The FLORIDA CENTERS of SLEEP MEDICINE

A NIGHT IN THE SLEEP FACILITY

The architecture of sleep – that is, the distribution of sleep stages – is revealed through sleep studies. Excessive sleepiness, insomnia, depression and disturbing physical events (such as breathing and muscle problems) can be diagnosed with such testings.

You are not alone with your sleep problems. In fact, more than 100 million Americans are poor sleepers. The good news is that sleep disorders can be diagnosed accurately and managed effectively. If you have been scheduled to spend a night in a sleep lab, RELAX! Results obtained from patients around the country have shown that a positive difference in sleep can be achieved in approximately 85% of patients following a polysomnogram (sleep study) and appropriate treatment by sleep specialists.

YOU WILL HAVE THE SAFEST SLEEP STUDY POSSIBLE

The same sleep you experience at home will also occur in the sleep facility except that it will be observed and measured. Nothing is done in the lab to change sleep-related events nor is anything inserted into the body. In fact, an elaborate, well-planned pre-sleep regimen is undertaken. This regimen includes preparing and applying external electrodes and answering any questions that you may have concerning sleep and the sleep lab. Some patients may feel uncomfortable when they are wired with electrodes or are monitored by microphones and visual observation but they usually sleep adequately. The sleep lab environment is safe and conducive to sleep. It is dark, quiet and pleasing with controlled, comfortable temperatures.

HOW TO PREPARE FOR THE SLEEP LAB

Most importantly, maintain your normal daily schedule but avoid starting a new diet or exercise program until after the sleep study. If you are taking any sleep medications, your physician may ask you to discontinue taking it for at least one week before coming for your study. Generally, patients do not need to discontinue their medications. However, ask you physician and be sure to tell the sleep center personnel about any medications that you are taking.

Your appointment is for 9:00 P.M. Please eat your evening meal at least 1 to 1 ½ hours before arriving at the facility. Avoid foods that contain caffeine including coffee, tea, cola and chocolate during the day of the scheduled study. Also, avoid alcoholic beverages and do not take naps during the day. Bring your regular, comfortable night clothes, a robe, slippers and even your own pillow if you think it will help you to sleep better. Finally, please do not apply any oils or conditioners in your hair since these may interfere with the application of electrodes. Also, please let the sleep lab know before your appointment if you have any type of hair weaves, wigs, caps, etc., that would prevent the technician from applying the electrodes directly on your scalp. Your sleep study will need to be rescheduled for a time when these items are not preventing access to your scalp.

HOW IS THE POLYSOMNOGRAM PERFORMED?

A certified technician (polysomnographer) will conduct the evaluation. After you are dressed for sleep, the technician will use a paste to apply approximately 20 small, lightweight electrodes to your scalp and skin. Once you are in bed, the technician will apply an oxygen sensor to a finger and 2 straps to your chest/stomach. These devices will help us to measure your breathing and determine why your sleep is being disturbed. The attachments are plugged into a box which is easy to disconnect if you need to get our of bed during the night. The technician will be in an adjacent monitoring room. If you need anything, you will be observed both by camera and intercom.

HOW LONG WILL THE STUDY LAST?

An overnight sleep study usually ends between 5:30 – 6:00 A.M. the following morning. If a “nap study” during the day (Multiple Sleep Latency Test/MSLT) is requested, it follows the overnight study and ends around 4:30 – 5:00 P.M. the next day.

WHEN ARE THE RESULTS KNOWN?

A tremendous volume of sleep information is collected on paper and in the computer. The scored study, sleep history, physical examination, the technician’s observation notes and any other testing that you may have had performed will be forwarded to one of our interpreting physicians who are sleep specialists. Careful interpretation of all results is then undertaken. This leads to a diagnosis of the sleep problem as well as recommendations for treatment. The final report is completed within 10 to 14 business days. You will be able to get the results of your study from your referring/ordering physician. Please do not call us directly for the results. We will not be able to discuss them with you.

If you have any questions, please do not hesitate to ask. All sleep facility personnel are ready to help you to have a comfortable stay during your sleep study.

THE FLORIDA CENTERS OF SLEEP MEDICINE
Sleep History Questionnaire

GENERAL INFORMATION

Date: _____

Name: _____ Age _____ DOB: _____

Address: _____
Street Apt. / Lot / Unit #

_____
City State Zip

Phone(s): Home _____ Cell _____

Permission given to leave messages at: ___ Home ____ Cell ____ Both ____ Permission not given

Last 4 SSN: _____ Marital Status: Married Divorced Single Widowed Other

Height: _____ Weight: _____ Sex: Male Female Are you a shift worker? Yes No

Referral Source: Physician TV Newspaper Friend Other: _____

Ordering/Referring Physician/Provider's Name: _____

Primary Care Physician's Name: _____

Employer Name: _____

INSURANCE INFORMATION

Self Pay: Yes No If no, please provide the following information for your insurance policy(ies).

Primary Insurance Name: _____ Phone #: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy/Member/ID #: _____ Group #: _____

Secondary Insurance Name: _____ Phone #: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy/Member/ID #: _____ Group #: _____

SLEEP AND WAKE BEHAVIOR

Please state in your own words the reason that you and/or your doctor have contacted the Sleep Center: _____

_____.

FALLING ASLEEP

What time do you usually try to fall asleep? _____ A.M. or P.M. Does this vary? Yes No
How long does it usually take you to fall asleep? _____ minutes or hours
How many days each week does it take you more than 30 minutes to fall asleep? 1 2 3 4 5 6 7 Never
How many days each week does it take you more than 60 minutes to fall asleep? 1 2 3 4 5 6 7 Never

Check one answer for each question.

When falling asleep or trying to fall asleep, how often do you

	NEVER	SOMETIMES	OFTEN
have thoughts racing through your mind?	_____	_____	_____
feel sad or depressed?	_____	_____	_____
have anxiety / worry about things?	_____	_____	_____
feel muscular tension?	_____	_____	_____
feel unable to move?	_____	_____	_____
have creeping, crawling, aching or twitching feelings in your legs (like you have to move them)?	_____	_____	_____
have vivid, dream-like scenes even though you know you are not totally asleep?	_____	_____	_____
have any kind of pain or discomfort?	_____	_____	_____
feel afraid of the dark or anything else?	_____	_____	_____
suddenly become aware or alert?	_____	_____	_____

SLEEPING

How much does your nightly amount of sleep vary?
FROM _____ hours and _____ minutes *TO* _____ hours and _____ minutes

How many times do you usually awaken each night? _____ Do you have trouble getting back to sleep? Yes No

On a typical night, what is your longest period of wakefulness? _____ hours and _____ minutes

How long are you awake all together during the night? _____ hours and _____ minutes

Check One

If you awaken during the night, is it usually during the :

_____ first part of the sleep period? _____ second part of the sleep period? _____ third part of the sleep period?

Check one answer for each question.

How often do you

	NEVER	SOMETIMES	OFTEN
feel afraid you won't return to sleep after awakening?	_____	_____	_____
sleep with someone else in your bed?	_____	_____	_____
sleep with someone else in your room?	_____	_____	_____
have restless, disturbed sleep?	_____	_____	_____
get up at night to attend to your children or to something else?	_____	_____	_____
snore loudly?	_____	_____	_____
feel your heart pounding during the night?	_____	_____	_____
sweat a lot during the night?	_____	_____	_____
walk in your sleep?	_____	_____	_____
fall out of bed while asleep?	_____	_____	_____
wake up screaming, violent or confused?	_____	_____	_____
have unusual movement while asleep?	_____	_____	_____
wet the bed?	_____	_____	_____
have dreams?	_____	_____	_____
grind your teeth at night?	_____	_____	_____

Circle all that are true.

My sleep is frequently disturbed by:

heat choking coughing cold indigestion, gas or heartburn frightening dreams

light hunger thirst noise shortness of breath asthma

chest pain need to urinate noise or movement of your bed partner

creeping, crawling or aching feeling in your legs (like you have to move them)

WAKING UP

What time do you usually have your final awakening? _____ A.M. / P.M.

What time do you usually get out of bed after your final awakening? _____ A.M. / P.M.

How much does your final awakening time vary? *FROM* _____ hours & _____ minutes *TO* _____ hours & _____ minutes.

Check one answer for each question.

How often do you	NEVER	SOMETIMES	OFTEN
depend on an alarm clock to wake up?	_____	_____	_____
"sleep in" in the morning (more than 1 hour) past your usual wake-up time?	_____	_____	_____
have a very hard time waking up?	_____	_____	_____
feel unable to move when waking up?	_____	_____	_____
have dream-like images when waking up even though you know you are not asleep?	_____	_____	_____
wake up confused or disoriented?	_____	_____	_____
wake up with a headache?	_____	_____	_____
wake up nauseous (sick to your stomach)?	_____	_____	_____
wake up with a dry mouth?	_____	_____	_____
wake up 1 or 2 hours before you have to get up?	_____	_____	_____

DAYTIME FUNCTIONING

How many naps do you take in a week? _____ How long do you usually sleep during a typical nap? _____ minutes / hours

Are the naps refreshing? Yes No

Check one answer for each question.

How often do you	NEVER	SOMETIMES	OFTEN
feel sleepy during the day?	_____	_____	_____
fall asleep unintentionally? Please give an example.	_____	_____	_____
have thoughts racing through your mind?	_____	_____	_____
feel sad or depressed?	_____	_____	_____
have anxiety (worry about things)?	_____	_____	_____
feel muscular tension?	_____	_____	_____
feel weakness in your muscles when laughing, surprised, angry, excited, etc?	_____	_____	_____

OTHER QUESTIONS

Does anyone in your family have a sleep problem? Yes No If yes, relationship to you? _____

Describe their problem:_____

_____

How much of the following fluids do you drink?

	During a typical day	Within 2 hours before bedtime
coffee, caffeinated	_____ cup(s)	_____ cup(s)
coffee, decaffeinated	_____ cup(s)	_____ cup(s)
tea	_____ cup(s)	_____ cup(s)
soda	_____ cup(s)	_____ cup(s)
beer	_____ cup(s)	_____ cup(s)
wine	_____ cup(s)	_____ cup(s)
other alcoholic beverages	_____ cup(s)	_____ cup(s)

Check one answer for each question.

How often do you use	**NEVER**	**SOMETIMES**	**OFTEN**
marijuana?	_____	_____	_____
cocaine?	_____	_____	_____
hallucinogens (LSD, mescaline, angel dust, etc)?	_____	_____	_____
stimulants (uppers)?	_____	_____	_____
depressants (downers)?	_____	_____	_____
narcotics (heroin, morphine, opium, etc.)?	_____	_____	_____

MEDICATIONS

Please list the name and dose (in mg.) of all medications that you take ***NOW or WITHIN THE PAST 30 DAYS***. Attach a list if necessary.

MEDICATION	DOSE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the name of any pill for sleeping or for helping you to stay awake that you have taken in the ***PAST.***

Name	Did it help?	
_____	Yes	No
_____	Yes	No
_____	Yes	No

How many times each week do you participate in a sport of partake in some form of exercise? _____

What is your personal interpretation as to why you have your particular sleep/wake problem? _____

_____

HEALTH HISTORY

Present Height: _____ Present Weight: _____ Has you weight recently changed? Yes No

If yes, please explain: _____

Please circle all problems or illnesses you have or have had.

Heart disease	High blood pressure	Heart attack	Low blood pressure	Fainting	Dizziness
Headaches	Ringing in the ears	Epilepsy	Black outs	Hemophilia	Prostate problems
Ulcers	Mental problems	Depression	Hernia	Back trouble	Gout
Seizures	Asthma	Allergies	Bronchitis	Cancer	Kidney trouble
Bladder Trouble	Eye trouble	Hearing problems	Pneumonia	Meningitis	Heartburn
Arthritis	Impotence	Venereal disease	Tuberculosis	Muscle Cramps	

SURGERIES AND HOSPITALIZATIONS

Please list any hospitalizations and/or surgeries that you have had. ***RECORD THE MOST RECENT FIRST.***

When **Where** **What** **Why**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

BED PARTNER QUESTIONNAIRE

Name of Patient _____

Name of the person completing this form _____

I have observed this person's sleep (Circle one) Never Once or twice Often Every Night

Circle any of the following that you have observed this person doing while asleep.

Light snoring Loud snoring Occasional loud snorts Pauses in breathing Choking Sleepwalking

Grinding teeth Biting tongue Head rocking/banging Bed wetting Crying out Twitching or kicking legs

Shaking Getting out of bed not awake Twitching or jerking of arms Sitting up in bed not awake

Becoming rigid and/or awakening with pain Other: _____

Please describe the sleep behaviors circled above in more detail. Include a description of the activity, the time during the night when it occurs, the frequency during the night and whether the behavior occurs every night.

_____

_____

_____

_____

_____

_____

_____

_____

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

If yes, please explain: _____

_____