West Region Sleep Center

Dear Patient,

In order to serve you more effectively, we ask that you take some time and fill out the enclosed questionnaires and return them to us on your appointment.

We thank you in advance for your time and your cooperation. If you should have any questions, please feel free to call us at 216-267-5933.

Sincerely,

West Region Sleep Center

Please note that every effort has been exercised to obtain precertification and Authorization for your polysomnogram study with the insurance information provided to us. However, you are responsible for any follow-up and any payment that is not covered by your insurance company.

West Region Sleep Center

POLYSOMNOGRAPH PREPARATION LIST

- The day of your study, do not drink beverages containing caffeine or alcohol after noon.
- Bring clothing that can be accessible, loose fitting and comfortable to sleep in.
- No hairpieces, wigs, braids or weaves are to be worn. Make sure your hair is clean and dry. Electrodes will be placed on your scalp.
- Artificial nails and nail polish must be removed.
- We do have a shower facility for your convenience.
- Parking is well lit and close to the building.
- There is a remote possibility of continued testing on the following day, however the technicians will not know until that morning. If you can stay, breakfast and lunch will be provided. If you cannot stay, please sign the document provided by the technician and we will schedule you at a later date.
- If you stay or are coming for a daytime study, please bring something to occupy yourself during the awake hours.
- Daytime study patients must have at least four hours or more of sleep prior to having this study. If you are taking antidepressants, please notify the lab.
- Please note that obtaining referrals is the responsibility of the patient. Charges not covered or denied by the insurance company are also the financial responsibility of the patient.
- If your insurance company requires a referral to see a specialist, please call your primary care physician to submit the correct paperwork. Questions can be directed to us at (216-267-5933).

- Please note that appointments missed without 24 hour notice will result in a $100.00 fee charged to the patient.

Thank you,

West Region Sleep Center

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SLEEP HYGIENE

Do not nap during the day.

Maintain a regular bedtime (even on the weekends)

Maintain a regular awakening time (avoid sleeping in)

Adjust your total sleep time to fit your needs that which will allow you to feel alert and energetic during the day.

Regular exercise in the morning or early afternoon may deepen sleep but avoid strenuous physical activity just before bedtime.

Find a comfortable bedroom temperature and maintain it throughout the night, avoiding temperature extremes.

Avoid stimulants and caffeine, (coffee, tea, cola drinks, cocoa, chocolate) after 3 pm.

Avoid the use of tobacco.

Do not drink alcohol after dinner and do not eat too close to bedtime.

If you have difficulty falling asleep, don't stay awake on bed for more than 30 minutes. Instead, get up and engage in some quiet activity, such as reading, until you become sleepy, them return to bed.

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SLEEP DISORDER QUESTIONNAIRE

PERSONAL INFORMATION

LAST NAME: ____________________________________ FIRST NAME: ______________________

ADDRESS: ____

EMPLOYED Y_______ N ________ OCCUPATION: ____

WORK PHONE ____________________________ SHIFT WORK ________ YES ________NO

MARITAL STATUS: M D S W SS# _____________________________ DATE: _______________

HOME PHONE: ______________________ DATE OF BIRTH _________________ AGE: _________

SEX: ________ M _________F

MEDICAL HISTORY

HEIGHT _________ FT __________IN WEIGHT _____________

CHANGES IN WEIGHT __________6 MOS 2 YRS. ____________ NECK SIZE __________

MAJOR ILLNESSES? ______YES _______NO HOSPITALIZATION/SURGERY? _____YES_____NO

PLEASE SPECIFY
DATE ILLNESS

____
____
____
____

PLEASE SPECIFY
DATE ILLNESS

____
____
____
____

MAJOR INJURIES? ______YES _____NO

PLEASE SPECIFY

DATE ILLNESS

____
____
____
____

GENERAL HEALTH:

___________________ EXCELLENT

___________________ABOVE AVERAGE

___________________AVERAGE

___________________BELOW AVERAGE

___________________POOR

ALLERGIES:
____
____

CURRENTLY UNDER A DOCTOR'S CARE? _______YES ________NO

PHYSICIAN: ________________________ REASON: ____

HOW MUCH CAFFEINE DO YOU CONSUME PER DAY?
(COFFEE, TEA, SODA,) ____________ 8 OZ SERVINGS

DO YOU SMOKE? __________YES ___________NO CIG/DAY__________________

USUAL ALCOHOL CONSUMPTION: ___________________________ (DRINKS PER WEEK)

MEDICATIONS:
MEDICATIONS:

CURRENT MEDICATIONS NAME

PRESCRIPTIONS _______YES _____NO ______________________________
_______YES _____NO ______________________________
_______YES _____NO ______________________________
_______YES _____NO ______________________________

NON-PRESCRIPTION _______YES _____NO ______________________________
_______YES _____NO ______________________________
_______YES _____NO ______________________________
_______YES _____NO ______________________________

HAVE YOU EVER HAD ANY OF THESE:

ASTHMA _______YES______NO
CHRONIC LUNG DISEASE _______YES______NO
THYROID DYSFUNCTION _______YES______NO
SEIZURES/EPILEPSY _______YES______NO
HIGH BLOOD PRESSURE _______YES______NO
HEART DISEASE _______YES______NO
STOMACH ULCER _______YES______NO
SHORTNESS OF BREATH _______YES______NO
DEPRESSION _______YES______NO
SCARLET FEVER _______YES______NO
TONSILECTOMY _______YES______NO
BROKEN NOSE ______YES ______NO
SINUS PROBLEMS _____YES______NO
DENTAL PROBLEMS___YES ______NO
HEPATITIS ______YES______NO
PSYCHIATRIC
TREATMENT ______YES______NO
STROKE ______YES______NO
ANXIETY ______YES______NO
NIGHT SWEATS ______YES______NO
PARALYSIS ______YES______NO

IN PAST MEDICAL TREATMENTS HAVE YOU USED ANY OF THE FOLLOWING DRUGS THERAPIES?

BIOFEEDBACK _______YES ________NO
ALTERNATIVE MEDICINE _______YES ________NO
ACUPUNCTURE _______YES ________NO

WHAT TIME DO YOU USUALLY GO TO BED WEEKDAYS? ___________: ____________AM/PM
WEEKENDS? ___________: ____________AM/PM

WHAT TIME DO YOU USUALLY GET UP WEEKDAY? _____________: ____________AM/PM
WEEKENDS? _____________: ____________AM/PM

DOES YOUR BEDTIME VARY? ________YES _________NO

HOW MUCH SLEEP DO YOU GET EACH NIGHT? _________________ HOURS.

HOW LONG DOES IT TAKE YOU TO FALL ASLEEP? __________________ MIN/HOURS

HOW OFTEN DO YOU WAKE UP AT NIGHT? __________________OCCURENCES

DO YOU HAVE A PROBLEM WAKING IN THE MORNING? ________YES _________NO

HAVE YOU EVER HAD EXCESSIVE DAYTIME SLEEPINESS? ________YES _________NO

DO YOU TAKE SLEEEPING PILLS? ________YES _________NO

DO YOU EVER USE ALCOHOL TO SLEEP? ________YES _________NO

HAVE YOU EVER USED "STREET DRUGS" (MARIJUANA, AMPHETAMINES, SEDATIVES, NARCOTICS, HALLUCINOGENS, COCAINE)? ________YES _________NO

DO YOU EVER SMOKE TWO HOURS WITHIN BEDTIME? ________YES _________NO

DO YOU EXERCISE CLOSE TO BEDTIME? ________YES _________NO

DO YOU ROTATE SHIFTS IN YOUR JOB? ________YES _________NO

DO YOU HAVE TROUBLE WITH YOUR NOSE BLOCKING UP WHEN YOU TRY TO GO TO SLEEP? (I.E. ALLERGIES, INFECTIONS) ________YES _________NO

DO YOU TAKE STIMULANTS TO STAY AWAKE DURING THE DAY? ________YES _________NO

IS YOUR SLEEP DISTURBED OR RESTLESS? ________YES _________NO

DO YOU HAVE THE FEELING OF "RESTLESS LEGS" (A FEELING OF CRAWLING, ACHING, OR INABILITY TO KEEP YOUR LEGS STILL)? ________YES _________NO

DO YOU WAKE FROM YOUR SLEEP BECAUSE OF NECK, BACK, MUSCLE, JOINT, LEG, OR ARM PAIN? ________YES _________NO

HAS A FAMILY MEMBER HAD "RESTLESS LEGS" WHILE SLEEPING (CRAWLING, ACHING, OR INABILITY TO KEEP LEGS STILL)? ________YES _________NO

DO YOU FEEL MUSCULAR TENSION AT BEDTIME? ________YES _________NO

DO YOU WALK IN YOUR SLEEP? ________YES _________NO

DO YOU WAKE UP OUT OF YOUR SLEEP CONFUSED AND AT TIMES VIOLENT (NIGHT TERRORS)? ________YES _________NO

DO YOU HAVE VIVID DREAMS IN YOUR SLEEP? ________YES _________NO

DO YOU HAVE A LOT OF NIGHTMARES? ________YES _________NO

DO YOU FEEL PARALYZED (UNABLE TO MOVE) AFTER A NAP OR UPON AWAKENING? ________YES _________NO

DO YOU HAVE DREAMLIKE IMAGES (HALLUCINATIONS) WHEN GOING TO SLEEP OR WAKING UP? ________YES _________NO

HAVE YOU GOTTEN BAD GRADES BECAUSE OF BEING TOO SLEEPY? ________YES _________NO

DO YOU GRIND YOUR TEETH IN YOUR SLEEP? ________YES _________NO

DO YOU EVER GET "WEAK KNEES" WHEN YOU LAUGH? ________YES _________NO

DO YOU EVER GET MUSCULAR WEAKNESS (EVEN BRIEFLY) WHEN LAUGHING, ANGRY, OR IN SITUATIONS OF EXTREME EMOTION? ________YES _________NO

DO YOU WAKE UP OFTEN DURING THE NIGHT? ________YES _________NO

DO YOU FEAR NOT BEING ABLE TO GO BACK TO GO TO SLEEP AFTER YOU AWAKEN? ________YES _________NO

IS YOUR SLEEP RESTLESS AND DISTURBED? ________YES _________NO

DO YOU SNORE? ________YES _________NO

DO YOU AWAKEN GASPING FOR BREATH, UNABLE TO BREATHE? ________YES _________NO

DOES YOUR HEART POUND OR BEAT IRREGULARLY AT NIGHT? ________YES _________NO

DO YOU HAVE CHEST PAIN DISTURBING YOUR SLEEP? ________YES _________NO

DO YOU SLEEP FOR SEVERAL DAYS AT A TIME, OR AT LEAST HAVE YOU BEEN OVERWHELMINGLY SLEEPY FOR LONG PERIODS OF TIME? ________YES _________NO

DO YOU HAVE DIFFICULTY SLEEPING
BECAUSE OF HEADACHES? ________YES _________NO

DO YOU FEEL THE QUALITY OF SLEEP
IS POOR NO MATTER HOW MUCH SLEEP
YOU GET? ________YES _________NO

ARE YOU VERY SLEEPY DURING THE DAY
AND STRUGGLE TO STAY AWAKE? ________YES _________NO

HAVE YOU EVER FALLEN ASLEEP EATING
A MEAL, TALKING ON THE PHONE, TALKING TO
SOMEONE, RIDING ON A BUS OR IN A CAR, WATCHING
TV, AT A THEATER, AT A LECTURE, OR READING
A BOOK? ________YES _________NO

DO YOU HAVE DIFFICULTY DOING YOUR JOB
BECAUSE OF BEING TOO SLEEPY OR FATIGUED? ________YES _________NO

DO YOU NEED TO LET SOMEONE ELSE DRIVE
DUE TO SLEEPINESS OR FATIGUE? ________YES _________NO

HAVE YOU EVER DRIVEN YOUR CAR TO THE
WRONG PLACE AND CAN'T REMEMBER HOW
YOU DID IT? ________YES _________NO

DO YOU TEND TO WAKE (SUDDENLY) DURING
THE NIGHT WITH AN UNPLEASANT FEELING OF
FEAR, ANXIETY, WORRY OR DEPRESSION? ________YES _________NO

DO YOU WAKE DURING THE NIGHT FEELING
THIRSTY, HUNGRY, OR NEEDING TO GO TO THE
RESTROOM. ________YES _________NO

DO YOU WAKE WITH HEARTBURN? ________YES _________NO

DO YOU NAP?
(IF YES):
HOW OFTEN? __________/DAY
HOW LONG? __________MIN _______HOURS

ARE YOU UNDER AN UNUSUAL AMOUNT OF STRESS
AT THIS TIME? ________YES _________NO

DO YOU HAVE PROBLEMS WITH YOUR TONSILS
AND ADENOIDS? ________YES _________NO

DOES ANYONE IN YOUR FAMILY SUFFER
FROM EXCESSIVE DAYTIME SLEEPINESS? ________YES _________NO

HAS ANY FAMILY MEMBERS EVER DIED IN
THEIR SLEEP? ________YES _________NO

IS YOUR SNORING OR BREATHING
MUCH WORSE ON YOUR BACK? ________YES _________NO

DOES ANYONE IN YOUR IMMEDIATE FAMILY
HAVE TROUBLE WITH INSOMNIA (BROTHER
SISTER, MOTHER/FATHER, SON/DAUGHTER,
GRANDPARENT)? ________YES _________NO

DOES ANYONE IN YOUR IMMEDIATE FAMILY
HAVE PSYCHIATRIC OR EMOTIONAL ILLNESS? ________YES _________NO

HAVE YOU EVER HAD A HEAD INJURY OR LOSS
OF CONSCIOUSNESS? ________YES _________NO

EPWORTH SLEEPINESS SCALE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS IN CONTRAST TO JUST FEELING 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*
SITTING AND READING. ……………………………………………………	___________________
WATCHING TV. ………………………………………………………………	___________________
SITTING INACTIVE, IN PUBLIC (E.G. A THEATER OR 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 A LUNCH WITHOUT ALCOHOL…………………………………………………………	____________________
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC………………………………………………………..	_____________________

TOTAL _____________________