Rocky Mountain Health Diagnostics, LLC.

Sleep Questionnaire

Please complete the following questionnaire and bring it to your scheduled appointment.

Patient Name _____ SSN _____
Last First Middle

Address _____ DOB _____

City, State, Zip _____ Male ☐ Female ☐

Home Phone (_____) _____ Other Phone (____) _____ Email _____

Referring MD: _____

MD Address: _____

1. Please describe the sleep-related problems you are experiencing _____

_____

_____

_____

2. List all of your medical problems: _____

_____

_____

_____

3. List all current medications (or bring a list with you) _____

_____

_____

4. List all drug allergies _____

5. List any medication you have used to help you sleep. _____

   Last time used _____

6. Have you ever walked in your sleep? Yes ☐ No ☐
   If yes, have you been told that you exhibit complex behaviors when sleep walking that you cannot recall?
   If yes, please circle all that apply:

   Wandering out of the room Eating Performing tasks

7. Do you ever awaken from sleep screaming, violent and confused, or hit, slap, kick things or bed partners while asleep? Yes ☐ No ☐
8. According to your bed partner, do you ever seem to act out a dream or show violent behavior while asleep which you do not remember afterward? Yes ☐ No ☐
9. Do you grind your teeth while you sleep? Yes ☐ No ☐
10. Do you wear dentures? Yes ☐ No ☐
11. Do you have irresistible urges/sensations that only movement will solve? Yes ☐ No ☐
12. Do you snore? Yes ☐ No ☐

    If yes, in which sleeping positions, and how long? _____

13. Do you ever stop breathing while you sleep? Yes ☐ No ☐
    If yes, in which sleeping positions, and how long? _____
14. Do you ever awaken during the night gasping for breath? Yes ☐ No ☐
15. Do you ever snore so loudly you awaken yourself? Yes ☐ No ☐
16. Do you drink alcoholic beverages? Yes ☐ No ☐

    If yes, how much and when? _____

17. How many alcoholic beverages do you have within 2 hours of bedtime? _____

18. How many cups of caffeinated beverages do you have in an average day? _____

_____ Coffee _____Tea _____ Cola _____ Cocoa

19. How many caffeinated beverages do you have within 2 hours of bedtime? _____

20. Do you smoke?
If yes, how much and for how long? _____

21. Please circle any substances you have used within the past month:

Cocaine ◯ Marijuana ◯ Amphetamines ◯ Heroin ◯ Other

22. Has anyone in your family been diagnosed with narcolepsy?
If yes, what is their relation to you? _____

23. Do you have any family member with sleep apnea or severe snoring (in the absence of being overweight?)
If yes, what is their relation to you? _____

24. Do you have any family members who walk in their sleep or have other unusual behaviors during sleep?

25. What is your neck collar size and current height/weight? Neck Size _____ Height/ Weight _____

26. Have your neck size or weight changed in the last year? Yes ☐ No ☐

27. Do you feel excessively sleepy during the day? Yes ☐ No ☐

28. Do you have sleepiness during the day that you cannot resist? (e.g. fallen asleep while driving, eating, at work) Yes ☐ No ☐

29. How many times do you get up from bed to use the bathroom? _____

30. What is your normal bedtime? _____

31. Are you currently on Oxygen at home or own a CPAP/BiPAP machine? Yes ☐ No ☐

32. If so what DME Company do you use? _____

33. Has anything unexplained ever happened to you that resulted in an accident? If yes, please explain:

_____

_____

_____

Is there anything else you wish to add that will help the clinicians better understand your sleep patterns?

_____

_____

_____

_____

Rocky Mountain Health Diagnostics, LLC.

As of April 14, 2003, **Rocky Mountain Health Diagnostics, LLC**, in compliance with the HIPPA Privacy Rule, has drafted a Notice of Patient Privacy Practices. Your signature here acknowledges that you have been made aware of this notice and a copy is available to you upon your request.

Signature:_____ Date:_____

Rocky Mountain Health Diagnostics, LLC.

CONSENT FOR SPECIAL PROCEDURES

TIME: _____

I_____ authorize the performance of the following procedure

(**PSG, SPLIT NIGHT, CPAP, MSLT, MWT, 24 HOUR VIDEO EEG, ROUTINE EEG OR AMBULATORY EEG/PSG)** to be performed under the direction of Dr._____.

The nature and purpose of the procedure, possible alternative methods of treatment, and risks involved and the possibility of complications have been fully explained to me. No guarantee of assurance has been given by anyone as to the results that may be obtained.

I authorize administration of such medications as deemed necessary by the physician or the procedure.

I understand the room itself is adapted for sleep environment and the bedroom environment is necessary to simulate, as near as possible a real life sleep situation. In the event of an emergency it may be necessary for me to be transported by ambulance to the nearest hospital for definitive treatment.

I consent to the taking of videotape pictures with soundtrack during by nocturnal polysomnogram recording as part of the diagnostic study by Rocky Mountain Health Diagnostics, LLC.

I understand that the videotape will be used for diagnostic study and for the purpose of medical education. Any use of the tape for medical education purposes will not identify me by name and I consent to the use of the tape under these circumstances.

_____ _____

PATIENT'S SIGNATURE WITNESS SIGNATURE

_____

DATE

Rocky Mountain Health Diagnostics, LLC.

Patient's Name:_____ Today's Date:_____

1. What time did you go to bed last night?_____
2. How long did it take you to fall asleep?_____
3. What time did you wake up today?_____
4. During the day today, did you:

		If YES, Explain
a. Take any naps?	Yes / No	What time?_____
		How long?
b. Drink any coffee, tea, or cola?	Yes / No	What _____
		How many cups of each?_____
		What time?_____
c. Drink any alcoholic beverages?	Yes / No	What_____
		How much?_____
		What time?_____
d. Take any medication?	Yes / No	What_____
		How much?_____
		What time?_____
e. Do anything physically strenuous?	Yes / No	What_____
		How much?_____
		What time?_____
f. Has anything unusual happened?	Yes / No	What?_____
		What time?_____

5. If you have to have CPAP which DME Company would you like to use? (Medi-Home, Lincare)

_____

COMMENTS:_____

_____

_____

_____

_____

_____

_____

Patients Signature _____

POST-SLEEP QUESTIONS

1. How long did it take you to fall asleep last night?_____

2. Did you wake up during the study? Yes No

   If yes, how many times did you wake?_____

   How long altogether were you awake during the night?_____

   What awakened you?_____

3. How many hours of sleep do you feel you obtained?_____

4. How well did you sleep here last night compared to sleeping at home?_____

_____

_____

5. Do you feel refreshed this morning Yes No Somewhat

POST-CPAP QUESTIONS (complete only if CPAP initiated)

1. Did you fully understand the CPAP instructions? Yes No

2. Was it difficult getting used to CPAP before falling asleep? Yes No

3. Did you have difficulty with CPAP last night (please circle)

   Not at all Minor Moderate Extreme Didn't know I was wearing it

4. Was the CPAP mask comfortable? Yes No

5. Was the headgear comfortable? Yes No

6. Did you wake up during the night? Yes No

   If YES, why and for how long were you awake:_____

_____

7. Was it difficult falling back to sleep:_____
8. Do you feel refreshed this morning after using CPAP? Y N Somewhat

Comments/suggestions:_____

_____

_____

_____

_____

_____

_____

Rocky Mountain Health Diagnostics, LLC

EPWORTH SLEEPINESS SCALE

Patient Name:_____ Date:_____ Total Score:_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in the last three weeks. Even if you have not done some of these recently, try to work out how they would have affected you. Rate you chance of dozing in each situation.

PLEASE CIRCLE ONE FOR EACH QUESTION

SITUATION:	**CHANCE OF DOZING:**
Sitting and reading	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing
Watching TV	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing
Sitting, inactive in a public place (theater or meeting)	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing
As a passenger in a car for an hour w/o a break	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing
Lying down to rest in the afternoon	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing
Sitting and talking to someone	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing
Sitting quietly after a lunch without alcohol	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing
In a car, while stopped for a few minutes in the traffic	0 Would never doze 1 Slight chance of dozing 2 Moderate chance of dozing 3 High chance of dozing

Please consult with your physician if your score is equal to 10 or greater.