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 QUESTIONNAIRE

NAME _____ BIRTHDATE _____ SS# _____
LAST FIRST MI SOCIAL SECURITY NUMBER

ADDRESS _____ CITY _____ FL ZIP _____

MALE / FEMALE _____ HEIGHT _____ WEIGHT _____ MARITAL STATUS _____

Number(s) we may use to contact and/or leave messages regarding your appointments, results and recommendations:

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PLACE OF EMPLOYMENT _____ IF RETIRED, PREVIOUS OCCUPATION _____

(PERSONAL) EMAIL ADDRESS _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY _____ PHONE _____

PRIMARY INSURANCE _____ ID# _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

INS. PHONE # _____ GROUP# _____ NAME OF INSURED _____

RELATIONSHIP TO INSURED _____ BIRTHDATE OF INSURED _____

SECONDARY INSURANCE _____ ID# _____

ADDRESS _____ CITY _____ ST _____ ZIP _____ PHONE # _____

PHYSICIAN WHO ORDERED SLEEP STUDY _____ OFFICE PHONE# _____

PRIMARY CARE PHYSICIAN _____ OFFICE PHONE# _____

I hereby authorize my insurance benefits to be paid directly to the Advanced Sleep Disorder Center. I hereby authorize release of pertinent medical information to insurance carriers, medical equipment companies and /or other physicians for the continuation of health care. I understand that if my appointment is not cancelled within the guidelines of our confirmation policy, I will be responsible for a $250 cancellation fee.

Patient Signature _____ Date _____

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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 the 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?_____

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

Add the above values to determine your score _____

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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	☐	☐		Lung Cancer	☐	☐	
Hypertension	☐	☐		Asthma	☐	☐	
Kidney Disease	☐	☐		Cancer	☐	☐	

Exposure History:

	Yes	No	If yes, please explain		Yes	No	If yes, please explain
Asbestos	☐	☐		Animals/Pets	☐	☐	
Welding	☐	☐		Soldering	☐	☐	
Mining	☐	☐		Other inhalants	☐	☐	

Have you ever been given?

Pneumonia Vaccine When_____ Where_____

Flu Vaccine When_____ Where_____

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PATIENT NAME

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

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Do you have any of the following?

	Yes	No	If yes, please explain		Yes	No	If yes, please explain
Fevers	☐	☐	_____	Cough up blood	☐	☐	_____
Wheezing	☐	☐	_____	Shortness of Breath	☐	☐	_____
Chest Pain	☐	☐	_____	Difficulty swallowing	☐	☐	_____
Cough	☐	☐	_____	Hay fever (allergies)	☐	☐	_____
Cough up phlegm	☐	☐	_____	Recent weight change	☐	☐	_____

Recent lab work:

Test	When	Where	Results if Known
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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_____
PATIENT NAME

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	☐	☐	_____	Depression	☐	☐	_____
Heart Failure	☐	☐	_____	Sinusitis	☐	☐	_____
Angina	☐	☐	_____	Poliomyelitis	☐	☐	_____
Hypertension	☐	☐	_____	Cancer	☐	☐	_____
Heart Burn	☐	☐	_____	Arrhythmia	☐	☐	_____
Previous Stroke	☐	☐	_____	Stomach Ulcers	☐	☐	_____
Diabetes Mellitus	☐	☐	_____	Colitis	☐	☐	_____
Anxiety	☐	☐	_____	Arthritis	☐	☐	_____
Bronchitis	☐	☐	_____	Asthma	☐	☐	_____
BiPolar Disorder	☐	☐	_____	Emphysema	☐	☐	_____
Fibromyalgia	☐	☐	_____	Pneumonia	☐	☐	_____
Thyroid Problems	☐	☐	_____	Tuberculosis	☐	☐	_____
Pleurisy	☐	☐	_____	Seizures	☐	☐	_____
Obesity	☐	☐	_____	Pulmonary Fibrosis	☐	☐	_____
Bronchiectasis	☐	☐	_____	Pneumothorax	☐	☐	_____
				Pulmonary Emboli	☐	☐	_____

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

1._____ Date_____

2._____ Date_____

3._____ Date_____

4._____ Date_____