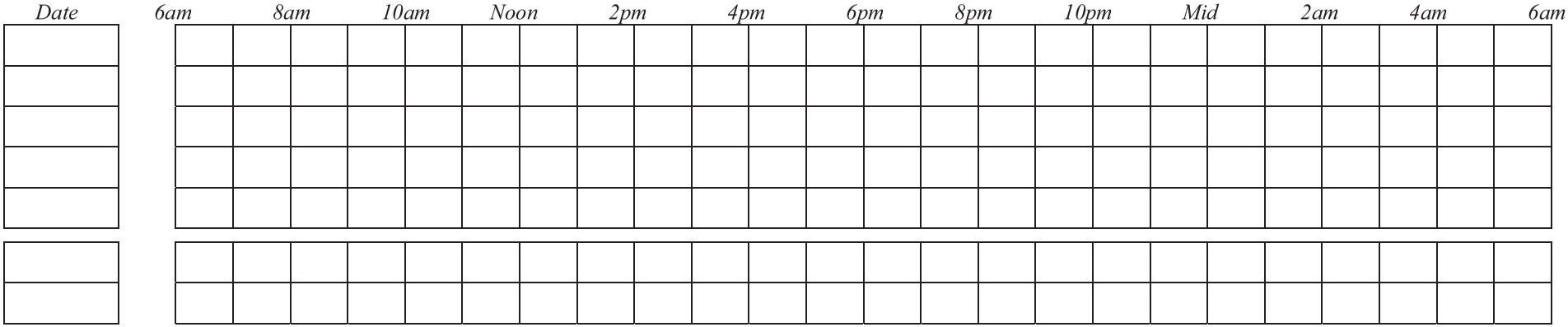
EXAMPLE:



FIRST WEEK



SECOND WEEK



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