ENGLEWOOD HEALTH

# SLEEP CENTER PRE-TEST QUESTIONNAIRE

Patient Label

These questions are necessary for the physician to evaluate your test and must be filled out prior to your appointment. If you are not sure how to answer a question it can be discussed with the technician at the time of your test. Do not alter your normal routine or make any adjustments in medications that you have been using for sedation, sleep or to maintain wakefulness. Please do not consume alcohol or caffeine on the day of your test.

NAME: ________________________________ DOB: ____________AGE: _______

ADDRESS: ________________________________ PHONE: ____________________

________________________________

Emergency Contact: ________________________________ PHONE: ____________________

Referring MD:________________________________ PHONE: ____________________

Reason for Study________________________________________________

Patient Occupation____________________ Shift Day Evening Night Rotating

SEX______ HEIGHT______ Feet. _____Inches WEIGHT______lbs NECK SIZE________Inches

What was your weight: 6 months ago _____ 2 years ago________ At age 20 _________

What was your heaviest weight _____________

**MEDICAL CONDITIONS (check if present):**

____High Blood Pressure ____Heart Disease ____Heart Attack

____Congestive Heart Failure ____Kidney Disease ____Asthma

____Emphysema ____Bronchitis ____Diabetes

____Thyroid Dysfunction ____Seizures ____Stomach Problems

____Chronic Headaches ____Depression ____COPD

____Obesity (Mild/Moderate/Severe) ____Ear, Nose, Sinus or Throat Problems

____Deviated Septum ____Claustrophobic

Other ________________________________________________________________

**MEDICATIONS:**

| 1.____________ | 2.____________ | 3.____________ | 4.____________ |
|---|---|---|---|
| **Frequency:** ________ | ____________ | ____________ | ____________ |
| **Dosage:** ________ | ____________ | ____________ | ____________ |

*Use back of page for additional meds.*

ALLERGIES ________________________________________________________________

1. Have you ever had a Sleep Study done? YES ______ NO ______

If YES, where and when was it performed? ________________________________________________

________________________________________________________________

________________________________________________________________

2. What positions do you tend to sleep in?

On right side____ On left side____ On back____ On stomach____

3. How many pillows do you sleep with? 1____ 2_____ 3______ More______

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4. Do you use any breathing aid for sleep? YES____ NO____
   a. Do you use a CPAP or BIPAP breathing machine when you sleep? YES____ NO____
   b.. If yes, what is the setting? ___________________
   c. Do you use oxygen at home? YES____ NO____
   d. If yes, what is the setting? ___________________

5. Do you have any problems with:
   a. Nasal Congestion YES____ NO____
   b. Nasal Obstruction YES____ NO____
   c. Nasal discharge YES____ NO____
   d. Nasal Polyps YES____ NO____
   e. Sinuses YES____ NO____
   f. Tonsils YES____ NO____
   g. Adenoids YES____ NO____

6. Have you ever had any of the following surgeries:
   a. Tonsillectomy YES____ NO____
   b. Adenoidectomy YES____ NO____
   c. Nasal Surgery YES____ NO____
   d. Sinus Surgery YES____ NO____
   e. Vocal Cord Surgery YES____ NO____

## PARTNER QUESTIONNAIRE

***Please check the appropriate box regarding your relationship to the patient***

**SPOUSE ☐** **PARTNER ☐** **ROOMMATE ☐** **PARENT ☐**

***Please check which of the following behaviors you have observed the patient doing while asleep***

| | | | |
|---|---|---|---|
| Loud Snoring | ☐ | Light Snoring | ☐ |
| Flailing of arms and legs | ☐ | Twitching of legs and feet | ☐ |
| Breathing pauses (10 sec or more) | ☐ | Grinding teeth | ☐ |
| Sleep talking | ☐ | Sleepwalking | ☐ |
| Bed Wetting | ☐ | Sitting up in bed while asleep | ☐ |
| Rocking or banging of head | ☐ | Getting out of bed while asleep | ☐ |
| Tongue biting | ☐ | Becoming very rigid and/or shaking | ☐ |

How long have you been aware of these sleep behaviors? ___________________________________________

Please describe in further detail these observed sleep behaviors: _______________________________________

# SLEEP CENTER EPWORTH SLEEPINESS SCALE

Patient Label

Patient Name: ____________________________ DOB: ________________ Date: __________

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 activities. 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**

## **PATIENT** (please complete)

| SITUATION | 0 | 1 | 2 | 3 |
|---|---|---|---|---|
| Sitting and Reading | | | | |
| Watching TV | | | | |
| Sitting, inactive, in a public place | | | | |
| 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 with no alcohol | | | | |
| In a car, while stopped for a few minutes in traffic | | | | |

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# SLEEP CENTER SLEEP DIARY

Patient Label

Patient Name: ____________________________ DOB: ________________ Date: __________

The purpose of this form is to provide us with your typical sleep habits. Please start filling it out daily, a week prior to your scheduled sleep study. If your study is less than a week away, give us as many days as you can. This will aid us in the diagnosis of your condition.

Complete the top box each evening prior to bed, and complete the bottom box each morning when you get up. If there is an unusual event on a given night (e.g. illness, emergency, phone calls) make a note of it in the "Unusual Events" row.

- Are you a shift worker YES ☐ NO ☐ If yes, what hours do you work? _________
- How many pillows do you usually sleep with? _________

| DATE | **Example 9/30** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Each nap time if any | **11am 3pm** | | | | | | | |
| Total sleep during Each nap time | **15min 1 hr** | | | | | | | |
| Meds or alcohol taken as a Sleep aid at bed time (Y or N) | **Y** | | | | | | | |
| Bedtime | **11pm** | | | | | | | |

| How long did it take you to Go to sleep? | **1 hr** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rise time | **6am** | | | | | | | |
| Total sleep during night | **5hrs** | | | | | | | |
| Number of Night-time Awakenings | **4** | | | | | | | |
| Duration of each Awakening | **5, 15, and 25 mins** | | | | | | | |
| When I awake, I feel: 1= exhausted – 5=refreshed | **3** | | | | | | | |
| My sleep last night was: 1= very restless – 5=refreshed | **2** | | | | | | | |
| Unusual Events | **Phone call at 1am** | | | | | | | |