DATE SCHEDULED: ____________________

ARRIVAL TIME: ____________________

Directions to Sweet Dreams Sleep Center:


On the Day of Your Study:

• Bring comfortable, loose fitting clothing or pajamas to sleep in.

• Bring any toiletries that you would need for an overnight stay. Private room and bathroom are available for your convenience. Shower facilities are not available.

• You should continue taking any prescription medications unless your physician has advised otherwise.

• Avoid alcohol and caffeine (chocolate, coffee, tea, and soda) after 12:00PM on the day of the study.

• Do not use hair gels, spray, oils, make-up and/or skin lotions.

• Avoid taking a nap on the day of your study.

• We recommend that you eat prior to arriving for your study. Food is not provided.

• Complete ALL paperwork, questionnaires and consent forms prior to arriving for your appointment.

• Please bring your insurance card(s), and referrals to your appointment.

• Your study will end at 5:45AM at which time the technician will remove your sensors and you will be given time to freshen up prior to leaving.

• The lab closes at 6:15AM. Please be sure transportation is available at this time.
What is a Sleep study?

Type 1: Polysomnogram

A sleep study is a method that records brain waves, breathing patterns, muscle activity, heart activity, oxygen saturation and eye movement while you are sleeping. Sensors, electrodes, and monitoring equipment will be attached to the body with tape paste prior to bedtime. These sensors transmit data to a computer and recording continuously monitored by a certified technologist. A technologist will monitor and keep a record throughout the night. He or she will be available to assist you with anything you need including trips to the restroom. You will be video monitored to document sleep position including snoring and any other activity that happens throughout the night. If your test is positive for sleep apnea, then a second overnight stay is required to prepare you for the use of CPAP.

Type 2: Split-night Sleep study:

If your physician has ordered a split night study, the technologist will assist you using CPAP (Continuous Positive Airway Pressure) therapy will be considered after 2 hours of diagnostics monitoring.

What is Continuous Positive Airway Pressure?

CPAP is a machine used to treat sleep apnea. Positive air pressure is delivered through a nasal or mask and using splints to open the airway. This positive pressure will prevent obstruction or collapsing of the airway that causes apnea which means pauses in breathing. During this part of the test, the technologist will adjust the levels of the air pressure to determine what level works best for you.

What happens after the Study?

The recording of your sleep study will be stored permanently at Sweet Dreams Sleep Center. It will be interpreted and analyzed by a board certified doctor. The information will be forwarded to your referring doctor and you will be contacted by a representative at Sweet Dreams Sleep Center as soon as the results are available. If your test is positive, a follow up appointment will be scheduled with our sleep center. During you visit, you will be discuss the results of your study and treatment options with a physician.
Please Read and Sign the Following Statements

Consent for Release of Information and Physician Reimbursement:

I certify that the patient and insurance information provided to Sweet Dreams Sleep Center is accurate and authorize the release of any medical information necessary to process any medical claims. I authorize my insurance company to remit benefits for the services provided directly to Sweet Dreams Sleep Center.

Financial Agreement:

I understand that payment for any services are not covered or denied by my insurance (co-payments, deductible, pre-existing condition, failure to obtain a prior authorization or referral, etc.) will be my responsibilities. I understand that if my account is forwarded to a collection agency, I will be responsible for any and all reasonable collection and/or attorney fees.

Medical Records

I ____________________________, hereby authorize Sweet Dreams Sleep Center to release my medical/psychological records to:___________________________________________________________

Address:___________________________________________________________________________________________

Phone #: (_____) _________-___________________ Fax # (_____)_________ ________________________________

Print Name:_______________________________________________________________________________________

Video and Monitoring Consent

As part of my diagnostic sleep study, I fully understand that video surveillance is required.

__________I hereby authorize the use of video surveillance for the purpose of medical diagnosis.

Patient Signature (or responsible party)_____________________________________________ Date:________________
SLEEP HISTORY QUESTIONNAIRE

Name: ____________________________________________ Date of Birth: ____________________________________________
Age: ____________________ Sex: ____________________ Height: ________________ Weight: ______________

List any previously diagnosed sleep disorders: ____________________________________________________________

List all prescription and non-prescription medications you are currently taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason Taken</th>
<th>Dose</th>
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List any allergies below:

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<thead>
<tr>
<th>Allergy</th>
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List all past or present medical conditions and/or surgeries:

<table>
<thead>
<tr>
<th>Condition</th>
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Check if you have had any of the following:

- Acid Reflux
- Bleeding Disorder
- Head Injury or Brain Surgery
- Parkinson’s disease
- Allergies/Hay Fever
- Dizziness
- High Blood Pressure
- Prostate Disease
- Anemia
- Emphysema
- Heart Murmur/Palpitations
- Seizures
- Anxiety
- Enlarged Tonsils/Adenoids
- Heartburn
- Sinusitis
- Asthma
- Fibromyalgia
- Impotence
- Stroke
- Back pain
- Headaches/Migraines
- Muscle Aches/Cramps
- Tuberculosis
- Bipolar Disorder
- Heart Failure/Heart Attack
- Menopause
- Thyroid Condition
- Weakness/Paralysis
- Other
SLEEP HISTORY QUESTIONNAIRE - SLEEP PATTERNS

1) On Workdays
   What time do you go to bed? ___:____AM/PM
   What time do you wake up? ____:____AM/PM Usual
   Amount of sleep you get? ________Hours

2) On weekends/Days Off/Holidays
   What time do you go to bed? ____:______AM/PM
   What time do you get out of bed?____:_____AM/PM
   Usual amount of sleep you get? _______Hours

3) How long does it take you to fall asleep? ________ Minutes

4) How many times do you awaken? ____________
   A. How long does the awakening last? _____:_______Minutes/ Hours
   B. List any symptoms or reasons for awakenings? ____________________________________________

5) Do you feel un-refreshed and still sleepy upon awakening? ___Yes ___No ___Sometimes

6) How long does it take you to fully awaken in the morning? __________________________________

7) How many hours of sleep does it take to make you feel rested? ________________________________

8) Do you wake up too early and are unable to go back to sleep? ___Yes ___No ___Sometimes

9) Do you have a special routine when going to bed? ___Yes ___No

10) What is your usual sleeping position? ___Back ___Side ___Stomach ___Varies

11) Do you take medication (prescription or over-the-counter) to help you fall asleep?
    ___Yes (If yes what do you take? __________________Dosage) No

12) Do you have wandering thoughts or does your mind race as you are trying to fall asleep?
    ___Yes ___No

13) Do you sleep with a bed partner?
    ___Yes ___No

14) Does your sleep problem affect your bed partner?
    ___Yes ___No ___Sometimes
SLEEP HISTORY QUESTIONNAIRE

___Yes  ___No 1. Are you sleepy during the day?
___Yes  ___No 2. Has there been a recent change in your sleepiness?
___Yes  ___No 3. Do you take naps? (if yes, how often?______ weekly)
___Yes  ___No 4. Do you dream during naps?
___Yes  ___No 5. Are these naps refreshing?
___Yes  ___No 6. Have you ever experienced weakness or paralysis while laughing or angry?
___Yes  ___No 7. Have you ever had hallucinations or dreamlike images while not actually asleep?
___Yes  ___No 8. Do you have trouble concentrating or difficulty remembering thing.
___Yes  ___No 9. Do you snore?
___Yes  ___No 10. Do you snore every night?
___Yes  ___No 11. Does your snoring disturb others?
___Yes  ___No 12. Does your sleep position affect your snoring?
___Yes  ___No 13. Have you or anyone else noticed pauses in your breathing during sleep?
___Yes  ___No 14. Have you ever awakened gasping or short of breath?
___Yes  ___No 15. Do you awaken with a dry mouth or throat?
___Yes  ___No 16. Do you have morning headaches?
___Yes  ___No 17. Do you breathe through your mouth while you are asleep?
___Yes  ___No 18. Do you have difficulty breathing through your nose?
___Yes  ___No 19. Do you experience unpleasant leg or arm sensations at bedtime?
___Yes  ___No 20. Do you kick or jerk your legs during sleep?
___Yes  ___No 21. Do you have pain which delays or prevents you from falling asleep?
___Yes  ___No 22. Do you have pain which awakens you from sleep?
___Yes  ___No 23. Do you have frequent nightmares or vivid dreams?
___Yes  ___No 24. Do you grind your teeth or have you ever bitten your cheek during sleep?
___Yes  ___No 25. Have you ever walked or talked in your sleep?
___Yes  ___No 26. Have you ever been unable to move for moments as you are awakening from sleep?
___Yes  ___No 27. Have you ever had unusual movements or behaviors during sleep?
___Yes  ___No 28. Have you ever wet the bed (as an adult)?
___Yes  ___No 29. Have you ever fallen out of bed (as an adult)?
___Yes  ___No 30. Do you get out of bed frequently to urinate?
**THE 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** = would *never* doze
- **1** = *slight* chance of dozing
- **2** = *moderate* chance of dozing
- **3** = *high* chance of dozing

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
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<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
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<tr>
<td>Sitting, inactive in a public place (e.g. a theater or a meeting)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after a lunch without alcohol</td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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<tr>
<td><strong>Total Epworth Score</strong></td>
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</table>
# Social History

___Yes  ___No  1. Do you smoke? (If yes, how many times per day? ______)

___Yes  ___No  2. Have you ever smoked? (If yes, how many years? ______ How much? __________

___Yes  ___No  3. Do you drink alcohol?

___Yes  ___No  4. Do you consume caffeine? (soda, coffee, tea, etc.) (If yes, how much daily? ________)

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<table>
<thead>
<tr>
<th>Is there a History of</th>
<th>Sleep Apnea</th>
<th>Heavy Snoring</th>
<th>Narcolepsy</th>
<th>Restless Leg Syndrome</th>
<th>Other Sleep Disturbances</th>
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</thead>
<tbody>
<tr>
<td>Mother</td>
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<td>Father</td>
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<td>Sister</td>
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<td>Brother</td>
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<tr>
<td>Grandparents</td>
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