SLEEP STUDY INSTRUCTIONS

ABOUT THE TEST: In order to diagnose sleep abnormalities, your oxygen level, snoring, air flow from your nose and mouth, eye movement, leg movement, brain waves, and heart must be monitored while you sleep. To do this, electrodes will be placed on your head, face, and legs and a belt will be placed around both your chest and waist. A very small light probe will be placed on your finger. The results of this monitoring will be interpreted by a physician with specialized training in sleep disorders. **The ordering physician will contact you regarding the results of your sleep study. If you have not heard from them within 10 days, please contact their office.**

There are two different sleep studies:

1. A diagnostic sleep study is performed to determine or diagnose a sleep disorder; if indicated.
2. A therapeutic sleep study is performed to treat and correct a diagnosed sleep problem.

Each test will be billed separately. You will only be billed for the test(s) performed.

Your sleep technician will be in the Control Room keeping a watchful eye on you and the monitors throughout the night.

REGISTRATION: You will receive a call from the hospital prior to your appointment in which you will be pre-registered and notified of your estimated charges. If you have not received a call within 48 hours prior to your appointment, please call (580) 251-6684.

SCHEDULE:

- Check in at the DRH Sleep Center 2434 Harville Rd, Ste 600 by your appointment time.
- Preparation will take approximately one hour. Please eat before you arrive.
- The lights will be turned off and the study begun by 10:30 p.m. The study will end at approximately 5:00 a.m.

Please let the technician know if you need to be released from the Sleep Center earlier than 5:00 a.m.

If you have any questions, concerns, or you need to reschedule your test, call us at (580) 251-8178 or 580-251-6684.

INSTRUCTIONS:

- Complete the Sleep History questionnaire about your sleep habits and medical history. Give the completed questionnaire to your technician when you arrive at the Sleep Lab for your study.
- Please, **NO caffeine** within 4 hours prior to bedtime and refrain from napping if possible.
- Follow your usual routine. You may take your usual medications or bring your bedtime dose with you. **If you normally take medications for sleep, pain, or muscle relaxants please do not take them and drive. Bring them with you**.
- If you have a favorite pillow or blanket, feel free to bring it.
- Shower before the test and have clean hair. Do not use gels, mousse, hair spray, body lotions, oils, or powders. Contact us if you wear hair pieces of **ANY** kind, as this may impeded with electrode placement.
- Bring any toiletries you may need (showers are **not** available).
- Bring pajamas or other two-piece combination (shirt / loose pants / shorts) to sleep in (preferably cotton).
- If you have any special needs, please contact us. If you are diabetic, please bring any supplies you might need.
- Do not bring any valuables with you. Duncan Regional Hospital is not responsible for the loss of your personal belongings.

Thank you for choosing the Duncan Regional Hospital Sleep Center

DRH HEALTH

PATIENT SLEEP HISTORY QUESTIONNAIRE

Today's Date: _____

SECTION I PATIENT INFORMATION

Patient Name: _____ DOB: _____ Height (inches): _____

Age: _____ Gender: _____ Neck Circumference (inches): _____ Weight (pounds): _____

Referring Physician: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SECTION II MAJOR SLEEP-RELATED COMPLAINT

☐ Excessive sleepiness ☐ Awaken with headaches ☐ Waking too early ☐ Snoring

☐ Choking sensation during sleep ☐ Difficulty falling asleep ☐ Stop breathing during sleep ☐ Sleep walking

☐ Frequent sleep disruptions ☐ Difficulty staying asleep ☐ Other (please explain):

1. How long have you had your symptom(s)? _____ Years _____ Months

2. How did your symptom(s) begin? ☐ Suddenly ☐ Gradually ☐ Other _____

SECTION IIIa: DAYTIME SYMPTOMS

3. Please answer the following questions with the understanding that FATIGUE means feeling "worn out" and SLEEPINESS means "a need to sleep" or dozing off unintentionally

3a. What word best describes your level of daytime FATIGUE in the last month?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

3b. What word best describes your level of daytime SLEEPINESS in the last month?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

4. How long has daytime sleepiness been a problem for you? (Check NA is you have no sleepiness.) _____ **years** ☐ NA

5. Do you feel rested when you wake up from your usual sleep period? ☐ Never ☐ Sometimes ☐ Most times

6. Do you take naps during the day? ☐ Never ☐ Sometimes ☐ Most times

7 Do you feel refreshed after brief (less than 1 hour) naps? ☐ Never ☐ Sometimes ☐ Most times

8. Do you sleep longer on weekends or holidays than on weekdays? ☐ Never ☐ Sometimes ☐ Most times

9. Do you use medicine to help you stay awake? ☐ Never ☐ Sometimes ☐ Most times

10. During the past month, how much has sleepiness interfered with your normal work performance? ☐ Never ☐ Sometimes ☐ Most times

11. During the past month, how much has sleepiness interfered with normal social activities with family, friends and other groups? ☐ Never ☐ Sometimes ☐ Most times

12. Have you had recent accidents or near accidents because of sleepiness? (i.e., car, work, home) ☐ Yes ☐ No

13. Have you had sudden physical weakness of arms, legs or face when angry, laughing, crying or during other heightened emotional situations? ☐ Yes ☐ No

14. When you fall asleep or just before you awaken do you have bizarre dreams? ☐ Yes ☐ No

15. When you fall asleep or just before you awaken do feel as if you are paralyzed? ☐ Yes ☐ No

16. Have you ever been told that you have Narcolepsy? If yes, when and by whom? ☐ Yes ☐ No

SECTION IIIb EPWORTH SLEEPINESS SCALE

Please read the questions below and rate the chances that you would doze off or fail asleep (in contrast to just feeling tired) during different routine situations. These situations should refer to your usual way of life in recent times. Please use the scale described below (0 through 3) to rate each question.

0 = Would **never** doze or sleep 1 = **Slight** likelihood of dozing or sleeping	2 = **Moderate** likelihood of dozing or sleeping 3 = **High** likelihood of dozing or sleeping

Situation	**Rating**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (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 down and talking to someone	
Sitting quietly after a lunch	
In a car, while stopped for a few minutes in traffic	
17. Total Score	

SECTION IV SLEEP HABITS

18. Workday usual bedtime _____ ☐ a.m. ☐ p.m. **20.** Non-workday usual bedtime _____ ☐ a.m. ☐ p.m.

19. Workday usual wake time _____ ☐ a.m. ☐ p.m. **21.** Non-workday usual wake time _____ ☐ a.m. ☐ p.m.

21. Do you use electronics or watch tv while in bed? ☐ Yes ☐ No

22. How many hours of sleep do you feel that you achieve on average during this period? _____ Hours

23. How many hours of sleep do you feel you need to feel alert during your waking period? _____ Hours

24. How long does it usually take you to fall asleep? _____ Hours _____ Minutes

25. How often are you likely to awaken during the night? ☐ Rarely ☐ 3 times or less ☐ Frequently

26. Do you currently have a bed partner or sleep observer? (If yes, ask them to complete Section IX.) ☐ Yes ☐ No

27. Have you been told that you snore loudly? (If Yes, how many years has snoring been noted?) _____ ☐ Yes ☐ No

28. Have you been told that you stop breathing during sleep? ☐ Yes ☐ No

29. Have you been told that your arms and legs jerk during sleep? ☐ Yes ☐ No

30. Do you often awaken at night with a sensation in your lower legs that goes away when you walk around? ☐ Yes ☐ No

31. If yes, to #30 above, do the sensations in your lower leg become worse when you get into bed, making it difficult to fall asleep? ☐ Yes ☐ No

SECTION V RELATED MEDICAL INFORMATION

32. Do you or have you ever suffered from any of the following? (Check all that apply.)

- ☐ High blood pressure
- ☐ Chronic nasal /sinus problems
- ☐ Chronic lung disease (COPD, Emphysema, asthma)
- ☐ Tonsillectomy and/or adnoidectomy
- ☐ Angina / Heart attack
- ☐ Heart failure (CHF)
- ☐ Irregular heart beat (AFib)
- ☐ Pacemaker and/or Defibrillator
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Treatment for depression
- ☐ Restless Leg Syndrome

33. List any major medical problems or illnesses you have had in the past that are not listed.

_____

_____

SECTION VI MEDICATIONS

34. List all **MEDICATIONS** that you are currently taking. Be sure to list prescription and non-prescriotion medications, including sleep agents.

Medication Name	*Dosage Per Day*	*For How Long*	*Purpose*
		____ Yrs ____ Mos	
		____ Yrs ____ Mos	
		____ Yrs ____ Mos	
		____ Yrs ____ Mos	
		____ Yrs ____ Mos	
		____ Yrs ____ Mos	
		____ Yrs ____ Mos	
		____ Yrs ____ Mos	

35. List all **MEDICATION ALLERGIES** you may have. _____

_____

36. Do you have any allergies or sensitivities to any tape or bandage? ☐ Yes ☐ No

37. Do you have any allergies or sensitivities to latex? ☐ Yes ☐ No

SECTION VII: PREVIOUS SLEEP APNEA DIAGNOSIS & TREATMENT

38. Have you ever been diagnosed with sleep apnea? If Yes, when? _____ ☐ Yes ☐ No

If Yes to above, are you currently being treated with CPAP / Bilevel therapy? ☐ Yes ☐ No

Do you feel any difference when using CPAP / Bilevel during sleep? ☐ Yes ☐ No

If currently using positive airway pressure therapy, please indicate the prescribed pressure. _____ cmH2O

39. Have you had any surgical treatment(s) for sleep apnea? ☐ Yes ☐ No

40. Do you use a dental appliance for sleep apnea or teeth grinding? ☐ Yes ☐ No

SECTION VIII: SOCIAL HABITS& FAMILY HISTORY

41. Do you drink alcoholic beverages? If yes, please indicate type, quantity, and frequency below. ☐ Yes ☐ No
If Yes, What type? _____ Number of glasses/cans/bottles? _____ per ☐ day ☐ week ☐ month

42. Do you drink caffeinated beverages? If yes, please indicate type, quantity, and frequency below. ☐ Yes ☐ No
If Yes, What Type? _____ How many glasses/cans/cups? _____ per ☐ day ☐ week ☐ month

43. Have you gained any weight over the last year? ☐ Yes ☐ No
If Yes, how much? _____ pounds

44. Do other family members have similar sleep problems? ☐ Yes ☐ No

45. What is your occupation? _____

46. What are your usual working hours? _____

47. Please use the following space to elaborate on other related information about your medical or sleep complaints.

_____

_____

_____

_____

_____

_____

_____

_____

SECTION IX OBSERVATIONS OF OTHERS

48. If you have had opportunities to observe this patients sleep please check any behaviors that apply and how long they have occurred.

☐ Snore or Snort	___ Years	___Months	☐ Stop breathing/Gasp for air	___ Years	___Months
☐ Leg/arm/body jerks	___ Years	___Months	☐ Violent Behavior/Acting Out Dreams	___ Years	___Months
☐ Grind teeth	___ Years	___Months	☐ Screaming/walking in sleep	___ Years	___Months

49. Use the space provided for additional comments. _____

_____

_____

_____

_____

_____