Patient Name:

Appointment Date: 

Time: 8:00 PM

Sleep Study

We are located at the corner of 4th Street and Cedar Ave or 4th Street and Oak Ave. We are at the back of the Upper Cumberland Ear Nose & Throat building, the same entrance as the Allergy, Asthma and Sinus Center. Take the elevator to the 3rd floor.
Instructions for your test:

1. **Patients who require assistance with mobility, personal care, medications or other special needs during the night must bring a caregiver who can stay throughout the test to provide the needed assistance. Please call in advance to inform us if the patient has special needs.**

2. Avoid taking naps, if possible.

3. Make sure your hair and skin are clean and oil free. Please remove braids, hairpieces and extensions.

4. No caffeine after 2:00 P.M.

5. Bring all medications with you. We do not dispense any medications. Do not take night time medications before you arrive.

6. Make sure your hair and skin are clean, dry and oil and product free. Please remove braids, hairpieces and extensions. For male patients: if you are usually clean-shaven, please shave before you arrive.

7. Bring comfortable and loose fitting clothes to sleep in. Try to avoid silky-type garments. (Two-piece pajamas or shorts and shirt are best)

8. You may bring your own pillow, however, one will be provided.

9. You may eat dinner. Try not to overfill. No caffeine or chocolate.

**REMINDERS:**

- If you consulted the clinic for excessive daytime sleepiness, make sure that someone drives you to the clinic and back home in the morning. Excessive daytime sleepiness may be dangerous when you drive.

- Please complete this paperwork and bring it with you to your appointment. Bring your insurance cards and an identification card. We will need to make a copy for each appointment. If you have any questions, you anticipate being late or cannot make this appointment, please contact us at 931-783-2753.
General Questionnaire

Date: ______________

Full Name: ____________________________  DOB: __________  SSN: __________________________

Address: ___________________________________________________________ City __________ State ______

Home Phone: ________________ Alternate number: ______________________

Occupation: ___________________ Employer: ___________________ Employer Address: ______________________

Disabled: Yes  No (Circle)  Retired: Yes  No (circle)  Year Retired: ______

Age: ___ Height: _____ Weight: _____ Weight 6 months ago: _____ At age 20: _____ At your heaviest: _____

Referring Physician: ____________________________  Family Physician: __________________________

1. What is the reason you (or your doctor) contacted the Sleep Center?

________________________________________________________________________

________________________________________________________________________

2. How long have you had this problem?

________________________________________________________________________

3. Has anyone in your family had any type of sleep disorder?

________________________________________________________________________

4. What time do you usually try to fall asleep? ________________________________

5. What time do you usually try to get out of bed? ______________________________

6. Do these times vary? _____  If yes, please explain: ______________________________

7. How much time do you sleep at night? ________________________________

8. How many times do you usually awaken each night? _________  Do you have difficulty returning to sleep? _________

9. How long are you awake altogether during the night? ________________________________
10. How often do you:

(when you are trying to fall asleep)

- have difficulty falling asleep? □ □ □ □
- have thoughts racing through your mind? □ □ □ □
- feel sad or depressed? □ □ □ □
- have anxiety? □ □ □ □
- worry about not being able to sleep? □ □ □ □
- worry you won’t return to sleep after awakening? □ □ □ □

(just prior to or during sleep)

- have creeping, crawling or aching feeling in your legs? □ □ □ □
- kick or twitch your legs? □ □ □ □
- have unusual movements while asleep? □ □ □ □
- wake up frequently? □ □ □ □
- have trouble waking up in the a.m.? □ □ □ □
- have restless or disturbed sleep? □ □ □ □
- feel muscular tension? □ □ □ □
- have any kind of pain or discomfort? □ □ □ □
- wake up with chest pain? □ □ □ □
- feel alert and energetic all day? □ □ □ □
- snore loudly? □ □ □ □
- wake up gasping for breath? □ □ □ □
- sweat a lot during the night? □ □ □ □
- wake up with a headache? □ □ □ □
- wake up with a dry mouth? □ □ □ □
- wake up sick to your stomach? □ □ □ □
- walk in your sleep? □ □ □ □
- fall out of bed while asleep? □ □ □ □
- wake up screaming, violent or confused? □ □ □ □
- wet the bed? □ □ □ □
- grind your teeth while sleeping? □ □ □ □
11. Have you ever had vivid dream-like scenes just as you are falling asleep? ________
If yes, briefly explain: _______________________________________________________

12. Have you ever felt paralyzed (could not move) just as you were falling asleep or waking up? ________ If yes, please explain: __________________________________________

13. How many naps do you take in a usual week? _______ length of naps? ________ Are they refreshing? ______

14. Do you have episodes of sudden muscular weakness when laughing, angry or in an emotional situation? ________ If yes, please explain: __________________________________

15. Have you had your tonsils or adenoids removed? _______

16. Can you breathe easily through your nose? ________

17. Have you ever had your nose broken or a facial fracture? ________

18. Do you have a problem with job performance due to sleepiness? ________

19. Do you have a problem driving due to sleepiness? ________

20. My sleep is frequently disturbed by: (check all that apply)

☐ heat  ☐ choking  ☐ shortness of breath
☐ cold  ☐ indigestion or heartburn  ☐ frightening dreams
☐ light  ☐ hunger  ☐ cough
☐ noise  ☐ thirst  ☐ chest pain
☐ bed partner  ☐ children  ☐ pets
☐ need to urinate  ☐ phone  ☐ asthma
☐ creeping, crawling feelings in legs

21. How much of the following fluids do you drink?

<table>
<thead>
<tr>
<th>Fluid</th>
<th>During a typical day</th>
<th>Within 2 hrs of bedtime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coffee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>caffeinated</td>
<td>_______ cups</td>
<td>_______ cups</td>
</tr>
<tr>
<td>decaffeinated</td>
<td>_______ cups</td>
<td>_______ cups</td>
</tr>
<tr>
<td>Tea</td>
<td>_______ cups</td>
<td>_______ cups</td>
</tr>
<tr>
<td>Soda</td>
<td>_______ glasses</td>
<td>_______ glasses</td>
</tr>
<tr>
<td>Alcohol</td>
<td>_______ drinks</td>
<td>_______ drinks</td>
</tr>
</tbody>
</table>

22. How much tobacco do you smoke during a 24 hour period?
   Cigarettes? ________
   Cigars? ________
   Pipe bowls? ________

23. Do you use any type of illicit drugs? _____ If so, what? ____________________________
24. Please list the name and dosage of all medications you take NOW or have taken in the last 30 days, including over the counter (non-prescription) medications.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

25. Please list any allergies or write NONE. ___________________________________________________________________________________

26. Please check any problem or illness you have now or have had in the past.

☐ heart disease ☐ headaches ☐ depression ☐ eye trouble
☐ low blood pressure ☐ fainting ☐ mental problems ☐ hearing trouble
☐ high blood pressure ☐ ringing of the ears ☐ muscle cramps ☐ pneumonia
☐ heart attack ☐ black outs ☐ thyroid condition ☐ heartburn
☐ pacemaker ☐ ulcers ☐ meningitis ☐ erectile dysfunction
☐ hernia ☐ dizziness ☐ prostate trouble ☐ cancer
☐ back trouble ☐ gout ☐ kidney trouble ☐ TB
☐ asthma ☐ allergies ☐ bladder trouble ☐ Diabetes- Type I or II?
☐ bronchitis ☐ seizures ☐ arthritis ☐ Stroke
☐ COPD ☐ Parkinson’s

27. Please list any illness not listed above, hospitalizations or surgeries you have had:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

28. Do you wear CPAP or BiPAP at home? ____________ if yes, what company are you currently using for CPAP/BiPAP supplies? ______________

29. Do you use oxygen at home? ____________ if yes how many hours daily do you use it?

Anything you would like to add:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Patient Name: ________________________________  Date: ____________

Sleep Facts

Do you have a history of snoring?

_____ Never
_____ Rarely – only once or a few times
_____ Sometimes – occasionally or under special circumstances
_____ Every night or almost every night
_____ Don’t know

Has your bed partner ever moved, temporarily or permanently to another bedroom (or had you move to another room) due to snoring or restless sleep?  YES  NO

Have you ever been told you seem to have momentary periods during sleep when you stop breathing or breathe abnormally?  YES  NO

Do you ever gasp for air during the night?  YES  NO

Have you ever been told you kick or make disruptive movements during sleep?  YES  NO

Do you have a family history of sleep apnea?  YES  NO

Epworth Sleepiness Scale

How likely are you to 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 the things recently, try to determine how the situation would affect you.

0 = never doze  1 = slight chance  2 = moderate chance  3 = high chance

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of dozing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Watching TV</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting passive in a public place (ex. Theatre or meeting)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>In a car while stopped for a few minutes in traffic</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>

TOTAL _______________
Bed-Partner Questionnaire

Patient Name: ___________________________ Date: ______________

I have observed this person’s sleep (circle one)

Never       One or twice       Often       Every night

Check any of the following behaviors that you have observed this person doing while asleep
Circle those that you consider severe problems

___ Light snorer
___ Occasional loud snorts
___ Pauses in breathing
___ Sleep talking
___ Bed-wetting
___ Awakening with pain
___ Getting out of bed not awake
___ Becoming very rigid and shaking
___ Apparently sleeping even if he/she says otherwise

___ Loud snorer
___ Choking
___ Twitching or kicking of legs
___ Grinding teeth
___ Sitting up in bed not awake
___ Head rocking or banging
___ Biting tongue
___ Crying out
___ Other ___________________________

If this person snores, what makes it worse?

___ Sleeping on his/her back
___ Sleeping on his/her side
___ Alcohol
___ Fatigue

Describe the sleep behaviors checked in more detail. Describe the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night

Has this person even fallen asleep during normal daytime activities or in dangerous situations?

Yes  /  No

If yes, please explain ____________________________

Does this person use sleeping pills?     Yes  /  No     What kind?    ______________

How often? __________________________

Signed: ____________________________ Relationship to person: __________________________