If you are unable to keep an appointment, you are expected to call and let us know at least 24 hours ahead of time. Missing your appointment is not helpful to you. It also means that others cannot use that appointment time.

PLEASE BRING YOUR INSURANCE CARD WITH YOU TO YOUR APPOINTMENT.

Most people have some questions about what will happen during their sleep study. The following information will try to address these questions, but if not, please do not hesitate to call me.

1. Early in the evening, you will need to shower or bathe, wash your hair and dry it. Do not use mousse or gel in your hair. You must remove any hair pieces glued to the scalp prior to your appointment. Please do not use any lotions or powders on your skin, unless prescribed by your physician. This allows for good contact between the monitoring devices and the skin. You will want to wash your hair in the morning to remove the paste used to monitor your EEG (brain waves).

2. If you are clean shaven, please shave again in the evening. Monitoring devices will be taped to the face and legs, and whisker stubble on the chin (men) or on the lower legs (women) may make it difficult for the tape to stick, If you have a full beard, don't worry about it! Our technicians will work around it.

3. Take all of your medication as you normally do. If they are sleeping pills or tranquilizers, please check with the physician who ordered your study. They may want your sleep monitored without the aid of sleeping medication.

4. Feel free to eat and drink as you normally do with the exception of beverages containing caffeine. Please do not drink any caffeine after noon. Caffeine does interfere with your sleep.

5. Your sleep attire should be loose fitting, comfortable garments (shorts, tee-shirt, pajamas, or night gown.)

6. Please note: This facility does have showers available. It is wise to bring your usual toiletries (toothbrush, soap, shampoo, etc.) as you may wish to use these items in the morning.

Please call 24 hours in advance if you are unable to make your appointment! No shows may be charged an out of pocket expense which will not be covered by your insurance provider.

We appreciate you allowing us to participate in your care. Again, if you have any questions, please contact our technical staff.

Thank you,
somniTech, Inc. (877) 917-0900 (515) 226-0900

Clinical Sleep Disorders Questionnaire

Name ____________________ Age ________ Height ____________

Address ____________________ Sex ________ Weight ____________

____________________ SSN # ____________________

Phone Number (   ) ____________________ Date of Birth ______/______/_____

Referring Physician: ____________________ Phone number:____________________

Family Physician:____________________ Phone number:____________________

How did you hear about us?____

Please consult your bed partner when answering the following questions. Answer the questions as if you are describing a typical night or sleep pattern. In answering the questions about frequency, circle one of the choices or write in your own if one the choices does not apply. Please answer as completely as possible.

1. What is your main concern regarding your sleep? (Why did your doctor order a sleep study?):
____
____
____

2. What is the most you have ever weighed? ____________________
   What did you weigh 5 years ago? ____________________
   What did you weigh 1 year ago? ____________________

3. When did your sleep problem begin?
   (month and/or year) ____________________

4. Have you ever had a sleep study before? YES NO
   If yes, where was the test performed? ________________________________
   When was the test performed? ____________________
   What were the results? ________________________________
____
____

5. Please list your current medications: (use back of page for additional information if needed)

MEDICATION	DOSE/FREQUENCY	LAST TAKEN

Interp. Physician Review_____

PT NAME: ____ **DATE:** _________________

6. My ideal amount of sleep is __________________ hours per night.

During the week I usually:	During the weekend I usually:
go to bed at ___________ (TIME)	go to bed at __________ (TIME)
get up at _____________ (TIME)	get up at _____________(TIME)
sleep a total of __________(HOURS)	sleep a total of __________(HOURS)

7. My job requires shift work: YES NO If yes, my hours are__________________

8. It usually takes me __________________ minutes to fall asleep.

9. I usually wake up ________________ times during the night. Please explain what wakes you up:
____
____

10. I have difficulty going back to sleep once I wake up:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

11. I snore:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

12. My snoring started at age: ___________

13. I snore in all sleeping positions: YES NO

14. My snoring has been described as: LIGHT MODERATE LOUD

15. I have problems with my nose or nasal breathing: YES NO
If yes, please explain:____
____

16. I wake up at night gasping, wheezing, short of breath, or feeling that I cannot breathe:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

17. I have been told that I toss and turn to an extreme amount:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

18. Immediately after falling asleep, I dream:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

Interp. Physician Review_____

PT NAME: ___________________________________ **DATE:**____________________

19. I have been told that I talk or scream in my sleep:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

20. I have been told that I grind my teeth while I sleep:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

21. I wake up with a sour or stomach acid taste in my mouth:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

    Last meal is eaten at what time? __________ a.m./ p.m.

22. I wake up with my heart beating irregularly:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

23. I wake up at night with muscle or joint aches and pains:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

24. I have the feeling of burning or tingling in my legs or the feeling of restless legs:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

25. I feel like I cannot move after lying down, before going to sleep:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

26. I see or hear things that are not real when lying in bed, but not asleep:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

    Type of sound or visualization: ____

27. After a typical night's sleep, I feel stiff or achy:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

28. After a typical night's sleep, I feel:

    REFRESHED FAIRLY RESTED SOMEWHAT TIRED VERY DROWSY

29. I take naps. YES NO If yes, how many per day? ____________
    If no, is there a reason why you do not take naps?

    NO NEED SITUATION DOES NOT PERMIT

Interp. Physician Review_____

PT NAME: ____ **DATE:**___________________

30. I fight sleep uncontrollably for short periods of time while sitting:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

This occurs when (circle each that applies):

Watching T.V. During Meetings At the Movies Riding in a Car

Other: ____

31. I fight sleep while driving:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

This last occurred when?: ____

This primarily occurs (circle the one that applies): Morning Afternoon Evenings

32. I have fallen asleep while driving a car: YES NO

If yes, how many times? __________

33. I dream during my naps:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

34. After my naps, I feel:

REFRESHED FAIRLY RESTED SOMEWHAT TIRED VERY DROWSY

35. I feel a sudden weakness in my knees, neck, jaw, or arms when I get angry, sad, while laughing or when emotional:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

36. I have episodes of doing strange things without realizing it or losing a period of time:

ALWAYS FREQUENTLY OCCASIONALLY NEVER

37. Drowsiness is greatest in the: MORNING AFTERNOON EVENING

38. Within the last year, depression, anxiety, or stress has interfered with my sleep:

YES NO

If yes, please explain: ____

____

Interp. Physician Review_____

PT NAME: ____ DATE:___________________

39. Is there a history in your family of difficulties with sleep, sleep apnea, excessive daytime sleepiness or snoring? ____

40. I have lost interest in sex or have trouble functioning sexually?

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

41. My spouse or bed partner has noticed that I quit breathing at night:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

42. I have headaches in the morning:

    ALWAYS FREQUENTLY OCCASIONALLY NEVER

43. Do you smoke or have you smoked? YES NO
    If yes, how many years have (did) you smoked? ___________________________
    How many cigarettes (cigars) per day? ___________________________
    If you quit, how long ago? ___________________________

44. Do you drink caffeinated beverages? YES NO
    If yes, how many cups or cans per day? _________________________________
    My usual beverage is: COFFEE TEA SODA

45. I consume alcohol. YES NO
    If yes, how often? DAILY WEEKLY MONTHLY
    I usually drink in the: MORNING AFTERNOON EVENING
    My usual beverage is: ____

Interp. Physician Review_____

PT NAME: ____ **DATE:**____________________

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

	SITUATION	CHANCE OF DOZING
1.	Sitting and reading	____________
2.	Watching television	____________
3.	Sitting inactive in a public place, (theater, meeting, etc.)	____________
4.	As a passenger in a car for an hour without a break	____________
5.	Lying down to rest in the afternoon when circumstances permit	____________
6.	Sitting and talking to someone	____________
7.	Sitting quietly after lunch without alcohol	____________
8.	In a car, while stopped, for a few minutes in traffic	____________
	Total Score	____________

Interp. Physician Review_____

PT NAME:____ **DATE:**_________________

MEDICAL HISTORY:

Have you ever been diagnosed or treated by a physician for any of the following (**circle answers**):

		If yes, when?
Angina (heart pain/chest pain)..	NO	YES_________
Attention Deficit Disorder	NO	YES_________
Cardiac Arrhythmias (heart irregularities)	NO	YES_________
Chronic Lung Disease (asthma, bronchitis, emphysema,etc.)................	NO	YES_________
Congestive Heart Failure	NO	YES_________
Coronary Heart Disease (hardening of the arteries)	NO	YES_________
Depression	NO	YES_________
Deviated Nasal Septum..	NO	YES_________
Diabetes	NO	YES_________
Edema (water retention)	NO	YES_________
Gastric Reflux (heart burn)...	NO	YES_________
Hay fever or allergic rhinitis..	NO	YES_________
Hepatitis (please designate type below)	NO	YES_________
Hiatal Hernia...	NO	YES_________
HIV	NO	YES_________
Hypertension (high blood pressure)	NO	YES_________
Hypothyroidism (low thyroid)...	NO	YES_________
Myocardial Infarction (Heart Attack)..	NO	YES_________
Nasal Polyps	NO	YES_________
Polycythemia (excessive red blood cells)..	NO	YES_________
Pulmonary Hypertension	NO	YES_________
Vocal Cord Disease (example: polyps)	NO	YES_________
Head and Neck surgery (tonsillectomy, deviated septum repair, etc.)....	NO	YES_________

Past surgeries? If yes, what and
when:____

____

____

Known Drug Allergies:____

I hereby authorize somniTech, Inc. to release the results of my study to any physician participating in my care or to the home health care agency designated by my physician to perform any follow-up care.

____

PATIENT'S OR GUARDIAN'S SIGNATURE DATE

Interp. Physician Review_____

Observer / Bed partner Survey

Please have an observer or your bed partner complete this survey to help aid us in your sleep pattern evaluation. Thank you.

1. Briefly describe the individual's sleep problems. Indicate how long you have noticed these problems and how often do they occur.
   ____
   ____
   ____

2. Does he/she snore at night? ____
   If yes, then please circle one:
   A. ***Loudly*** or ***Quietly***
   B. ***Sometimes*** or ***Continuously***
   C. Is he/she mainly on their ***back***, ***side***, ***stomach***, or ***all the time.***

3. Does he/she appear to stop breathing at night or wakes up gasping? ___________
   If yes, then please circle one:
   A. Periodically or Frequently
   B. Is he/she mainly on their ***back***, ***side***, ***stomach***, or ***all the time.***

4. Does he/she kick often at night? ***Yes*** or ***No***
   If yes,explain:____
   ____
   ____

5. Does he/she have trouble falling asleep at night? ***Yes*** or ***No***
   If yes, explain: ____
   ____
   ____

6. Does he/she fall asleep involuntarily during the day? ***Yes*** or ***No***
   If yes, explain: ____
   ____
   ____

7. Is it hard to wake him/her in the morning? ***Yes*** or ***No***
   If yes, explain: ____
   ____
   ____

8. Does he/she wake frequently at night? ***Yes*** or ***No***
   If yes, explain: ____
   ____
   ____

Information Regarding Sleep Studies

A sleep study has been ordered to rule out suspected sleep problems. The test may require ***TWO*** overnight stays at the sleep testing facility. There are certain sleep problems (mainly sleep apnea) that if severe in diagnosis, can be treated all in one visit to the sleep center. However, if sleep apnea is present, but does not meet criteria for a split-night study, then you will return to the center for the treatment portion of your study. Just because treatment was not initiated on your first visit does not mean that you do not have sleep apnea. It is always in the best interest of the patient to fully evaluate the extent of all sleep-related complaints. Some patients may only have the sleep disorder while in certain sleeping positions, or while in certain stages of sleep. Due to these determining factors, the physician will want to review all data before therapeutic recommendations are suggested.