



Sleep Study Information Sheet

Study Date: _____ **Time of Arrival to Sleep Lab:** _____

A polysomnogram is a test designed to monitor and evaluate your sleep characteristics and physical state during sleep. You will spend the night in a private bedroom at the sleep center. Every attempt is made to make you as comfortable as possible. Small electrodes or sensors will be attached to your body to monitor sleep efficiency, breathing patterns, heart function, muscle activity and other parameters. All patients are routinely video taped to correlate body position and movement with physiologic data. Other parameters may be monitored and if so, they will be explained to you. We need to collect AT LEAST (6) hours of data. Please arrive at the sleep center at the date and time as shown above.

***Light Snacks and Beverages are available before bed.**

***A full complimentary breakfast is available after the sleep study is completed.**

INSTRUCTIONS:

- 1. Please wash your hair the day of the study. Please try not to use hairspray, cream rinse or conditioners for they may interfere with the sensors used during the study.**
- 2. Take your regular medications unless instructed otherwise by your physician.**
- 3. Please try to get a normal night sleep the night before the study. Do not take any naps during the day of the study.**
- 4. Do not drink any beverages containing alcohol what so ever.**
- 5. Do not drink any beverages containing caffeine four (4) hours prior to the study.**
- 6. Please park in the St. Clare Medical Building parking garage. As you enter the lobby area of the St. Clare Medical Building, we are located in Suite M20 on the ground floor.**
- 7. You must have a written prescription from the ordering physician with you. If you do not have a written prescription, the sleep study cannot be performed. Please also make sure you have your insurance card and referral if required.**
- 8. Please complete and bring the enclosed questionnaire with you to the night of your study.**
- 9. Please bring something to sleep in (pajamas, tee-shirt, shorts or what ever you are comfortable in).**
- 10. There is a TV/VCR/DVD in the room. You may bring a movie or something to read. Also feel free to bring your own pillow or blanket for his/her comfort.**
- 11. Private bathroom facilities are provided for your convenience.**

Sleep Evaluation Questionnaire



Sleep/Wake Disorder Center
 Langhorne – Newtown Road – Langhorne PA 19047
 Tel: (215) 710-6744 Fax: (215) 710-6695



Patient Information

Name:	Date of Birth:
Gender: Male / Female	Age:
Address:	Spouse Name:
Social Security #	Phone: (H) _____ (W) _____ (C) _____
Height:	Weight:

Insurance Information

Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____

Policy#: _____ **Group#:** _____
Name of Insured: _____ **Relation:** _____
Medicare#: _____ **Medicaid#:** _____

Physician Information

Referring Physician: _____ **Phone#:** _____
Address: _____

Primary Care Physician: _____ **Phone#:** _____
Address: _____

May we contact your physician for further information? Yes _____ **No** _____
 (PLEASE INCLUDE PHYSICIAN(S) FULL NAME AND ADDRESS FOR PROPER MAILING OF TEST RESULTS)



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. This information will be held in strict confidence.

1. Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past.

2. Has it been a continuous or intermittent problem?

Almost every night.

For Periods of at least one week

Irregularly

Other (Please Explain) _____

3. How long has this particular problem bothered you?

Longer than two years.

One to two years.

Several Months

Within the last three months

Within the last month.

4. How do you describe your sleep problem? (Check all that apply to you)

Difficulty falling asleep

Waking up during the night.

Excessive daytime sleepiness

Difficulty Awakening



Family Sleep History

Does any family member have a sleep disorder? Yes / No

If so, who? _____

Please circle the sleep disorder:

- Insomnia
- Snoring
- Sleep Apnea
- Restless Legs Syndrome
- Periodic Limb Movement Disorder
- Sleepwalking / Sleep Terrors
- Sleep Talking
- Narcolepsy
- Other: _____

Personnel Sleep History

- How many hours of sleep do you usually get per night? _____
- What time do you usually go to bed? Weekdays: _____ Weekends: _____
- What time do you usually wake up? Weekdays: _____ Weekends: _____
- How long does it take you to fall asleep? _____
- How many times do you typically wake up at night? _____
- If you do awaken 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

Please list if any treatment that you have received for your sleep problem



Past Medical History

Please circle any Current or Past Medical Problems that you incurred (if any) and note date diagnosed.

- Frequent nasal congestion _____
- Trouble breathing through his/her nose _____
- Sinus problems _____
- Chronic bronchitis or cough _____
- Allergies : (Please Describe) _____
- Asthma _____
- Frequent colds or flu _____
- Frequent ear infections _____
- Frequent strep throat infections _____
- Difficulty swallowing _____
- Acid reflux (gastro esophageal reflux) _____
- Poor or delayed growth _____
- Excessive weight _____
- Hearing problems _____
- Speech problems _____
- Vision problems _____
- Seizures/Epilepsy _____
- Morning headaches _____
- Cerebral palsy _____
- Heart disease _____
- High blood pressure _____
- Sickle cell disease _____
- Genetic disease _____
- Chromosome problem (e.g., Down's) _____
- Skeleton problem (e.g., dwarfism) _____
- Craniofacial disorder (e.g., Pierre-Robin) _____
- Thyroid problems _____
- Eczema (itchy skin) _____
- Pain _____
- Attention Deficit Disorder (ADD) _____



PAST PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Please list your past psychiatric/psychological history (if any).

Current Medications

Please list any medications and dose you are currently taking:

1. _____
2. _____
3. _____
4. _____

Are you being treated or followed by a physician for lung disease?

_____ YES _____ NO (Circle) Bronchitis or Emphysema

Are you being treated or followed by a physician for heart disease?

_____ YES _____ NO (Circle) Angina / Heart Failure / Arrhythmia / Heart Attack
Diabetes Mellitus / Hypertension

Do you Smoke?

_____ YES _____ NO If yes, how much and how often? _____

Do you consume alcoholic beverages?

_____ YES _____ NO If yes, how much and how often? _____



Do you consume caffeine?

 YES NO If yes, how much and how often? _____

Please Rate how often you:	Never	Rarely	Sometimes	Frequently	Always
Awaken from sleep short of breath.					
Awaken at night with heart-burn, belching or with cough or wheezing.					
Snore					
Snore loudly enough that others complain.					
Suddenly wake up gasping for breath during the night.					
Have breathing problems during the night.					
Notice your heart pounding or beating irregularly during the night.					
Fall asleep during the day					
Fall asleep involuntarily					
Fall asleep while driving					
Fall asleep during physical effort					
Fall asleep when laughing or crying					
Experience muscle weakness when extremely emotional					
Have trouble at school or work because of sleepiness					
Feel unable to move (paralyzed) when waking up or falling asleep.					



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Please Rate how often you:	Never	Rarely	Sometimes	Frequently	Always
Experience vivid dream like scenes upon waking up or falling asleep.					
Have nightmares.					
Remember your dreams.					
Notice that parts of your body jerks during the night.					
Kick during the night					
Experience crawling and aching feeling in your legs.					
Experience any type of leg pain during the night.					
Have morning jaw pain					
Grind teeth during sleep.					

How did you first hear about our Center for Sleep Disorders?

_____ Physician

_____ Relative

_____ Friend

_____ Newspaper (Please list exact name) _____

_____ TV (Please list exact name) _____

_____ Radio (Please list exact name) _____

_____ Seminar/Lecture/Workshop



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**

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and Reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., Theater or a Classroom)	_____
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	_____
In a Car, While stopped for a few minutes in traffic	_____

THANK YOU FOR YOUR COOPERATION