

SLEEP DIAGNOSTICS, INC

www.sleepwellmt.com

900 N. Montana Ave. Suite A9, Helena, MT 59601 Phone: 406-449-8999 Fax 406-449-8989

You have an appointment at Sleep Diagnostics Inc. For an all-night “sleep study”

PATIENT NAME	TIME	DAY OF WEEK	MONTH	DAY OF MONTH

Directions: We are in the Upper Level of the Professional Plaza on the corner of Missoula Ave. and Montana Ave. One block south of Helena High School and the building NORTH of Sage Medical Clinic. Park in the upper level parking lot.

Keep this first page---please complete all paperwork and mail it back in envelope provided.

(24 HOURS NOTICE IS REQUIRED TO AVOID A \$100.00 CANCELLATION FEE)

*****If you are coming due to excessive sleepiness please have someone drive you and pick you up ****

ON THE DAY OF YOUR SLEEP STUDY: Do not take any naps if possible.

1. Eat meals as usual, but don't drink caffeinated drinks (such as coffee, cola or tea) after 1:00 pm.
2. Please make certain that your hair is clean and **DRY**. Do not use hair oils such as VO5 or Brillo Cream.
3. Please perform nighttime routine AT HOME: Brush your teeth, Wash your face etc. Do not apply any lotion to your face or legs.
4. Take your medications as instructed by your physician (if you take them right before bed then bring them with you to take at that time)
5. For men: If you have a beard please consider shaving before coming in. (It is best to have a shaved chin if possible☺) If you do not wish to have a shaved chin, please leave your beard a bit longer rather than short and stubbly. A goatee style works nicely.
6. For women: You will need to **REMOVE YOUR NAIL POLISH!** (don't get your nails done prior to the study or we will have to mess it up ☹)
7. If you have long hair, it would help to loosely braid your hair. There is **NO SHOWER** available in the morning.

WHAT TO BRING:

1. Bring nightwear to sleep in, (should be 2-piece, cotton is best) (**t-shirt and shorts are ideal**)
2. Bring medications that you take before bed, including any sleep aids. We do not provide sleep medication. If you have a sleep aid that you take regularly, bring it with you. If you don't take a sleep aid regularly, we would prefer to see a normal night of sleep. If you feel strongly that you may not be able to sleep, then talk to your doctor about a sleep aid. You will need to have a family member or friend give you a ride home the next day. Remember to bring glucose testing if you have it in the event you need to test your glucose levels.
3. Bring your insurance cards, reading material (if you read before bed), snack (if you snack before bed – refrigerator/ microwave is available)

What is a sleep study?

A sleep study is an all-night study designed to provide vital information about your sleeping health by monitoring various signals from your body. These signals include: brain-waves, heart activity, muscle activity, eye movements, breathing patterns and oxygen levels. The signals are obtained from small sensors attached to you scalp, face and body. No needles are used and you should not experience any unusual discomfort. Sleep studies help to identify causes of various sleep-related health disorders and to plan for effective treatment.

What is the procedure during a sleep study?

It will take a sleep technician about 40 minutes to attach small sensors to your head, chest stomach and legs and you will be asked to fill out short pre-sleep questionnaire. After set up you can unwind as usual (read, or watch TV). The tech will monitor you from another room. If you need anything just ask aloud in a normal speaking voice and the tech will come into the room to aid you. You can use the restroom at any time in the night, it is an easy process (urinal is available upon request). If a breathing problem is observed during your study the tech may awaken you to ask you to try a device that treats breathing problems during sleep. Generally the tech will discuss this with you prior to bed. The device is PAP (Positive Airway Pressure) and it includes a small mask that fits over your nose or silicone plugs in your nostrils.

What is the procedure after a sleep study?

It will take approximately 7-9 working days for the study results to get back to your primary care physician. He/She will contact you concerning the results. A copy of the interpretation and a sleep center survey will be mailed to you.

*****BILLING PROCEDURE:** There are **two parts** to a sleep diagnostic testing bill. The technical component is what is performed on the night of your sleep study. A board certified sleep specialist will bill the professional component of the sleep study for his/her interpretation report. (Just like when you have an x-ray. You get a separate bill from the radiologist)

NOTE: FIREARMS ARE NOT PERMITTED IN THE SLEEP CENTER

TYPES OF CARE/SERVICE AVAILABLE

Sleep Diagnostics' offers the following services

- Diagnostic in-facility testing
- Split Night in-facility sleep testing
- Titration in-facility sleep testing
- CPAP titration in-facility testing
- Home sleep testing
- Multiple Sleep Latency Testing
- CPAP and supplies for non-Medicare/Medicaid patients
- Nocturnal pulse oximetry testing

CARE and SERVICE LIMITATIONS

Sleep Diagnostics' has the following limitations to care and services

- Weight limit for in-facility testing is 425lbs
- Age criteria is 5yr-90yr (Special considerations if ≥ 3 yr or ≤ 95 yr must be approved by Medical Director)
- Patient must be able to transfer into and out of bed independently or caregiver must be present
- Patient must be able to perform activities of daily living independently
- Medications are never dispensed by our staff. Patients must come with any medications that they need to take.

HOURS OF OPERATION

Sleep Diagnostics' office hours are Days Mon-Fri 8:00 AM to 5:00 PM Sleep studies are by appointment only Mon-Sun 7:00 PM to 7:00 AM.

CONTACT INFORMATION

Sleep Diagnostics' contact information is as follows:

Phone Number: 406-449-8999 extension 100 Toll Free 1-855-449-8999

Fax Number: 406-449-8989

Website: www.sleepwellmt.com

REFERRAL PROCEDURES

Sleep Diagnostics' has the following referral procedures

- Must be referred by a licensed medical provider, doctor of:
 - Medical or Osteopathy (M.D. or D.O.)
 - Dental surgery or Dental medicine
 - Podiatric medicine
 - Optometry or Ophthalmology
- Exceptions:
 - Non Medicare/ Medicaid/ Tricare/ United patients may self-refer; however, they must complete a valid sleep screening questionnaire with ESS and FSS prior to scheduling that will be reviewed by the medical director and authorized for sleep testing.
 - These patients MUST be followed up in clinic by the board-certified sleep physician.

CHARGES FOR SERVICES

Sleep Diagnostic will provide a copy of the charges for services time of service.

Clients can call the contact information listed above prior to service and request verbal confirmation of the charges for any services scheduled.

Bedtime Habits: Please fill in your answers to the right.

My normal bedtime is at: _____
 I usually get up for the day at: _____
 My bedtime varies on weekends between? _____
 It usually takes me _____ minutes to fall asleep
 I usually get up to use the bathroom _____ times in the night
 I am awake _____ times in the night
 I am usually awake at the following times in the night: _____
 The total time I am awake in the night is _____ minutes

Please put an X in front of all that apply and remark on the days per week on average that you do this

<input type="checkbox"/> I drink caffeinated beverages within 2 hrs of bed	Days per week on average that you do this _____
<input type="checkbox"/> I drink alcohol within 2 hours of bed	Days per week on average that you do this _____
<input type="checkbox"/> I use tobacco (smoke/chew) within 2 hrs of bed	Days per week on average that you do this _____
<input type="checkbox"/> I exercise within 2 hours of bed	Days per week on average that you do this _____
<input type="checkbox"/> I take medications to aid sleep	Days per week on average that you do this _____
If yes which medication _____	

Caffeine, Alcohol and Tobacco section: Please indicate how many of each of the following do you consume PER DAY?

Coffee w/ caffeine- 6 oz cups _____ Per day	Wine – 6 oz glasses _____ Per day
Soda w/ caffeine -12 oz cans _____ Per day	Hard Liquor in ounces _____ Per day
Tea w/ caffeine 12 oz glasses _____ Per day	Beer – 12 oz can _____ Per day
Energy drinks(Monster-Red Bull) _____ Per day	Cigarettes – packs _____ Per day
Water 8 oz glasses _____ Per day	Chewing Tobacco – cans _____ Per day
Chocolate in ounces _____ Per day	Cigars - number _____ Per day

Smoking History : Please answer all questions ACCURATELY

Number of Years you have smoked _____ Have you quit for good? _____
 Average packs per day over that whole time period _____ What year did you quit? _____

SPECIAL NEEDS SECTION Please check all that apply		OTHER MEDICAL HISTORY Please check all that apply			
<input type="checkbox"/>	I walk independently without assistance	<input type="checkbox"/>	Coronary Artery Disease	<input type="checkbox"/>	COPD
<input type="checkbox"/>	I use a cane or walker to walk	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	I use a wheelchair	<input type="checkbox"/>	High blood pressure even if treated	<input type="checkbox"/>	Pulmonary Hypertension
<input type="checkbox"/>	I need assistance getting in and out of bed	<input type="checkbox"/>	Blood Clot or DVT	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	I sleep with more than 1 pillow under HEAD	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	I need to sleep in a recliner	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	I have a hearing problem	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	GERD (gastric reflux)
<input type="checkbox"/>	I wear a hearing aid	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	I wear a hearing aid	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	I wear my dentures at night	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	I use a wheelchair	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	HIV
<input type="checkbox"/>	I wear incontinence pads	<input type="checkbox"/>	Bipolar Disorder	<input type="checkbox"/>	Thyroid disease
<input type="checkbox"/>	I walk independently without assistance	<input type="checkbox"/>	PTSD	<input type="checkbox"/>	Restless Leg Syndrome
<input type="checkbox"/>	I use a cane or walker to walk	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Glaucoma

Surgeries: Please put an X in front of all that apply

<input type="checkbox"/>	I have had cardiac bypass /stent surgery
<input type="checkbox"/>	I have a pacemaker
<input type="checkbox"/>	I have had lung resection surgery
<input type="checkbox"/>	I have a Vaso Nerve neve stimulator in place
<input type="checkbox"/>	I have had pneumothorax surgery

<input type="checkbox"/>	I have had a tonsillectomy and adenoidectomy
<input type="checkbox"/>	I have been told I have a deviated septum
<input type="checkbox"/>	I have had a deviated septal repair
<input type="checkbox"/>	I have had sinus surgery
<input type="checkbox"/>	I have had jaw advancement surgery

History section: Please put an X in front of all that apply **AND** **Describe how long you have had the problem.**

<input type="checkbox"/>	Insomnia (difficulty falling or staying asleep)	
<input type="checkbox"/>	Restless Sleep	
<input type="checkbox"/>	Non-Restorative Sleep (waking unrefreshed)	
<input type="checkbox"/>	Frequent nighttime awakenings	
<input type="checkbox"/>	Sleepiness during the day	
<input type="checkbox"/>	Snoring	
<input type="checkbox"/>	Sleep Apnea (pauses in breathing during sleep)	
<input type="checkbox"/>	Nightmares	
<input type="checkbox"/>	Sleepwalking	
<input type="checkbox"/>	Acting out dreams (punching, kicking, grabbing?)	

Symptoms section: Please put an X in front of all that apply and mark the frequency

<input type="checkbox"/>	I have allergy/sinus problems	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wake with a dry mouth.	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I have trouble breathing through my nose	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I take medications to help me sleep	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I am incontinent (wet the bed)	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wake with heartburn	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wake with night sweats	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wake short of breath	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wake gasping	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wake with headaches	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wake with pain	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	If yes what kind of pain?						

Sleep Habit section: Please put an X in front of all that apply and mark the frequency

<input type="checkbox"/>	I have an irregular sleep schedule	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I am a shift worker	<input type="checkbox"/>	Evenings	<input type="checkbox"/>	Nights	<input type="checkbox"/>	Rotating
<input type="checkbox"/>	Pets in my home disturb my sleep	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My pets sleep in my bedroom	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My sleep is disturbed by caring for others	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My productivity is down because of my sleep	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I use tobacco when awake at night	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I eat when awake at night	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I drink when awake at night	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I grind my teeth at night	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I wear a mouth guard to protect my teeth						

Motor Vehicle section: Please put an X in front of all that apply, mark the frequency and explain further if required

<input type="checkbox"/>	I fall asleep while driving	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
	Please explain _____						
<input type="checkbox"/>	I pull over to nap to avoid sleeping while driving	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I have had a motor vehicle accident because I fell asleep at the wheel						
	Please Explain _____						

Put an X in front of the severity of your sleep problem (how you perceive it to be)

<input type="checkbox"/>	Mildly Upsetting
<input type="checkbox"/>	Moderately Upsetting
<input type="checkbox"/>	Very Severe
<input type="checkbox"/>	Extremely Severe
<input type="checkbox"/>	Totally Incapacitating
<input type="checkbox"/>	I don't think I have a sleep problem

Oxygen, CPAP, and HTN section: Please put an X in front of all that apply and answer all other questions or explain further.

<input type="checkbox"/>	I want help with my sleep problem	_____
<input type="checkbox"/>	I am willing to wear CPAP if necessary	_____
<input type="checkbox"/>	I am NOT willing to wear CPAP (WHY NOT?)	_____
<input type="checkbox"/>	I am claustrophobic	_____
<input type="checkbox"/>	Other blood relatives have sleep problems (WHO and WHAT?)	_____
<input type="checkbox"/>	I wear oxygen (WHAT setting, WHEN and WHO is your company)	_____
<input type="checkbox"/>	I wear CPAP (WHAT is you settings and WHO is your company and what MASK do you wear? FULL FACE OR NASAL?)	_____
<input type="checkbox"/>	I have high blood pressure	_____
<input type="checkbox"/>	I take medication to help control high blood pressure	_____

Insomnia and Mood section: Please put an X in front of all that apply and mark the frequency

<input type="checkbox"/>	I have insomnia	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My insomnia is related to stress						
<input type="checkbox"/>	My insomnia is related to pain						
<input type="checkbox"/>	I feel depressed	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I feel anxious	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My mind races when I'm trying to fall asleep	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I sleep better in an unfamiliar place						
<input type="checkbox"/>	I sleep worse in an unfamiliar place						
<input type="checkbox"/>	I read, work or watch TV in bed	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My sleep is disturbed by being too hot	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My sleep is disturbed by being too cold	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently

Eye Questions: Please put an X in front of ALL that apply and MARK the frequency

<input type="checkbox"/>	My eyes are dry	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My eyes are red	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My eyes are irritated	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I have been told I have glaucoma	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
<input type="checkbox"/>	I have an Ophthalmologist	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
The last time I had my eyes checked (other than for vision correction) was:							

Movement / Position section: Please put an X in front of all that apply and remark on the frequency if applicable

<input type="checkbox"/>	Weird sensations in my legs <u>keep me from falling asleep.</u>	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	My legs feel like they have to move, but do not keep me awake	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I have nighttime leg cramps	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I toss and turn in sleep	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I prefer to sleep on	<input type="checkbox"/>	Back	<input type="checkbox"/>	Sides	<input type="checkbox"/>	Belly
<input type="checkbox"/>	I sleep on my back	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently

Nap and Narcolepsy section: Please put an X in front of all that apply and mark the frequency and explain if required

<input type="checkbox"/>	I take intentional naps	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	How many naps per week on average?	<input type="checkbox"/>	Per week				
<input type="checkbox"/>	How many naps per day on average?	<input type="checkbox"/>	Per day				
<input type="checkbox"/>	How long do you nap for?	<input type="checkbox"/>	Minutes				
<input type="checkbox"/>	After I nap I feel refreshed	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I dream when I nap	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I have hallucinations as I'm falling asleep	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I have hallucinations as I'm waking up	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I can't move sometimes even though I know I am awake	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
<input type="checkbox"/>	I have episodes of muscle weakness at times of emotional intensity (laughing or crying really hard)	<input type="checkbox"/>	Rarely	<input type="checkbox"/>	Occasionally	<input type="checkbox"/>	Frequently
IMPORTANT				If yes to episodes of muscle weakness, Please use this space to describe these episodes IN DETAIL			

List any allergies you have include environmental, tape, food, medication and metals:

Please list any previous sleep testing that you have had. Where you had the testing, when and what the results were

Date of Testing	Where testing was performed	What type of Testing	Results of Sleep Testing

Patient Name _____ Date _____

EPWORTH SLEEPINESS SCALE – (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. > 8 may indicate excessive daytime sleepiness. A score of 8 or more is considered excessively sleepy

Use this 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

It is really important that you report a number of 0-3 on each of the questions.

SITUATION	Chance of Dozing 0-3
	Sitting and reading
	Watching television
Sitting inactive in a public place such as a theater or a meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances would permit that	
	Sitting and talking to someone
Sitting quietly after lunch (where you have had no alcohol)	
	In a car, while stopped for a few minutes in traffic
	Total Score

STOP BANG QUESTIONNAIRE

	YES	NO
Do you S nore loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?		
Do you often feel T ired, fatigued, or sleepy during the day (such as falling asleep during driving or talking to someone)?		
Has anyone O bserved you stop breathing or choking /gaspings during your sleep?		
Do you have or are you being treated for high blood P ressure?		
Is your B ody mass index more than 35 kg/m2?		
Are you A ged – older than 50?		
Is your N eck size large: For male, is your shirt collar 17 inches or larger? For female, is your shirt collar 16 inches or larger? (Measured around the Adam's apple)		
Is your G ender male?		
TOTAL NUMBER OF YES ANSWERS		

Each **YES** question is worth 1 point and 4 or more points is positive for suspected sleep apnea.

SLEEP DIAGNOSTICS, INC BED PARTNER SURVEY

Please have a spouse, family member, or someone who has observed you sleeping, complete this page

Name of Patient: _____
 Name of Observer: _____

Briefly describe the individual's sleep problems. How long have you noticed these sleep problems?
 How often do they occur? Why do you think they need a sleep study? How is their sleep problem negatively affecting your life?

Bed Partner section: Please put an X by all that apply and remark on the frequency if applicable

	He/ She snores		Rarely		Occasionally		Frequently
	If yes state the level of		Quiet		Medium		Loud
	He/She kicks when sleeping		Rarely		Occasionally		Frequently
	He/ She falls asleep involuntarily during the day		Rarely		Occasionally		Frequently
	He/She is hard to wake in the morning		Rarely		Occasionally		Frequently
	He/She wakes up in the night		Rarely		Occasionally		Frequently
	He/She wakes with a snort or gasp		Rarely		Occasionally		Frequently
	He/She stops breathing in sleep		Rarely		Occasionally		Frequently
	If yes what body position is it related to		Back		Side		Doesn't matter
	He/She acts out their dreams? IE: Punches, kicks, yells and can remember if you wake them what they were dreaming about and why their actions match what was happening in the dream?				How often?		

Patient Name _____

Date at Beginning of week _____

Complete at Bedtime	Day 1	Day 2	Day 3	Day 5	Day 5	Day 6	Day 7
Naps (Number, time, length of naps)							
Alcoholic Drinks (How many and what time)							
Overall Stress level during the day: High Moderate Low							
Rate how you felt Overall today: Very tired/sleepy Somewhat tired/sleepy Fairly Awake Wide Awake							
Irritability overall today: None Some Moderate Very High							

Complete in Morning	Day 1	Day 2	Day 3	Day 5	Day 5	Day 6	Day 7
Time you went to Bed							
Estimated time it took to fall asleep							
Estimated number of awakenings							
Estimated total time spent awake							
Time you work up for the day							
Estimated amt. of sleep in hours							
Please add any additional notes:							