COMPLETE SLEEP STUDY PACKAGE

Your doctor suspects that you may have an abnormal sleep pattern and has requested a further evaluation through this office. Sleep abnormalities can cause serious health problems so in order to diagnose you properly we need to monitor you closely while you sleep.

Our goal is for you to have a normal nights sleep so we have strived very hard to make you feel at home even though you will be in an unfamiliar place and monitored with medical equipment. Monitoring is painless and is accomplished by wires and adhesive pads attached to various areas.

Monitor May Include The Following:

- Brain waves (attached to the scalp)
- Heart rate and rhythm (attached to the chest)
- Eye Movements (attached to the outside of the eyes)
- Leg Movements (attached to the lower legs)
- Breathing rate and rhythms (attached to the nose, mouth, chest and/or stomach)
- Oxygen levels (attached to finger or ear lobe)

In Preparation For Your Test:

- Shower and shampoo hair before arriving
- Do not use any oils, gels, lotions, etc
- Do not apply any wigs or weaves that do not allow for us to get to your scalp
- Avoid alcohol, caffeine, and naps
- Eat dinner before you arrive
- Continue taking your prescribed medications unless told otherwise
- Please arrive on time and if you are coming by transportation make sure they pick you up on time

To make yourself more comfortable, please bring the following items:

- Bed clothes- preferably two-piece pajama sets
- Change of clothes for the next day
- Personal toiletry items and a towel
- Reading materials during the non-sleep periods
- Medications you usually take

**** NO SHOW FEES FOR SLEEP STUDY - $100.00****

PLEASE LEAVE ALL VALUABLES AT HOME-**WE ARE NOT RESPONSIBLE FOR ANYTHING LOST OR STOLEN**

MAKE ARRANGEMENTS TO BE PICKED UP BY **6A.M.** IF YOU ARE COMING BY TRANSPORTATION

SLEEP TECHNICIANS AND/OR THE OFFICE ARE **NOT RESPONSIBLE FOR YOU AFTER THIS TIME**

IF YOU MUST RESCHEDULE YOUR APPOINTMENT, PLEASE CONTACT US AT LEAST **48 HOURS IN ADVANCE** AT (770) 991-3888 BETWEEN THE HOURS OF 9A.M. TO 5P.M.

THANK YOU FOR CHOOSING **SOUTH ATLANTA PULMONARY & CRITICAL CARE ASSOCIATES AND CENTER FOR SLEEP** TO CONDUCT YOUR SLEEP STUDY

SOUTH ATLANTA PULMONARY & CRITICAL CARE ASSOCIATES, L.L.C.
AND
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PULMONARY DISEASES
SLEEP MEDICINE
PULMONARY REHAB

RAO S. MIKKILINENI, M.D., F.C.C.P., F.A.C.P.
Board Certified in Pulmonary Diseases
Board Certified in Sleep Medicine
Board Certified in Internal Medicine

SLEEP HISTORY QUESTIONNAIRE

The purpose of this questionnaire is to determine the nature of your sleep problem. It is very important to be as accurate as possible in answering the questions. Your bed partner may be able to assist you.

*** Please remember to write your name at the top of each page.**

This information will become part of your medical record and will remain confidential.

GENERAL INFORMATION:

Date questionnaire completed: _____
(Month/ Date/ Year)

Name: _____
Last First MI

Address: _____
Street

_____
City State Zip code

Home: (____)_____ Work: (____)_____

Birth date:___/___/___ Age:____ Sex:___ Race: _____ Martial Status:_____

Height:_____ Weight: _____ Neck Size:_____ BMI: _____

SSN: _____ Occupation:_____

Contact in case
Of emergency: _____

Phone _____

Referring physician: _____

_____

Primary physician: _____

REVIEWED BY: _____ **DATE:** _____

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name: _____ **Date:** ____/____/____

SUMMARY OF YOUR SLEEP PROBLEM:

1. Describe your sleep problem(s) in your own words.

2. Describe haw and when this problem began.

3. Describe any treatments you have received for your problem.

4. Has this been a continuous or intermitted problem?
   [ ] intermittent, occasional problem
   [ ] frequent problem
   [ ] continuous, almost every night

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name:_____ **Date:** ____/____/____

5. How long has your sleep problem bothered you?

   [ ] longer then 2 years
   [ ] 1 to 2 years
   [ ] several months
   [ ] within the last 3 months
   [ ] within the last month

MEDICAL HISTORY/ CONDITIONS:

6. List current medical conditions for which you are being treated.

Problem or diagnosis	Physician

7. List all hospitalizations and surgeries you have has (Please be thorough and include Surgeries to remove your adenoids or tonsils, or hospitalizations for head injury, seizures or heart conditions).

Problem or diagnosis	Date

8. List medications you are currently taking. (Please include prescription and non-prescription medications of all types, including sleep and non-sleep related. Also indicate if you are on supplemental oxygen.)

Name of medication	Dosage	How often	Reason

_____

_____

_____

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name:_____ **Date:** ____/____/____

9. Please list/describe any allergies you have: _____

_____

_____

10. Do you have a family history of snoring or other sleep disorders? **[Circle the appropriate response. "N" for "No": "Y" for "Yes"]** N Y

If yes, please describe_____

_____

_____

11. Are you unable to sleep in a flat position due to shortness of breath? N Y

12. Have you ever sustained a brain concussion, head injury or serious blow to the head? N Y

13. Do you have spells or seizures? N Y

14. Do you have high blood pressure? N Y

15. Have you experienced a weight gain in the last year? N Y

a. If "yes" approximately how many pounds have you gained? _____pounds

16. Has your shirt collar size increased recently? N Y

a. if "yes" approximately how many inches has your collar increased? _____inches

17. Do you smoke?

a. If you smoke, how many packs per day? _____packs a day

b. How Long have you smoked? _____years

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name:_____ **Date:** ____/____/____

18. Are you a former smoker? N Y

a. If you are a former smoker, how much? _____packs a day

b. How long did you smoke? _____years

c. When did you quit smoking? _____

19. Do you drink alcohol? N Y

a. please estimate the number of drinks (including beer, wine, liquor) you have per day. _____ workdays _____ days off

b. Do you drink alcohol after 6:00 p.m.? [Circle the appropriate response. Use abbreviations at top of page.] N R O F A

20. Do you consume caffeinated drinks? N Y

a. If you drink caffeinated drinks, please estimate the number of drinks (including soft drinks, coffee, tea) you have per day. _____work days _____days off

b. Do you drink caffeine after 6 p.m.? N R O F A

21. (Males) Have you experienced difficulties with sexual functioning? N R O F A

22. (Females) Dose your sleep problem vary according to stage of your menstrual cycle? N R O F A

23. (Females) Have you gone through menopause or had a hysterectomy? N R O F A

YOUR SLEEP HABITS:

24. How many hours of sleep do you usually get per night? _____

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name:_____ **Date:** ___/___/___

25. What time do you usually go to bed? _____workdays

_____ days off

26. What time do usually wake up? _____workdays

27. How long dose it take you to fall asleep? _____

28. How many times do you typically wake up at night? _____

29. If you wake up, on the average how long do you stay awake? _____

30. Which shift do you work? (check all that apply)
_____ day
_____ evening
_____ night

31. How often do you rotate shifts? N R O F A

32. Dose your job require overnight travel? N R O F A

33. Are you able to fall asleep and awaken on a day to day, week to week bases according to your desired schedule? N R O F A

34. Do you nap during the day or evening? N R O F A

THE QUALITY OF YOUR SLEEP:

35. Do you feel refreshed after a typical night's sleep? N R O F A

36. Do you feel sleepy during the day even when you have slept all night? N R O F A

37. Do you feel refreshed after a short nap? N R O F A

38. Do you get sleepy while driving? N R O F A

39. Have you has an accident or near- accident when driving, due to excessive sleepiness? N R O F A

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name:_____ **Date:** ____/____/____

40. Do you fall asleep when you want to stay awake (movies, theater, church or watching television)? N R O F A

41. Are you able to fight off the excessive sleepiness? N R O F A

42. Do you have memory or concentration problems? N R O F A

43. Do you experience vivid dream-like scenes upon awakening or falling asleep? N R O F A

44. When you are angry or laugh, do you ever feel weak, as though you might fall? N R O F A

45. Are you ever unable to move or speak upon falling asleep or awakening? N R O F A

46. Do you have trouble falling asleep when you first go to bed? N R O F A

47. When you try to fall asleep does your mind race with many thoughts? N R O F A

48. When you try to fall asleep do you worry about whether or not you will be able to sleep? N R O F A

49. When you try to fall asleep do you feel pain? N R O F A

50. Dose pain ever wake you up, disrupt your sleep or keep you from going back to sleep? N R O F A

51. Are you a light sleeper, easily awakened? N R O F A

52. Is your sleep disturbed because of your bed partner or others in your household? N R O F A

53. Do you snore? N R O F A

54. Does your snoring stop for brief periods during the night (as seen by others)? N R O F A

55. Dose your breathing sometimes stop during sleep (as seen by others)? N R O F A

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name:_____ **Date:** ____/____/____

56. Is your bed partner disturbed by your snoring? N R O F A

57. Do you wake up choking or gasping for breath? N R O F A

58. Do you have night sweats? N R O F A

59. Do you have heartburn at night? N R O F A

60. Do you have a bitter bile taste in the back of your throat when you wake up (not "morning breath")? N R O F A

61. Do you have nasal/sinus congestion at night? N R O F A

62. Do you have morning headaches? N R O F A

63. Are you a restless sleeper, tossing and turning At night? N R O F A

64. Do you have a creeping or crawling sensation in your legs when you lie down to sleep? N R O F A

65. Do you experience any type of leg or back pain during the night? N R O F A

66. Do you wake up with sore or aching muscles or joints (including leg or back pain)? N R O F A

67. Do you grind or clench your teeth during sleep? N R O F A

68. Did you walk or talk in your sleep as a child or adolescent? N R O F A

69. Do you now walk or talk in your sleep? N R O F A

70. Do you have frightening dreams or nightmares? N R O F A

71. Do your dreams or nightmares awaken you? N R O F A

72. Do you wet your bed? N R O F A

N: Never (or no) R: Rarely O: occasionally F: Frequently A: Always Y: Yes

Name:_____ **Date:** ____/____/____

OTHER COMMENTS:

Are there any other aspects of your sleep problem which you feel have not been adequately covered on this questionnaire? If so, please describe below.

_____

_____

_____

_____

_____

_____

_____

_____

REVIEWED BY: _____
(Physician signature)

DATE: _____