SLEEP STUDY QUESTIONNAIRE

YOU HAVE BEEN SCHEDULED FOR A SLEEP STUDY AT
CENTRAL PENINSULA HOSPITAL SLEEP LABORATORY

Study Date: _____ Pre-study consultation: _____ Follow-up visit: _____

Finances: You can expect to receive a bill from the hospital as well as one from the interpreting physician.

Please read the following information. It should answer most, if not all of your questions.

- We are located in the rear of the hospital, in the wing with Cardiac Rehabilitation. Drive to the ER parking area and look toward the new tower. Our entrance is just between the ER entrance and the new tower. **Ring the bell on the outside marked "Sleep Lab". Give the tech a minute to get to the door.**
- **You must be on time.** You will not be the only patient that night. Allow extra time for parking, bad weather, etc.
- **Sleep medication.** You may have been prescribed a mild sleep aid to use on the night of your sleep study. Pick up the prescription at the pharmacy prior to your appointment. **Do not** take the medication before you get to the lab, bring it to the laboratory. Do not drive under the influence of sleep medication.

On the day of your study:

- Try not to nap
- No caffeine after noon
- Eat dinner before you arrive. There is no food in the lab.
- Be sure to bring comfortable clothing to sleep in.
- You may want slippers, or your one pillow, or reading material
- Men: If you usually shave your face, shave before coming to the lab. Full beards are OK, but stubble is problematic for keeping leads on. You have will three leads around your chin.

Diabetics: Bring snacks and your medication. Make sure the sleep tech knows you are diabetic.

Your private room has a restroom, shower, TV (cannot be on all night), and a "Sleep by Number" bed, which allows you to adjust the firmness of the mattress. There are fans, a white noise machine, earplugs, extra blankets. If you need a bed wedge or other accommodations, please let us know before your visit. Bring personal items such as shampoo if you plan on taking a shower in the morning.

You will be able to use the restroom during the night. If you are unable to get to the restroom safely **without assistance** you must let us know **in advance**. If you have an assistant at night they will need to come with you. If that is not possible, call us at **714-4439** so we can make arrangements to accommodate you.

Everyone dresses for bed. Shorts and a t-shirt, pajamas, nightgown... bring something you are comfy in. You may want slippers and **your own pillow**. You might have time to read or watch TV if you are the early patient.

Lights out at 10:30 pm. The study usually **ends at 6:00 am**. If you need to leave earlier for work, let the tech know. We need a minimum of 6 hours of recording time, but more is better.

central peninsula hospital
250 Hospital Place, Soldotna, AK 99669
(907) 714-4439 * www.cpgh.org

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Patient Name: Date of Birth: Date:

Age:_____ Height:_____ Weight:_____ Marital Status:_____ Referring Physician:_____

Why are you here? (Reason for the study in your own words):_____

Sleep Schedule

1. What time on weekdays do you usually	Go to bed?____	Wake up?____
What are your usual working hours (if applicable)	Begin:_____	End:_____
2. What time on weekends do you usually	Go to bed?____	Wake up?____
3. On average, how long do you actually sleep at night?	Week days?____	Weekends?____
4. Do you feel that you get too much or too little sleep at night?	Too much?____	Too little?____

Night Time Symptoms

1. How long does it normally take you to fall asleep at night?			_____ Minutes
2. Does anyone tell you that you snore badly?	Yes	No	How Often
3. Do you have difficulty breathing at night?	Yes	No	
4. Do you ever awaken coughing or snoring?	Yes	No	
5. Do you awaken with a sour or bitter taste in your mouth?	Yes	No	
6. Do you wake up with headaches?	Yes	No	
7. Do you awaken at night to use the bathroom?	Yes	No	
8. Do you have trouble getting to sleep at night?	Yes	No	
9. Do you have difficulty going back to sleep during the night?	Yes	No	
10. Do you have thoughts that prevent sleep?	Yes	No	
11. Do you awaken with racing thoughts, sadness, or anxiety?	Yes	No	
12. Is it difficult for you to awaken and get out of bed after sleeping?	Yes	No	
13. Do you have crawling sensations in your legs while falling asleep?	Yes	No	
14. Do you have twitching movements in your legs during the night?	Yes	No	
15. Have you experienced paralysis upon awakening from sleep?	Yes	No	
16. Do you have vivid dreams as you are falling asleep?	Yes	No	
17. Is your sleep disturbed by a medical problem? (Y/N) ; Describe:			

Day Time Symptoms

Do you take naps during the day?	No need	I want to but can't	Number of times per week
Do you feel rested or refreshed after a nap?	Yes	No	

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Epworth Sleepiness Scale

How likely are you to fall asleep in these situations?

0=No chance of dozing; 1=Slight chance of dozing; 2=Moderate chance of dozing; 3=High chance of dozing

Sitting and reading	0	1	2	3	
Watching TV	0	1	2	3	
Sitting inactive in a public place	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	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 stopped for a few minutes in traffic	0	1	2	3	Total

Have you noticed, or been told about any changes in your personality recently, such as:

a) Irritability	Yes	No	e) Loss of consciousness	Yes	No
b) Increased temper	Yes	No	f) "Spaced out" feeling	Yes	No
c) Anxiety	Yes	No	g) Decreased job productivity	Yes	No
d) Depression	Yes	No	h) Poor memory	Yes	No

Have you ever had the following kinds of weakness develop suddenly during an emotional situation

Check one on each line

	Never	1-5 times in life	Monthly	Weekly	Daily - almost daily
Knees buckling					
Mouth opening					
Head nodding					
Falling down					

Do you know or others tell you that you:	Age Started	Last occurred	Frequency	Treatment
Talk while apparently asleep?				
Walk while apparently asleep?				
Grit teeth while apparently asleep?				
Wake up screaming, anxious or afraid?				
Have disturbing dreams (nightmares)?				
Have unusual movements while asleep?				

Health History (please circle all that apply)

Weight Problems	COPD	Anxiety	Fibromyalgia
High Blood Pressure	Asthma	Depression	Chronic pain
Diabetes	Sinus problems	Stroke	Sinus surgery
Heart disease	Thyroid disorder	Dementia	Tonsillectomy
Congestive Heart failure	Cancer	Parkinson's	Other:_____

SLEEP STUDY QUESTIONNAIRE

Patient Name: Date of Birth: Date:

Please list any other health or surgical history:

Family History

Has an immediate family member (mother, father, sister, brother) had sleep problems or a diagnosed sleep disorder? Please indicate which family member (F: Father; M: Mother; S: Sister; B: Brother)

Sleep Apnea ___ Restless leg syndrome ___ Narcolepsy ___

Snoring ___ Sleep walking ___

Please Explain:

(Fill out or attach medication list.)

Medication	Dosage	How Often	Years	Reason

For each of the beverages listed below, please write the average amount you drink daily:

Regular coffee (cups) _____ Hot or Iced Tea (cups) _____ Caffeinated soft drinks _____

Do you smoke cigarettes? (Y/N) ___ If yes, how many packs per day? ____ For how many years? ____

If no, did you ever smoke? (Y/N) ___ When did you stop smoking? _____

How many alcoholic beverages do you drink per day on weekdays ____/weekends ____ or per month____

Any other details you feel are important:

BED PARTNER QUESTIONNAIRE

Patient Name: Date of Birth:

Your name Name: Relationship:

Check any of the following that you have observed this person doing while asleep. **Circle** those that you consider to be severe problems:

- ☐ Light snorer
- ☐ Moderate snorer
- ☐ Loud snorer
- ☐ Occasional loud snorts
- ☐ Holding breath or not breathing
- ☐ Sleep Talking
- ☐ Bed-wetting
- ☐ Awakening with pain
- ☐ Getting out of bed when not awake
- ☐ Becoming very rigid and shaking
- ☐ Apparently sleeping even if he/she says otherwise
- ☐ Twitching or kicking of legs
- ☐ Grinding teeth
- ☐ Sitting up in bed not awake
- ☐ Head rocking or banging
- ☐ Bitting tongue
- ☐ Crying out
- ☐ Other: _____

If this person snores, what makes it worse?

- ☐ Sleeping on his/her back
- ☐ Sleeping on his/her side
- ☐ Fatigue
- ☐ Alcohol

Please describe the behaviors checked in more detail. Describe the time when it occurs, how often it occurs during the night and whether it occurs every night. _____

Has this person fallen asleep during normal daytime activities or in dangerous situations? Yes No

If yes, please explain: _____

Dose this person use sleeping pills? Yes No What kind? _____ How often _____

Does this person drink alcohol? Yes No Please estimate the per nightly use of:

_____ Beer _____ Wine _____ Liquor

Please estimate how much alcohol this person consumes in the 3 hours before bed: _____

If this person uses recreational drugs, please describe both the types and frequency of usage:

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