



Who is the Physician ordering the Sleep Study? _____

Who is the primary care Physician? _____

Do you want this report sent to another Physician? _____

Personal Information

Patient's Name: _____
Last First Middle

Date of Birth: _____ Social Security #: _____

Home Address: _____

Street

City

State

Zip Code

Home Phone #: (____) _____ Email: _____

Cell Phone #: (____) _____ Work Phone #: (____) _____

Place of Employment: _____ Occupation: _____

Weight: _____ lbs. Height: _____ ft _____ in Age: _____ Sex: Male/ Female

Emergency Contact Person: _____

Name

Relationship

Home Phone #

Cell Phone #

Insurance Information

Primary Insurance: _____

Secondary Insurance: _____

(Complete only if you are not the Insurance Policy Holder)

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS# _____

Policy Holder's Address: _____

Street

City

State

Zip Code

Authorization

I authorize the release of any medical information necessary to process my insurance claim, to the durable medical equipment company for therapy and also authorize payment of medical benefits to the facility, the doctor for services rendered and. I also authorize the use of audio and video monitoring during my sleep study. I understand that the co-pay/ deductible is my responsibility. I am also aware that the Sound aSleep Sleep Diagnostic Lab facility is owned and operated by Dr. Narendra Kumar, M.D.

Sign: _____ Date: _____

1. On work days:
 I try to go to sleep at _____ AM/PM I wake up at _____ AM/PM
 I get out of bed at _____ AM/PM
2. When I am not working:
 I try to go to sleep at _____ AM/PM I wake up at _____ AM/PM
 I get out of bed at _____ AM/PM
3. Do you take naps? Yes No
 If yes, how many naps per week? _____ Average duration of naps? _____

Do you or have you been told that you...

- | | | |
|---|-----|----|
| 4. snore loudly and disruptively so that family members complain? | Yes | No |
| 5. hold your breath or stop breathing during sleep? | Yes | No |
| 6. have difficulty sleeping on your back or trouble breathing while lying flat? | Yes | No |
| 7. a dry throat or excessive thirst? | Yes | No |
| 8. having achy or restless legs? | Yes | No |
| 9. wake up gasping and/or choking? | Yes | No |
| 10. have an itching or crawling sensation in your legs? | Yes | No |
| 11. unable to fall asleep due to “restless legs”? | Yes | No |
| 12. take naps? | Yes | No |
| 13. at times, have to struggle to stay awake? | Yes | No |
| 14. have a problem with your performance at work due to sleepiness or fatigue? | Yes | No |

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? 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 | 0 | 1 | 2 | 3 |
| Watching TV | 0 | 1 | 2 | 3 |
| Sitting inactive in a public place (i.e., in a theatre) | 0 | 1 | 2 | 3 |
| As a car passenger for an hour without a break | 0 | 1 | 2 | 3 |
| Lying down to rest in the afternoon | 0 | 1 | 2 | 3 |
| Sitting and talking to someone | 0 | 1 | 2 | 3 |
| Sitting quietly after lunch (without alcohol) | 0 | 1 | 2 | 3 |
| In a car, while stopping for a few minutes in traffic | 0 | 1 | 2 | 3 |

TOTAL SCORE = _____

Please list any medications you are currently taking, including any medications that you have taken in the past 3 months. Please be sure to specify the dosage and the time of day you take them. (**unless otherwise instructed by the physician that ordered your sleep study, continue to take all medications as usual.)

Medication:

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are you allergic to any medications? Yes No

If yes, please list: _____

Have you ever taken a prescription medication to help you fall or stay asleep? Yes No

If yes, what and when?

Do you or have you been told that you...

- | | | |
|---|-----|----|
| 15. wake up with morning headaches? | Yes | No |
| 16. have restless sleep? | Yes | No |
| 17. walk in your sleep? | Yes | No |
| 18. talk in your sleep? | Yes | No |
| 19. grind your teeth? | Yes | No |
| 20. wet the bed (as an adult)? | Yes | No |
| 21. disturb the sleep of your bed partner? | Yes | No |
| 22. have disturbed sleep due to bed partner? | Yes | No |
| 23. awaken from sleep screaming or violent? | Yes | No |
| 24. have heartburn or gas during the night? | Yes | No |
| 25. wake up with a burning sensation in your throat? | Yes | No |
| 26. sweat excessively during sleep? | Yes | No |
| 27. eat during the night without being aware you do so? | Yes | No |
| 28. have a persistent cough at night? | Yes | No |
| 29. have frequent need to urinate while sleeping (more than twice)? | Yes | No |
| 30. have nasal congestion? | Yes | No |

How often do you...

- | | | | |
|--|-------|-----------|--------|
| 31. take naps? | never | sometimes | always |
| 32. feel refreshed after you nap? | never | sometimes | always |
| 33. experience dream-like images while falling asleep? | never | sometimes | always |
| 34. have episodes of muscular weakness when laughing, angry, or any extreme emotional situation? | never | sometimes | always |
| 35. ever feel paralyzed when waking up? | never | sometimes | always |
| 36. excessively sleepy during normal wake hours? | never | sometimes | always |
| 37. feel alert and Energetic the ENTIRE day? | never | sometimes | always |
| 38. awaken from noise, cold, pain, or other stimulus? | never | sometimes | always |

Please fill in the blanks:

39. How many unintentional naps do you take in a normal day? _____
40. How many times have you fallen asleep at work? _____
41. How many times have you had an accident at work due to sleepiness? _____
42. How many times have you had an auto accident caused by sleepiness? _____
43. How many times have you had a *near* auto accident (driving off the shoulder of the road, etc.) due to sleepiness? _____
44. How long does it take you to feel alert in the morning? _____
45. How many times during the night do you wake up? _____
46. How many times do you get out of bed during a typical night? _____

Circle the correct answer:

47. Have you previously been tested for a sleep disorder? Yes No
If yes, please list when and where. _____
Are you on treatment for this condition? Yes No
48. Have you ever used CPAP/BiPAP? Yes No
If yes, since which year? _____
49. Are you currently using CPAP/BiPAP? Yes No
If yes, list how many hours per night. _____
50. Have you had your tonsils or adenoids removed or palatoplasty (surgical procedure) for sleep apnea? Yes No
If yes, list what procedure and when. _____
51. Are you or have you ever been treated for the following? PLEASE CIRCLE
- | | | |
|---|-----|----|
| A. Diabetes | Yes | No |
| B. High Blood Pressure | Yes | No |
| C. Heart Disease (heart failure / atrial fibrillation / heart attack) | Yes | No |
| D. Do you have a pacemaker / defibrillator? | Yes | No |
| E. COPD / Emphysema / Asthma? | Yes | No |
| F. Do you use oxygen at home (Day / Night) | Yes | No |
| G. Heart burn / Reflux / Hiatal hernia) | Yes | No |
| H. Chronic Back / Neck or Hip pain? | Yes | No |
| I. Migraines or chronic headaches? | Yes | No |
| J. Depression | Yes | No |
| K. Insomnia | Yes | No |
| L. Neurological condition (Stroke / MS / Parkinson's) | Yes | No |
| M. Muscular skeletal disorders (Fibromyalgia / Muscle weakness) | Yes | No |
| N. Rheumatism / Rheumatoid arthritis or Osteoarthritis | Yes | No |
| O. Sleep related eating disorders? | Yes | No |
52. Which shift are you currently working? First Second Third
53. Do you drink alcohol in excess?
If yes, please list **what** you drink (beer, wine, liquor), **frequency** (daily, weekends, rarely) and **amount** per week (cans, glasses, shots)
-
54. Do you smoke? Yes No
If yes, list how much per day _____
If you used to smoke but no longer do, please list when you quit and how much you smoked prior to quitting. _____
55. How much of the following fluids do you drink during a 24 hour period (please designate in ounces):
- | | | |
|---------------------------|-------|-----|
| Caffeinated coffee or tea | _____ | oz. |
| Water or juice | _____ | oz. |
| Caffeinated pop | _____ | oz. |
| Alcohol | _____ | oz. |
| Other | _____ | oz. |
56. What problems are you currently having with your sleep? (please describe)
- _____
-
57. Do these problems seem to interfere with your daily life? Yes No
58. Do you feel that you get enough sleep? Yes No
59. Do you wake up after a night's sleep and feel that you are not rested or refreshed? Yes No

For the following statements, circle the number that best describes your answer:

0= Never 1= Rarely 2= Sometimes 3= Frequently 4= Always

- 60. You feel fatigued (exhausted) even when you are **NOT** sleepy 0 1 2 3 4
- 61. You have trouble falling asleep at night 0 1 2 3 4
- 62. You have trouble staying asleep once you fall asleep 0 1 2 3 4

When you go to bed you:

- 63. watch television 0 1 2 3 4
- 64. eat snacks in bed 0 1 2 3 4
- 65. read a book 0 1 2 3 4
- 66. listen to the radio 0 1 2 3 4
- 67. do homework or work brought home from your job 0 1 2 3 4
- 68. other _____ 0 1 2 3 4

At the beginning of the night when you are attempting to fall asleep, how often do you:

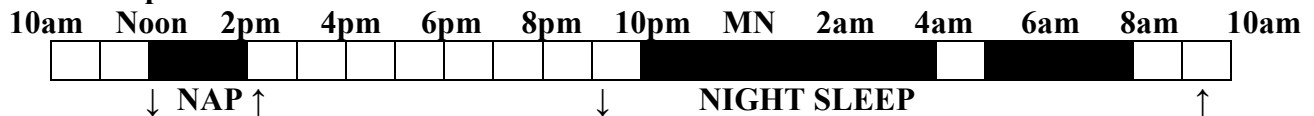
- 69. have thoughts racing through your mind that tend to keep you awake? 0 1 2 3 4
- 70. feel sad and/or depressed? 0 1 2 3 4
- 71. feel anxious and/or tense? 0 1 2 3 4
- 72. feel afraid that you will not be able to fall asleep? 0 1 2 3 4
- 73. worry about being rested and alert the following day? 0 1 2 3 4
- 74. try to make yourself fall asleep? 0 1 2 3 4

Sleep Log

Complete this sleep log as instructed using the directions provided below. Complete the log in the morning and in the evening. Write additional comments on the back.

1. **BLACKEN** in the times when you are sleeping.
2. **DOWN ARROW** indicating the time you are in bed to sleep.
3. **UP ARROW** indicating when you got out of bed.

Example:



In the sample sleep log, this person woke up at 8am, but did not get out of bed until 9am. Then he/she laid in bed for an afternoon nap at noon and fell asleep within minutes. When he/she woke up at 2pm, he/she immediately got out of bed. In the evening, this person went to bed at 9pm, but did not fall asleep until 10pm. During the night, this person was awake from 4am to 5am, but did not get out of bed. Again, he/she slept until 8am and got out of bed at 9am.

****Please fill out this sleep study- recording your sleep routine for the week prior to your sleep study****

| DAY | 10am | Noon | 2pm | 4pm | 6pm | 8pm | 10pm | MN | 2am | 4am | 6am | 8am | 10am |
|-----|------|------|-----|-----|-----|-----|------|----|-----|-----|-----|-----|------|
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | |

*****Please Complete This Questionnaire and Bring It with You on the Night of Your Study.*****
 If You Have Any Questions, Please Feel Free To Call Us