

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 any 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 electrodes and the skin. You will want to wash your hair in the morning to remove the electrode paste used to monitor your EEG (brain waves).
2. If you are clean shaven, please shave again in the evening. Electrodes 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. (800) 460-1147 (913) 498-8120



Clinical Sleep Disorders Questionnaire

Name _____ Age _____ Height _____
 Address _____ Sex _____ Weight _____
 Phone Number () _____ SSN # _____
 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_____

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.



Dear Mr./Ms. _____

PLEASE COMPLETE THE ENCLOSED SLEEP DIARY. YOU ARE TO START THIS DIARY ON _____. THE LAST DAY OF THE DIARY SHOULD END ON THE DAY OF YOUR SCHEDULED SLEEP STUDY. PLEASE BE AS DETAILED AS POSSIBLE WHEN FILLING IN THE INFORMATION. THIS DIARY WILL BE USED TO HELP RULE OUT CERTAIN SLEEP PROBLEMS. PLEASE BRING THE COMPLETED DIARY WITH YOU ON THE NIGHT OF THE STUDY. YOU ARE TO GIVE THE DIARY TO THE TECHNICIAN PERFORMING YOUR SLEEP STUDY.

IF THERE IS LESS THAN TWO WEEKS UNTIL YOUR SLEEP STUDY, PLEASE JUST FILL OUT AS MANY NIGHTS AS YOU CAN. ANY INDICATION FOR YOUR SLEEPING PATTERNS IS HELPFUL TO US WHEN MAKING A DIAGNOSIS.

IF YOU SHOULD HAVE ANY QUESTIONS OR PROBLEMS COMPLETING THIS DIARY, FEEL FREE TO CONTACT OUR OFFICE FOR ANY ASSISTANCE.

THANK YOU FOR YOUR CLOSE ATTENTION TO THIS DIARY, AS IT IS A VERY IMPORTANT TOOL FOR US AND YOUR PHYSICIAN.

SAMPLE

NAME: _____ *Sleeping Beauty* _____

DATE: _____ 5/1/2008 _____

TODAY IS: _____ Thursday _____

BEDTIME (LAST NIGHT): _____ 9:00 pm _____

WAKETIME (TODAY): _____ 6 a.m. _____

How long did it take to fall asleep? _____ 10 minutes _____

Please list how many times you awoke during the night: _____ 2 _____

Please list time and length of each awakening:

TIME

_____ 1:00 a.m. _____

_____ 2:45 a.m. _____

LENGTH

_____ 20 minutes (let dog out) _____

_____ 5 minutes (use restroom) _____

Please list time and length of any naps on this day:

TIME

_____ 3:00 pm _____

LENGTH

_____ 30 minutes _____

Please list all caffeine and alcohol consumed with times and amount: (Please list caffeine and alcohol only, caffeine includes: cola, coffee, tea and chocolate. Please do not list water, sprite, 7-up, juice, etc.)

CAFFEINE/ALCOHOL

_____ coffee _____

_____ soda _____

_____ beer _____

TIME AND AMOUNT

_____ 7:00 a.m.----4 cups _____

_____ 1:00 pm----2 cans _____

_____ 7:00 pm----1 can _____

Please list any special circumstances that may help us to interpret your diary: _____

_____ I do not regularly drink alcohol, but a dinner guest brought beer. _____

NAME: _____

DATE: _____

TODAY IS: _____

BEDTIME (LAST NIGHT): _____

WAKETIME (TODAY): _____

How long did it take to fall asleep? _____ Please list how many times you awoke during the night: _____

Please list time and length of each awakening:

TIME

LENGTH

Please list time and length of any naps on this day:

TIME

LENGTH

Please list all caffeine and alcohol consumed with times and amount: (Please list caffeine and alcohol only, caffeine includes: cola, coffee, tea and chocolate. Please do not list water, sprite, 7-up, juice, etc.)

CAFFEINE/ALCOHOL

TIME AND AMOUNT

Please list any special circumstances that may help us to interpret your diary: _____

DATE: _____

TODAY IS: _____

BEDTIME (LAST NIGHT): _____

WAKETIME (TODAY): _____

How long did it take to fall asleep? _____ Please list how many times you awoke during the night: _____

Please list time and length of each awakening:

TIME

LENGTH

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TIME

LENGTH

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TIME AND AMOUNT

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DATE: _____

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WAKETIME (TODAY): _____

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TIME

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TIME

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DATE: _____

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BEDTIME (LAST NIGHT): _____

WAKETIME (TODAY): _____

How long did it take to fall asleep? _____ Please list how many times you awoke during the night: _____

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TIME

LENGTH

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TIME

LENGTH

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DATE: _____

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WAKETIME (TODAY): _____

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TIME

LENGTH

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TIME

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TIME AND AMOUNT

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DATE: _____

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BEDTIME (LAST NIGHT): _____

WAKETIME (TODAY): _____

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TIME

LENGTH

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TIME

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TIME

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LENGTH

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BEDTIME (LAST NIGHT): _____

WAKETIME (TODAY): _____

How long did it take to fall asleep? _____ Please list how many times you awoke during the night: _____

Please list time and length of each awakening:

TIME

LENGTH

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TIME

LENGTH

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CAFFEINE/ALCOHOL

TIME AND AMOUNT

Please list any special circumstances that may help us to interpret your diary: _____