INSTRUCTIONS FOR YOUR SLEEP STUDY

Patient Name: ____________________________________

Your study will be done on: __________________________

Please arrive at the appointed time of: ___8 p.m._____

Our goal is to provide the best evaluation of your sleep. Your cooperation in the following steps is very important:

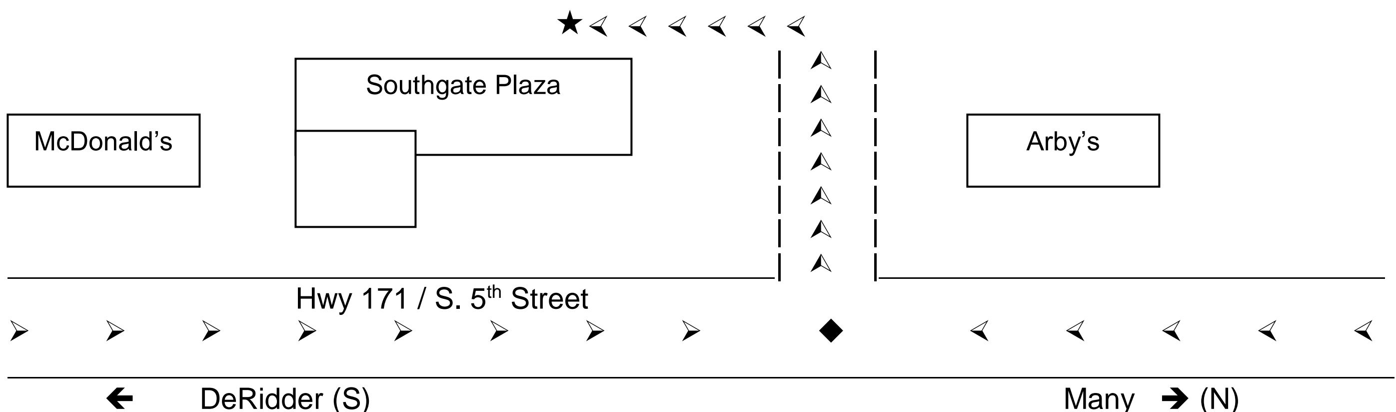
1.) Try to maintain your usual daytime schedule. Avoid unusual exercise and unusual meals.
2.) DO NOT TAKE NAPS ON THE DAY OF YOUR STUDY.
3.) Take your regular medications on the day of your study unless otherwise directed by your physician.
4.) Please bring something comfortable to sleep in.
5.) Please arrive with clean, dry hair. Do not use spray, oils or gels.
6.) Patients will need to shampoo their hair after each study; due to the use of paste with electrodes on scalp. For women who have hairpieces or hair extensions, or for women who have their hair done weekly, please arrange your appointment accordingly.
7.) Women, please do not wear any make-up.
8.) You may bring a favorite pillow or blanket to make you feel more comfortable. You may also bring reading materials.
9.) Do not wear any lotions or oils on the body.
10.) Please notify us as early as possible if you need to re-schedule your sleep study.
11.) Please avoid caffeinated beverages after 6:00 p.m.
12.) Please eat dinner before your appointment time of 8:00 p.m.
13.) Wake up time will be between 5:00 a.m. and 6:00 a.m. the next morning.
14.) Please bring insurance cards, driver's license and/or military ID.
15.) **Please complete the attached patient information packet and return to the lab on the night of your study.**

DIRECTIONS TO CLINIC

Awakening Sleep Center is located at 1608 S. 5th Street, Suite B, Leesville, LA 71446
In the Southgate Plaza Shopping Center, between Billy's Barber Shop and the Congressman's Office.
The entrance is located in the back of this building with a blue "Awakening Sleep Center" sign.

Please feel free to call with any questions or concerns you may have at (337) 392-5910.

Please give a 24 hour notice if you should have to re-schedule your sleep study.



NO SHOW AND CANCELLATION POLICY

Your sleep study has been reserved especially for you. If it is missed, cancelled or not confirmed by 12:00 (noon) the day of your scheduled sleep study, you will be billed **$250.**

Your insurance company does not cover this charge and you are fully responsible to pay this assessed fee. Repeated no show appointments and/or cancellations could result in referring you back to your referring physician for reassignment to another sleep center.

Please also note that calls must be received during our regular business hours. Our hours are Monday – Friday, 8am – 5pm.

I understand the above no show and cancellation policy of Awakening Sleep Center, LLC and accept financial obligation of this fee.

_________________________________ _______________________

Signature of Patient or Responsible Party Date

____

Printed Name of Patient

SLEEP HISTORY QUESTIONNAIRE
GENERAL INFORMATION

Name: ____________________________________ Age: _______ Date of Birth: ______________

Address: ____

Phone: (   ) ______- ________ (   ) ______- ________ (   ) ______- ________
Home Work Cell

Social Security Number: ________-______-________ Marital Status: __________________

Height: ________ Weight: ________ Sex: ________

Occupation: ____ Years on Job: ______________

Are You A Shift Worker? ☐ Yes ☐ No Do You Drive For Work? ☐ Yes ☐ No

Employer: ____

Referring Physician Name: ____

Address: ____

Phone: (   ) ______- ________ Fax: (   ) ______- ________

Allergies: ____

List of Medications Currently Taking:
____
____
____
____
____

Insurance Company: ____

Policy Number: ____________________________________ Group Number: ________________

I have read the above cancellation policy and understand the importance of confirming my sleep study.

PAST MEDICAL HISTORY

Medical Problems:	YES	NO	If Yes, Please Explain:
Heart Disease	☐	☐	____________________
Hypertension	☐	☐	____________________
Diabetes	☐	☐	____________________
Thyroid Disease	☐	☐	____________________
Kidney Disease	☐	☐	____________________
Asthma	☐	☐	____________________
Stroke	☐	☐	____________________
Trouble Swallowing	☐	☐	____________________
Seizures	☐	☐	____________________
Reflux	☐	☐	____________________
Depression	☐	☐	____________________
Anxiety Disorder	☐	☐	____________________
Post Traumatic Stress	☐	☐	____________________
Alcoholism	☐	☐	____________________
Parkinson's Disease	☐	☐	____________________
History of Head Injury/Coma	☐	☐	____________________
Surgery for Sleep Apnea	☐	☐	____________________

Please list any past surgeries:
____
____
____

FAMILY MEDICAL HISTORY

	Father	Mother	Siblings	Child
Heart Disease	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐
Bleeding Disorders	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Alcoholism/Drugs	☐	☐	☐	☐
Narcolepsy	☐	☐	☐	☐
Obstructive Sleep Apnea	☐	☐	☐	☐

MEDICAL SOCIAL HISTORY

Within the last year have you Gained _____________ / Lost _____________ Weight?

Within the last five years have you Gained _____________ / Lost _____________ Weight?

Tobacco:
Do you smoke? ☐ Yes ☐ No
Did you previously smoke? ☐ Yes ☐ No
How many years of smoking? _________________
How many per day? _________________
Do you use other tobacco forms? ☐ Yes ☐ No
How much per day? _________________
How close to bedtime do you use tobacco? ____

Alcohol:
Do you drink alcohol? ☐ Yes ☐ No
How much? _________________ drinks per [day / week / month]

Caffeine:
List your average daily consumption of the following:
Coffee: _________________________ Tea: _________________________ Cola: _________________________
How close to bedtime do you drink these? ____

ENVIRONMENT

Is your mattress? ☐ Soft ☐ Hard ☐ Just Right
Do you fall asleep with the television on? ☐ Yes ☐ No
Do you fall asleep with the radio on? ☐ Yes ☐ No
Is your sleep often disturbed by: ☐ Heat ☐ Light ☐ Bed Partner
☐ Cold ☐ Noise ☐ Not being in usual Bed
☐ Other ____________________________

PAIN ASSESSMENT

How many falls have you experienced in the last 10 years? ___________________________________
Do you require assistance walking or getting around? ____
What is the location and how often do you experience this pain or discomfort? ______________
____
Do you require crutches, walker or a wheelchair? ____

MAIN SLEEP QUESTIONNAIRE

Describe your main sleep problems in your own words, including when and how this began and what treatment you have received for this in the past.

____
____
____
____
____

How often does this problem occur?
☐ Almost every night
☐ For periods of at least one week
☐ Irregularly
☐ Other ____

How long has this problem bothered you?
☐ Longer than 2 years
☐ 1 to 2 years
☐ Several months
☐ Within the last 3 months
☐ Within the last month

On the scale below, please estimate the severity of your problem(s)
☐ Mildly upsetting ☐ Moderately upsetting ☐ Very severe
☐ Extremely severe ☐ Totally incapacitating

How strongly do you want help with your problems?
☐ Very much ☐ Much ☐ Moderately ☐ Could do without it

How do you describe your sleep problem? Check all that apply to you.
☐ Difficulty falling asleep
☐ Wake up during the night
☐ Wake up easily in the morning
☐ Excessive daytime sleepiness
☐ Difficulty awakening

Have you ever had a sleep study? If so, where and what were you told about it?

____
____
____
____

	Weekday	Weekend
What time do you get in bed?	________	________
What time do you fall asleep?	________	________
What time do you wake up?	________	________
What time do you get out of bed?	________	________
Do you take naps?	________	________

If so, how many naps a week on average? ________________________

And how long is the nap (on average)? ________________________

Do you generally go to bed at the same time and wake up the same time every day? ________

What else do you do in bed?	Yes	No
Read	________	________
Watch T.V	________	________
Listen to Radio	________	________
Pay bills/balance checks	________	________
Worry (life circumstances)	________	________
Worry about sleep	________	________
Eat / Drink	________	________
Sex	________	________
Studying/Working	________	________

Other (describe) ____

____

Is it hard for you to fall asleep? If so, how long does it take? ________________________

How many times a night do you wake up? And why? ________________________

____

What times at night do you wake up? ________________________

Do you eat or drink in the middle of the night? ________________________

Do you usually: (check all that apply)

☐ Sleep with someone else in your bed

☐ Sleep with someone else in your room

☐ Provide assistance to someone during the night (child, invalid, bed-partner, animal)

☐ Sleep with pet or object? ________________

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 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
Sitting and reading	______________
Watching TV	______________
Sitting inactive in a public place (theater, meeting)	______________
As a passenger in a car for an hour without a break	______________
Lying down to rest in the afternoon when circumstances permit	______________
Sitting and talking to someone	______________
Sitting quietly after lunch without alcohol	______________
In a car, while stopped for a few minutes in traffic	______________

SLEEP QUESTIONNAIRE

N: Never R: Rarely O: Occasionally F: Frequently C: Constantly

Please rate how often you:

Awaken from sleep short of breath	N	R	O	F	C
Awaken at night with heartburn, belching or coughing	N	R	O	F	C
Snore	N	R	O	F	C
Snore loudly enough that others complain	N	R	O	F	C
Have trouble sleeping when you have a cold	N	R	O	F	C
Suddenly wake up gasping for breath during the night	N	R	O	F	C
Stop breathing during sleep (observed by self or others)	N	R	O	F	C
Have morning headaches	N	R	O	F	C
Sweat excessively at night	N	R	O	F	C
Notice your heart pounding or beating irregularly	N	R	O	F	C
Fall asleep during the day, even after a full nights sleep	N	R	O	F	C
Fall asleep involuntarily	N	R	O	F	C
Fall asleep while driving	N	R	O	F	C
Fall asleep during physical effort	N	R	O	F	C
Fall asleep when laughing or crying	N	R	O	F	C
Experience loss of muscle tone when extremely emotional	N	R	O	F	C
Have trouble at school or work because of sleep	N	R	O	F	C
Feel unable to move when waking or falling asleep	N	R	O	F	C
Experience vivid dreamlike scenes upon waking or falling asleep	N	R	O	F	C
Feel afraid of going to sleep	N	R	O	F	C
Have nightmares	N	R	O	F	C
Remember your dreams	N	R	O	F	C
Have thoughts racing through your mind	N	R	O	F	C
Feel sad or depressed	N	R	O	F	C
Have anxiety (worry about things)	N	R	O	F	C
Notice parts of your body jerk	N	R	O	F	C
Have muscular tension	N	R	O	F	C
Kick during the night	N	R	O	F	C
Experience crawling and aching feelings in your legs	N	R	O	F	C
Experience any type of leg pain during the night	N	R	O	F	C
Have morning jaw pain	N	R	O	F	C
Grind teeth during sleep	N	R	O	F	C
Are bothered by pain during the day	N	R	O	F	C
Are awakened by pain during the night	N	R	O	F	C
Wake up feeling stiff in the morning	N	R	O	F	C
Wake up with sore or achy muscles	N	R	O	F	C
Wake up with pain in the neck, spine or joints	N	R	O	F	C

Circle any of the following that apply to you:

Headaches
Feel Panicky
Feel Tense
Unable to Relax
Feeling of Inferiority
Overambitious
Financial Problems
Can’t Keep Job
Take Drugs
Stupid
Morally Wrong
Guilty
Cowardly
Unloved
Worthwhile
Aggressive
Confused
Attractive

Fatigue
Sexual Problems
Feel Depressed
Shy With People
Worthless
No Appetite
Full of Hate
“Life is Empty”
Inadequate
Incompetent
Agitated
Hostile
Unassertive
Restless
Intelligent
Lonely
Full of Regrets
Considerate

Unable to Have a Good Time
Don’t Like Weekends/Vacations
Home Conditions Bad
Memory Problems
Don’t Care If Alive or Dead
Alcoholism
Can’t Make Friends
Can’t Make Decisions
Concentration Difficulties
“Can’t Do Anything Right”
Horrible Thoughts
Anxious
Ugly
Unconfident
Confident
Misunderstood
Sympathetic

Do you have any pain? ______________________________

If yes, describe pain level (1-10), intensity, location, frequency, duration, aggravating, and alleviating factors, pain management actions and pain levels after such actions:

____

____

____

____

____

____

____

What time of day do you feel most alert? ____

Do you have an irresistible urge to move your legs while you are in bed? _______________________

BED PARTNER QUESTIONNAIRE

Name of Patient: ___________________________________ Date: ______________________

Check any of the following behaviors that you have observed the patient doing while asleep.

_________ loud snoring
_________ light snoring
_________ twitching of legs or feet during sleep
_________ pause in breathing
_________ grinding teeth
_________ sleep talking
_________ sleep walking
_________ bed wetting
_________ sitting up in bed but not awake
_________ head rocking or banging
_________ kicking with legs during sleep
_________ getting out of bed but not awake
_________ biting tongue
_________ becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above?
____
____

Describe the behavior checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night and whether it occurs every night.
____
____
____
____
____

If you have heard loud snoring, do you remember pauses in the snoring or occasional loud “snorts”?
____