Denton Sleep Disorders Laboratory **Cooke County Sleep Disorders Laboratory**

GENERAL PRE-SLEEP STUDY INFORMATION

You have been scheduled for an overnight sleep study, per your physician's order. The study will be performed at the sleep lab located in Denton or Gainesville. Your study has been scheduled for ________________ night, ___________________ at __________ p.m. If you need to cancel your sleep study for any reason, please notify our office no later than 24-hours prior to your study date. Failure to call our office within the allotted time will result in a cancellation charge of $50.00.

In order to get the best results from your overnight stay, please review the following recommendations:

1. Do not drink or eat anything containing caffeine the day of your study. This includes chocolate, caffeinated soft drinks, coffee or tea.

2. Try to wake up earlier the day of your study and do not take a nap the day of the study.

3. You will need to take a bath/shower shortly before coming in for your study in order to remove oils that accumulate during the day. Make sure to wash with soap and a washcloth in order to properly remove all oils. Do not put on lotion or after-bath powders after bathing. Please make sure that you have a clean shaved face before coming in for your study.

4. If you would like to bring your own pillow, you may. However, the sleep center will provide you with pillows.

5. Bring something comfortable to sleep in. If you don't usually wear pajamas, don't feel the need to buy them for the study. Loose fitting shorts and a tee shirt are acceptable. Your comfort is an essential part of the diagnostic test. You may want to bring a robe to wear before you actually go to bed.

6. You will generally be awakened between 5:30 a.m. and 6:00 a.m., unless otherwise requested.

7. There is a shower at our facility with essentials such as towels, washcloths, shampoo, conditioner and soap provided for your convenience.

8. You may bring reading material or anything that will help you pass the time if you have trouble falling asleep or have a bedtime that is a half hour or more later than the scheduled hook-up time of sleep equipment. There is also satellite television available if you prefer.

9. Please remember to bring any and all completed **Questionnaires** that have been sent to you. These materials are crucial for the analysis and interpretation of your sleep study. The technician will make sure all of the information in your packet is completely filled out. If not, we will not begin your study until all information is completed.

10. If you have any further questions not answered by this pre-sleep information guide, please feel free to contact our office and we will be happy to answer any remaining questions you may have.

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Patient Registration

Name____Height_________Weight_________SS#______________________________

Street Address____Date of Birth________________Marital Status: S M W Sep D

City____State___________________Zip___________________

Telephone Home____Telephone Office____

Primary Care Physician_____________________________________Referring Physician____

Spouse's Name____

Spouse's Employer / Address____

Emergency
Contact_______________________________________Telephone______________________Relationship_____________________________

Patient Employer Information

Employer Name____Telephone_____________________________________

Employer Street Address____City/State____________________Zip_____________

Patients Occupation____

Insured Person (If not patient)

Employer Name____Telephone______________________________________

Employer Street Address____City/State____________________Zip_____________

Relationship to Patient____

Insurance

Medicaid # (if applicable)__________________________________Medicare # (if applicable)_____________________________________

Primary Insurance Company Name____

ID #____Group #_____________________Telephone_____________________________

Secondary Insurance Company Name____

ID #____Group #_____________________Telephone_____________________________

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of the authorization to be used in place of the original.

Date__________________________________ Signature____

I hereby authorize Dr. Mukesh Saraiya to apply for benefits on my behalf for covered services rendered by him or his order. I request that payment from my insurance company/companies by made directly to Dr. Mukesh Saraiya (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date__________________________________ Signature____

(Patient, parent, or guardian)

Dear Patient,

If you test positive for sleep apnea, there will be equipment that will need to be ordered for you. If you have any preference for where your equipment is ordered, please list below.

□ I have a company that I would like the order sent to the company listed below.

Company Name____________________________________

Telephone____

□ I have no preference; please send the order to a company that is preferred by my insurance.

Denton Sleep Disorders Laboratory **Cooke County Sleep Disorders Laboratory**

Patient Sleep / History Questionnaire

The following questionnaire aids in the determination of the possible presence of a sleep disorder. Therefore, this document becomes part of your medical records and is completely CONFIDENTIAL. Only the healthcare professionals involved in the diagnostic testing and in the interpretation of the questionnaire and raw sleep study data will have access to this information. Any other persons requesting this or any other information regarding test results or related information must obtain written permission from the patient before such information can be released. Some of the questions in this form may appear to be repetitive, but it is essential that you fill out each question as fully and accurately as possible.

Thank you for your patience.

Patient Observation

In as much detail as possible, please describe the problem you are having.
____

____

____

____

Have you had a sleep problem diagnosed before? _________Yes _________No

If yes, when and where was your study performed? ______________________________________

____

If yes, what was the diagnosis? ____

If yes, what treatment(s) was/were recommended? ____________________________________

____

Are you currently on a CPAP/BIPAP? _________Yes ________No

If yes, what pressures?____

Are you currently on home oxygen? ________Yes ________No

If yes, how often and when do you use it?____

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Patient Sleep / History Questionnaire

General Information

How often does the problem you are experiencing occur?
_____ Almost every night _____ For periods of at least one week _____ Irregularly
_____ Other: ____

How long has this problem bothered you?
_____ Within the past month _____ Within the past 6 months _____Within the past 12 months
_____ 1-2 years _____ 3-5 years _____ Over 5 years _____ Other:______________

On the scale below, please estimate the severity of your problem(s).
_____ Not upsetting _____ Mildly upsetting _____ Moderately upsetting
_____ Very upsetting _____ Extremely upsetting _____ Totally incapacitating

How strongly do you want help with this problem?
_____ Does not bother me _____ Could do without it _____ Would like to correct it
_____ Need to correct it _____ Cannot continue with it

How do you describe your sleep problem? (Check all the apply)
_____ I have difficulty falling asleep.
_____ I wake up repeatedly throughout the night
_____ I wake up far too early in the morning
_____ I feel excessively sleepy during the day
_____ I find it difficult to wake up in the morning

Has your environment changed recently? (moved, loss of family member, loss of job, new bed, divorce, etc.)
_____ Yes _____ No If yes, please explain: ____
____

Have you or anyone else noticed a change in your personality? _____ Yes _____ No

Do you have a high stress job? _____ Yes _____ No _____ N/A

Is your job satisfactory? (Does your sleep problem require you to cut back on social activities?)
_____ Yes _____ No If yes, please describe:____
____

Do you usually: (Check all that apply)
_____ Sleep with someone else in bed _____ Sleep with someone else in your room
_____ Provide assistance to someone during the night (child, invalid, partner, animal, etc.)

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Patient Sleep / History Questionnaire

Sleep Schedule and Noteworthy Events

Do you: _____ Work _____ Go to school _____ I don't work or go to school _____ Retired
Do you work/go to school: _____ Always the same hours _____ Rotating shifts _____ N/A
Which shift(s) do you work/go to school? (Check all that apply): _____ 1st _____ 2nd _____ 3rd
Do you maintain a regular and consistent sleep schedule: _____ Yes _____ No
How many hours of sleep do you average during work days? ___________ During days off?_________
What time do you usually go to bed during work days? ________________ During days off?_________
What time do you usually wake up during work days? ________________ During days off?_________
How long does it usually take you to fall asleep? ___________________________
Do you wake up at night? ______ Yes ______ No If yes, how many times?__________________
Do you nap during the day? ______ Yes ______ No If yes, how often and how long?_____________
Do you feel refreshed after naps? _____ Yes _____ No _____ N/A
While in bed, I: _____Read _____Write _____Watch TV _____Eat _____Worry/have arguments

Symptom Information

Have you ever had a near miss accident due to falling asleep while driving?	_____ Yes	_____ No
Have you had an accident in the past year due to falling asleep while driving?	_____ Yes	_____ No
Have you been diagnosed by a physician as having hypertension?	_____ Yes	_____ No
Have you ever had your nose broken?	_____ Yes	_____ No
Do you still have your tonsils?	_____ Yes	_____ No
Are you experiencing any memory or learning problems?	_____ Yes	_____ No
Are you having difficulty at work or school due to excessive sleepiness?	_____ Yes	_____ No
When you wake up, are your bed covers extremely messy in the morning?	_____ Yes	_____ No
Do you awaken yourself by kicking your legs during the night?	_____ Yes	_____ No
Has a bed partner ever complained of your legs kicking during the night?	_____ Yes	_____ No
Excluding leg kicks, do you make other unusual movements during sleep?	_____ Yes	_____ No

Patient Family History

History of Obstructive Sleep Apnea?	______ Yes	______ No	Father	Mother	Sibling
History of Insomnia?	______ Yes	______ No	Father	Mother	Sibling
History of Narcolepsy?	______ Yes	______ No	Father	Mother	Sibling
History of other sleep disorders?	______ Yes	______ No	Father	Mother	Sibling

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Patient Sleep / History Questionnaire

Frequency Scale

Using the following scale, please rate how often these symptoms occur:

N = Never **R** = Rarely **O** = Occasionally **F** = Frequently **A** = Always

_____ I exercise

_____ I sleep walk

_____ I wake up short of breath

_____ I wake up gasping for air

_____ I wake up coughing

_____ I wake up confused

_____ I have trouble breathing while asleep

_____ I stop breathing while asleep

_____ I get morning headaches

_____ I have frequent sinus congestion

_____ I wake up with a dry mouth or sore throat

_____ I snore

_____ I snore loudly enough to disturb others

_____ My sleep is restless

_____ I fall asleep during the day

_____ I notice irregular heart pounding at night

_____ I feel afraid to fall asleep

_____ I remember my dreams

_____ I have nightmares or night terrors

_____ I notice parts of my body jerk

_____ I move excessively at night

_____ I wake up with heartburn

_____ I wake up belching

_____ I feel sad and/or depressed

_____ I worry all the time

_____ Thoughts constantly race through my mind

_____ I am bothered by pain during the day

_____ I wake up at night due to pain

_____ I wake up with sore/achy muscles

_____ I wake up feeling stiff

_____ I wake up with neck, spine or back pain

_____ I have morning jaw pain

_____ I grind my teeth at night

_____ I fall asleep during emotional situations

_____ I fall asleep during physical effort

_____ I experience muscle weakness during emotional situation

_____ I feel unable to move when waking or going to sleep

_____ I have vivid dream-like scenes when waking or going to sleep

_____ I have vivid dream-like scenes when waking or going to sleep

_____ I have muscular tension

_____ I experience leg pain during the night

Patient Sleep / History Questionnaire

Self Worth Scale

I feel: (Check all that apply.)

_____ Attractive	_____ Unassertive	_____ Unloved	_____ Ugly
_____ Worthwhile	_____ Lonely	_____ Confused	_____ Naïve
_____ Confident	_____ Restless	_____ Like a nobody	_____ Morally wrong
_____ Sympathetic	_____ Full of regret	_____ Incompetent	_____ Cowardly
_____ Considerate	_____ Overweight	_____ Full of hate	_____ Depressed
_____ Intelligent	_____ Useless	_____ Agitated	_____ Bored
_____ Happy	_____ Stupid	_____ Aggressive	_____ In conflict
_____ Worthless	_____ Hostile	_____ Repulsive	_____ Unconfident
_____ Inadequate	_____ Evil	_____ Misunderstood	_____ Life is empty
_____ Anxious	_____ Panicky	_____ I can't do anything right	_____ I often have horrible thoughts
_____ Guilty	_____ Unattractive		

Self Worth Scale

Please check all that apply.

_____ I often have morning headaches
_____ I often have heart palpitations
_____ I suffer from bowel disturbances
_____ I have frequent nightmares
_____ I feel tense all of the time
_____ I am often depressed
_____ I seem unable to relax
_____ I don't like weekends or vacations
_____ I can't seem to make friends
_____ I have overwhelming financial problems
_____ I can't seem to keep a job
_____ I have no appetite lately
_____ I am an alcoholic
_____ I take drugs
_____ I can't seem to make decisions
_____ I an unable to have a good time
_____ I take antacids regularly (Tums, etc.)
_____ I often feel dizzy
_____ I have frequent stomach problems
_____ I am constantly fatigued
_____ I take sedatives
_____ I have frequent panic attacks
_____ Sometimes I have suicidal ideas or thoughts
_____ I have problems with sex
_____ I am over ambitious
_____ I have problems remembering things
_____ I suffer from fainting spells
_____ I feel I am inferior to others
_____ I suffer from insomnia
_____ I suffer from tremors
_____ I am shy with people
_____ My situation at home is bad
_____ I have difficulty concentrating
_____ Other:__________________________________

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Patient Sleep / History Questionnaire

Medical History and Information

Please list any surgeries/medical procedures that you have had performed in the past year.
(Please use other side of form if necessary.)

Procedure Date Reason

Please list any diagnosed medical conditions that you are currently receiving care from a physician.
(Please use other side of form if necessary.)

Medical Condition/Problem Course of Treatment (Medicine, surgery, etc.)

Please list any other health information that you feel is pertinent to your study or care.
(Please use other side of form if necessary.)

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Patient Sleep / History Questionnaire

Medication Information

Please list below any medications you have taken within the past 72 hours.
(Please use other side of form if necessary.)

Medication	Reason	Dose	Date	Time

If applicable, please list below any medications you have taken within the past week to help you go to sleep or stay awake. (Please use other side of form if necessary.)

Medication	Reason	Dose	Date	Time

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Epworth Scale

Patient Name ____ Date ______________

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 recent times. Even if you have not done some of the things recently, try to work out how they would have affected you.

Use the following scale to enter 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

Situation	Chance of Dozing
Sitting and reading	________
Watching TV	________
Sitting, inactive in a public place (e.g. theater)	________
As a passenger in a car for an hour without a break	________
Lying down to rest in the afternoon when circumstances permit	________
Sitting and talking to someone	________
Sitting quietly after a lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________

Total Score……….________

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Please fill out the next two pages the day of your study.

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Patient Bedtime Questionnaire

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Thank you.

Last Name ___________________________________ First ______________________________ MI _______

Test Date _____________________________________ Technician ___________________________________

1. What time did you go to bed last night? ___________________ AM PM
2. What is your estimate of how long it takes you to fall asleep at night? ___________ minutes
3. What time did you wake up this morning? _________________ AM PM
4. What time did you actually get out of bed? _________________ AM PM
5. Approximately how many times did you wake up last night? ________________
6. On average, how long were you awake each time? _______________ minutes hours
7. How long does the amount of sleep you got last night compare to an average night's sleep?
   ________ less than average _______ about the same _______ more than average
8. Did you take any naps today? _______ Yes _______ No If yes, how many? _________
9. What was the average length of each nap? _______________ minutes N/A
10. What time was your last nap? ______________ AM PM N/A
11. What time did you last eat? _______________ AM PM
12. Was this a snack or a meal? ____________ Meal ___________ Snack
13. Did you have any alcoholic beverages today? ___________ Yes __________ No
    If yes, what was the total number of ounces? ____________ ounces
    If yes, what time was your last drink? _____________ AM PM

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Patient Bedtime Questionnaire

14. Did you drink any beverages containing caffeine today? ________ Yes ________ No
    If yes, what was the total number of ounces? ___________ ounces
    If yes, what time was your last drink? ___________ AM PM

15 Choose the statement below that best describes the way that you feel right now.
    _____ Feeling active and vital, wide awake
    _____ Functioning at a high level, but not at peak; able to concentrate
    _____ Relaxed and awake; not at full alertness; responsive
    _____ A little groggy; not at peak; let down
    _____ Groggy; starting to loose interest in staying awake; slowed down
    _____ Almost in a daydream state; will fall asleep soon; lost the struggle to stay awake

16. Do you feel like going to bed now? _________ Yes _________ No

17. Do you have any physical complaints now? _________ Yes ________ No
    If yes, please describe:____
    ____
    ____

18. Did anything out of the ordinary happen to you today? _______ Yes _______ No
    If yes, please describe:____
    ____
    ____

19. Please make any additional comments that you feel are pertinent to your sleep problem/study.

____
____
____
____
____
____
____
____

Denton Sleep Disorders Laboratory **Cooke County Sleep Disorders Laboratory**

Sleep Hygiene – A Guide to a Better Night's Sleep

What is "Sleep Hygiene"? In the same way that dental hygiene is observed to promote strong and healthy teeth, sleep hygiene should be observed to promote good and healthy sleep. Your habits while awake affect the way that you sleep in many ways. In order to promote the best possible sleep, these following steps should be observed.

1. **Keep Regular Hours.** The best way to ensure a good night of sleep is to stick to a regular schedule. To keep your biologic clock in "sync", keep a regular bedtime and wake up at the same time, regardless of how much or how little you feel you've slept.

2. **Exercise Regularly.** Exercise helps by burning off tension, which allows you to "unwind" mentally and physically. The ideal time is late afternoon or early evening. However, exercise should be completed 4-6 hours before your bedtime.

3. **Reduce Stimulants.** People in the United States drink an average of 400 million cups of coffee daily and get extra caffeine in tea, cola, and chocolate. Have your last beverage containing caffeine at 6-8 hours before your bedtime. If you are taking any prescription or over-the-counter medications, ask your doctor whether they may affect your sleep.

4. **Sleep on a Good Bed.** If your bed is older than 8 years, consider obtaining a new one. Consider cervical supports or pillows if medical conditions warrant their use.

5. **Reduce or Stop Smoking.** The nicotine found in cigarettes is a stronger stimulant than caffeine. Studies have shown that smokers who break their habit have dramatic improvements in sleep.

6. **Don't Drink Alcohol or Only Drink in Moderation.** Even moderate drinking can suppress REM sleep and deep sleep and result in fragmented, unrefreshing sleep. If you do drink alcohol, have it at least 4-6 hours before sleep.

7. **Get Quality Sleep, Not Just Quantity.** The normal range of total sleep at night is from 6-10 hours, depending on the individual. Maintaining a sleep diary, as directed by your sleep doctor, can determine how much sleep you really need to feel refreshed. Too much sleep can be bad as well.

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Sleep Hygiene – A Guide to a Better Night's Sleep

8. **Set Aside a "Worry Time".** Try to resolve problems early in the evening, before going to bed. If distractions follow you to bed, tell yourself to deal with them during the next day's "worry time". Psychological stress may result from job insecurity, deadlines and competency testing. Marital conflict may be another source of stress. Do not attempt to solve these or other stress problems just before going to bed. Look for ways to handle them during your "worry time" the next day.

9. **Don't Go To Bed Stuffed or Starved.** Avoid late night meals. Avoid snacks cause gas, such as peanuts, beans or raw vegetables. If you are dieting, don't go to bed hungry. Eat a low calorie snack, such as an apple or banana.

10. **Avoid Napping.** Don't take naps during the daytime, particularly if you have trouble falling asleep at night. Prolonged naps, especially 8-12 hours after awakening can disrupt your biologic sleep rhythm.

11. **Get a Sleep Ritual.** Perform techniques to relax before going to bed on a routine basis. These may include gently stretching, listening to quiet music or reading books or magazines. A warm bath or warm drink within 2 hours of sleep time may be helpful also. Whatever method you decide on, be sure to follow the ritual each night until it becomes a cue for your body to settle down.

12. **Use Your Bedroom for Sleep Only.** Avoid arousing stimuli. Try to avoid activities in your bedroom such as watching TV, reading or eating while in bed. Staring at an alarm clock can only serve to keep you awake. Sexual activity can be arousing or sedating. If arousing, consider a time other than the hour preceding your major sleep period.

13. **Avoid Exposure to Bright Light at Night.** If you have to get up at night, try to use subdued lighting. Exposure to bright lights is arousing and may interfere with your ability to fall asleep later on.

14. **Get Exposure to Sunlight.** Try to get ½ hour of sunlight within the first hour of awakening from your major sleep period. This will help you set your biologic sleep rhythm.

Denton Sleep Disorders Laboratory **Cooke County Sleep Disorders Laboratory**

General Suggestions – Sleep Apnea / Sleep Hygiene / Insomnia

Sleep Hygiene Measures:

1. Keep a regular sleep schedule including weekends.
2. Avoid caffeinated beverages before sleep.
3. Avoid alcohol near bedtime (no night cap).
4. Avoid smoking close to bedtime.
5. Exercise for at least 20 minutes preferably 4-5 hours before bedtime.
6. Do not engage in planning next day activities at bedtime.
7. Avoid daytime napping.

Stimulus Control:

1. Go to bed only when sleepy.
2. Do no watch TV, read or eat while in bed.
3. Use bed only for sleep and intimacy.
4. Get out of bed if unable to fall asleep in 15-20 minutes and return to bed only when sleepy. Repeat this step as many times as necessary throughout the night.
5. Set up an alarm clock to wake up at a fixed time each morning, including weekends.
6. Avoid daytime napping.

General Conservative Treatment for Obstructive Sleep Apnea:

1. Avoid alcohol, particularly in the evening.
2. Avoid sedative or hypnotics.
3. Reduce weight to ideal body weight.
4. Exercise program.
5. Avoid supine position and sleep in the lateral or prone position if apneas are noted predominantly in supine position. (Stitch a tennis ball to the pajama top to avoid sleeping in supine position.)
6. Clinical/ENT evaluation for anatomic lesion of upper airway obstruction.

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Tips Regarding CPAP

1. In order to improve compliances, educate the patient regarding the importance of treatment of sleep apnea – reduced risk of hypertension, cardiovascular abnormality, stroke, and cognitive impairment.

2. Improve CPAP compliance with appropriately fitting nasal mask according to the patient preference. Other alternative such as nasal pillows can be explored.

3. Treatment of nasal congestion or irritation with steroids spray or addition of heated humidification to the CPAP machine.

4. If the patient absolutely refuses CPAP therapy, consider referral to an ENT Surgeon with interest in sleep medicine to explore other alternative measures such as surgical intervention, oral appliances, etc.

5. If the patient continues to be symptomatic in spite of compliance with CPAP, consider follow up titration.

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