Sleep and Wellness Center
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Appt. Date _____ Appt. Time _____

SLEEP STUDY CONSULT INSTRUCTIONS

PLEASE FILL OUT THE ENCLOSED QUESTIONNAIRE AND BRING IT TO YOUR APPOINTMENT WITH:

Carol Pelletier, ARNP

WE WOULD ALSO LIKE YOU TO BRING THE FOLLOWING ITEMS TO OUR APPT:

1.) A REFERRAL, IF REQUIRED BY YOUR INSURANCE COMPANY

2.) YOUR INSURANCE CARD OR CARDS

3.) ANY MEDICATIONS YOU ARE PRESENTLY TAKING, INCLUDING OVER THE COUNTER, IN THE ORIGINAL CONTAINERS.

4.) PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME TO FILL OUT PAPERWORK.

THANK YOU

FAQ

What should I expect during my initial consultation with the sleep specialist?

During your first visit you will meet with the physician/sleep specialist. The purpose of this evaluation is to identify any medical conditions that may be interfering with your sleep or any easily correctable behavioral patterns that may be interfering with your ability to get good rest. Your visit will start with a history and a review of your questionnaire. Please feel free to bring a spouse, family member, or a friend who can provide additional details about your condition. Next, you will have a physical examination. Special attention will be directed at clues to your sleep problem.

Based on this evaluation, you may be sent for laboratory testing, x-rays, or an overnight sleep study. You may also be referred back to your primary care physician for further medical evaluation.

What can I expect if a sleep study is needed?

The basic sleep study consists of an overnight test during which you sleep in the laboratory of the Sleep Disorder Center. You will be asked to arrive at the sleep lab about 15 minutes prior to your scheduled testing time. Setting up for the test takes about one hour. During that time you will be hooked-up to various monitors, including wires that rest on your scalp to monitor sleep stages, EKG (heart) monitoring, and a devise on your finger to monitor oxygen levels during the night. A belt will be placed around your chest and abdomen to record your breathing movement, and strips near your nose and mouth will monitor airflow. Many people ask if they will be able to sleep like this! Please be assured that people do manage to get enough sleep for a diagnosis to be made.

After you are set up for monitoring, you may watch TV in our living room where there are also some snacks and beverages provided for you. You can expect to go to bed around 10:00pm. You will be asked to sleep in a private, darkened, quite, climate controlled room. You will be monitored by infrared camera and a microphone. Please do not hesitate to speak to the technician about your needs, or if you need to use the restroom.

At approximately 6:00am the next morning, you will be awakened. Unless further testing was ordered, you will be unhooked from the monitoring equipment and you may go home at this time. There is a shower available in the sleep center for those patients who wish to go directly to work.

In some cases prior arrangements will have been made for a MSLT or nap test. In these cases, the wires will be left on. You will then stay in the sleep center and be asked to attempt to sleep over four or five daytime nap opportunities. Breakfast and lunch will be provided. At the latest you can expect to be ready to leave the sleep center at 3:30pm.

When will I get my results?

Analysis of the sleep study takes a considerable amount of time. Over the course of the evening, literally hundreds of pages of data will have been gathered for the computer-assisted analysis, which is part of the evaluation. The results will be carefully screened by one of our physicians. Full analysis takes approximately two to three weeks. In most cases arrangements will have already been made for a follow-up visit with your provider to go over your test results and discuss treatment options.

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT

Name: _____ Telephone (Home):_____

Address:_____ Telephone (Work):_____

City: _____ State:_____Zip Code:_____

Primary Care Physician:_____Ph#:_____

Approximate: Height: _____ Weight:_____

My main sleep complaint is:

☐ I have trouble sleeping at night

☐ I am sleepy all day

☐ I have unwanted behaviors when I'm sleeping

Explain:_____

_____

_____

_____

Current medical conditions for which I am being treated are:

_____

_____

_____

Medications I am currently taking are:

_____

_____

_____

SLEEP HABITS

On weekdays (work days) I usually go to bed at: _____

On weekdays I wake up at:_____

The number of days I nap each week: _____

The amount of time I usually wake up during the night: _____

If I wake up during the night, the time it takes me to fall asleep again: _____

My (estimated) total sleep time per night is: _____

Place a check beside any of the following statements that are true for you:

☐ I have a job that involves shift work or night work

☐ I frequently travel across time zones (east-west travel)

☐ I feel that sleep is a waste of time

☐ I enjoy sleeping very much

☐ I usually sleep with a bed partner

☐ I sleep with earplugs or eyeshades

During the first 30 minutes after waking up in the morning, I usually feel:

☐ Very groggy

☐ Somewhat drowsy

☐ Slightly drowsy, but awake

☐ Alert

DAYTIME SLEEPINES

☐ I have sometimes fallen asleep at very inappropriate times, such as driving, eating or during conversation

☐ I have sometimes been so sleepy that I become confused or lose track of the topic during a conversation

☐ I have frequently been so sleepy during the day that my work is poor

☐ I frequently do not feel sleepy at bedtime and stay up until it is so late that as a consequence I get too little sleep

☐ I would feel better if I slept at least one more hour every night

☐ I feel that I sleep too much

☐ I feel that I sleep too little

☐ I function best in the morning

☐ I function best in the evening

☐ I've "come to" or suddenly become alert and found myself doing things without being aware of having started them or how I got there

☐ I generally feel: ☐ Tired ☐ Sleepy …….all day

☐ When I get a good night sleep I feel better the next day

☐ Several times recently I got up later than planned, even though I went to bed at the right time

☐ Usually I find myself falling asleep during even half-hour TV shows

☐ Sometimes I perform a complex act, such as driving a car to the wrong destination, and don't remember how I did it

☐ I sometimes find myself doing things which make no sense (such as writing nonsense or mixing chocolate and gravy)

☐ I've had a sensation of a sudden weakness in my legs while awake (this may occur particularly in emotional situations, such as laughter or anger

☐ I sometimes have felt paralyzed or unable to move when waking up or falling asleep

☐ I have hallucinations or dream like images when I am not actually asleep, but while falling asleep or waking up

PARASOMNIAS

☐ I have been told that I grind my teeth when I sleep

☐ Sometimes a person cannot sleep in the same room with me because he/she is bothered by my snoring

☐ As an adolescent or adult I have been sleep-walking

☐ As an adolescent or adult I have been sleep-talking

☐ My dreams are often very vivid

☐ I feel that I dream too much

☐ My dreams often awaken me

☐ I often have frightening dreams

☐ As an adult I have wet my bed

☐ I've been told that I bang or twist my head at night

DISTURBED SLEEP

☐ I have been told that I snore very loudly

☐ Sometimes a person cannot sleep in the same room with me because he or she is bothered by my snoring

☐ My bed covers are very messed up in the morning

☐ I am a very restless sleeper

☐ I have been told that I hit or poke my bed partner while I am asleep

☐ I sometimes awaken with a choking sensation

☐ I've been told that I stop breathing when I sleep

☐ I have fallen out of bed

☐ I have been told that I make rolling or rocking movements during my sleep

☐ I wake up suddenly from sleep with an unpleasant feeling of fear, anxiety, tension, or unhappiness

☐ I wake up suddenly from sleep once or more having vomited

☐ When I wake during the night I often have to get up to go to the bathroom

☐ I sweat a lot when I sleep

☐ I have difficulty breathing through my nose at night

☐ I feel the quality of my sleep is unsatisfactory

☐ I have been told that my legs twist or jerk while I am sleeping

☐ I sometimes wake up with a headache

☐ I sometimes have pain in my heart

☐ I usually have a bitter taste in my mouth when I awaken at night or in the morning

☐ I often awaken with a dry mouth

INSOMNIA

☐ I have trouble falling asleep at night

☐ When I do not sleep well I worry about it the next day

☐ When I wake up during the night I have trouble going to sleep

☐ I wake up in the morning long before I have to

☐ Some nights I never get to sleep no matter how hard I try

☐ When I try to go to sleep my mind races with many thoughts

☐ At night when I go to bed I do not feel sleepy

☐ I often sleep better in an unfamiliar bedroom, such as a hotel or motel room

☐ When I try to fall asleep I become anxious and nervous

☐ When I try to fall asleep I worry about whether or not I can sleep

☐ When I try to fall asleep I often feel hungry or thirsty

☐ When I try to fall asleep I feel pain

☐ Pain often wakes me up or keeps me from going back to sleep

☐ I often take sleeping pills in order to sleep

☐ I have a creeping, crawling sensation in my legs when I lie down to sleep

☐ When I do sleep I feel that I sleep very well

☐ I am a very light sleeper and am easily awakened by noises

☐ My sleep is disturbed because of my bed partner

☐ Heat or cold disturbs my sleep

☐ Noise or light disturbs my sleep

☐ My bed is uncomfortable

☐ Generally I get up in the middle of the night for a snack

MEDICAL CONDITION

☐ I have been told that I shake my head at night

☐ I have been told that I have convulsions, fits, or seizures at night

☐ I have had convulsions, fits, or seizures during the day

☐ I have bitten my tongue while I sleep

☐ I sometimes wake up with heartburn

☐ I sometimes wake up with lower back pain

☐ I sometimes wake up with the feelings of aching or "pins and needles" in my legs

☐ I am unable to sleep in a flat position because of shortness of breath

☐ I sometimes cough-up sputum or mucus during the night or in the morning

☐ I have gained more than 10lbs. in the last year

☐ I have been told that I have high blood pressure

☐ I rarely drink alcoholic beverages

I CONSUME THE FOLLOWING:

	AMOUNT	
	WEEKDAYS	WEEKEND DAYS
Bottles/Cans of Beer	_____	_____
Glasses of Wine	_____	_____
Shots of Liquor	_____	_____

I use alcohol to get to sleep ☐ Often ☐ Sometimes ☐ Never

MEN

☐ I awaken with painful penile erections

☐ I have problems obtaining or maintaining penile erections

WOMEN

☐ My sleep problem(s) varies according to the stage of my menstrual cycle

☐ I am currently taking birth control pills

☐ My sleep problems started and got worse at menopause

SLEEP HISTORY

Place a check beside any of the following statements that are true for you. If possible, please ask your parents or older sibling(s) to help you remember your childhood behavior

☐ I sometimes wet the bed after the age of 6

☐ As a child I talked in my sleep

☐ As a child I sleepwalked

☐ As a child I screamed in my sleep

☐ As a child I had convulsions during sleep

☐ As a child I banged or rocked my head on the bed to sleep

☐ My current sleep problem(s) started in childhood

☐ I used to fall asleep in school as a child or adolescent

☐ I always had to fight the urge to sleep during my classes at school when I was a child or adolescent

☐ As a child I used to stay up late in the evening

☐ I was told that I snored while sleeping as a child or teenager

☐ I was considered a hyperactive or hyperkinetic child or teenager

FAMILY HISTORY

These questions apply to your extended family (such as parents, children, aunts, uncles, ect). Please included answers for only those family members that are related by blood.

☐ A relative died from "crib death" or sudden infant death

☐ Other members of my family have insomnia

☐ Other members of my family snore loudly at night

☐ Other members of my family frequently fall asleep during the day or evening

☐ Other members of my family are troubled by sudden attacks of physical weakness

or paralysis, particularly in emotional situations

☐ Other members of my family have been hyperactive or hyperkinetic

☐ Other members of my family have the same sleep problem(s) that I do

ALLERGIES

☐ None

☐ Medications Please list: _____

☐ Other (ex: food, environment) Please list: _____

HABITS

☐ Cigarettes _____Pack(s) per day for _____years

☐ Former smoker _____Pack(s) per day for _____years

☐ Marijuana

☐ Other substance(s) Please List: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of the things recently, think about how they would have affected you.

USE THE FOLLOWING SCALE TO CHOOSE THE MOST APPROPRIATE NUMBER FOR EACH SITUATION:

0 = WOULD NEVER DOSE OFF 2 = MODERATE CHANCE OF DOZING
1 = SLIGHT CHANCE OF DOSING 3 = HIGH CHANCE OF DOZING

*Please note: It is very important that you put a number (0-3) one each line below

SITUATION	**CHANCE OF DOZING** (0-3)
Sitting and reading	_____
Watching Television	_____
Sitting inactive in a public place (ex: theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (when you've had no alcohol)	_____
In a car while stopped in traffic	_____