PENSACOLA SLEEP DISORDERS CENTER

Preparation and Guidelines for Nighttime Sleep Study

- Arrival time at our facility is at 8:30 P.M. and departure is between 5:00-6:00 A.M., unless otherwise instructed. THE FACILITY IS NOT UNLOCKED UNTIL 8:30 P.M.
- Bring your insurance cards and a photo id with completed paperwork on arrival.
- Bring footwear/slippers and clean pajamas or shorts and a shirt to sleep in during your study.
- Bring all your medications that you will need during your stay at the sleep center in their original bottle. PSDC does not administer any medications, including over the counter. Sleep medications may not be taken after 10 pm.
- Any medications that you bring **must** be listed on your questionnaire. You will be provided a lock box for secure storage of medications. While under our care the technologists will document all medications and their time taken. Any medications left at PSDC will be properly disposed of.
- PSDC does not provide storage for medications that require refrigeration. Patients must provide their own means of temperature controlled storage (i.e. cooler, ice chest etc.).
- Please shower, wash and dry your hair prior to arrival. Please do not use any other products in your hair after it is dried.
- In order for us to get an accurate test we ask that you please have clean, dry hair, do not wear any make-up, nail polish/false nails, hair extensions/weaves, or lotion the night of your study.
- **If you need any special assistance please let us know prior to your appointment so we may better assist you.**
- We ask that you leave all valuables at home. PSDC is not responsible for any personal items.
- There are not to be any firearms or weapons of any kind at any time on the grounds of PSDC.
- No animals of any kind are allowed on the property unless medically necessary.
- Due to safety reasons we ask that you shower at home the morning after your study.
- PSDC **does not** honor "Do not resuscitate" Advance Directives. Our policy is to call 911 in the event of a medical emergency. If you have any questions, comments or concerns regarding this policy please let our office know.

Signature: ____ Date: ______________

If for any reason you have to reschedule, we require 48 hours' notice. You will be charged $300.00 if you fail to give the required 48 hours' notice or fail to show up for your appointment.

6706 N. 9th Avenue, Unit E1 ● Pensacola, FL 32504 ● Phone: 850-473-9709 ● Fax: 850-476-9519

Patient Name: ____________________ **DOB:**___________________ **Date:**____________ **Rec. ID:**________

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SLEEP HISTORY

What is the sleep problem you were referred for and for how long have you had this problem? :
____

Have you ever been diagnosed with a sleep disorder in the past? **Yes / No** If so, what type of sleep disorder? ____________________

Are you experiencing any of the following symptoms?

__snoring
__wake up coughing/choking
__feel very weak during day
__sleep restlessly
__issues waking in the A.M.
__feel paralyzed in bed
__difficulty shutting mind off
__jerk during the night
__move arms during sleep
__vivid dreams
__ wake up with dry mouth
__ wake up short of breath
__ daytime muscle aches
__sleepwalk
__feel sleepy all day
__wet the bed
__collapse when emotional
__unable to keep legs still at bedtime
__legs uncomfortable at bedtime
__start dreaming when falling asleep
__wake lump in throat
__wake up with headache
__heartburn at night
__talk in sleep
__feel tired during the day
__ have night sweats
__leg cramps
__act out your dreams
__nightmares or night terrors, if yes, do you remember them? Yes or No

What do you believe the cause of your sleep problem is?____

HEALTH HISTORY

Do you have or have you had the following:

____ HIGH BLOOD PRESSURE
____ CHRONIC BACK PAIN
____ CONGESTIVE HEART FAILURE
____ ALLERGIES/HAY FEVER
____ COPD or EMPHYSEMA
____ IRRITABLE BOWEL SYNDROME
____ ARTHRITIS
____ FIBROMYALGIA
____ SEIZURE or EPILEPSY
____ STROKE
____ IRREGULAR HEART BEAT
____ GLAUCOMA
____ MITRAL VALVE PROLAPSE
____ GOUT
____ DIABETES
____ MIGRAINE HEADACHES
____ DEPRESSION
____ TMJ SYNDROME
____ HEART ATTACK
____ ENLARGED PROSTATE
____ ANGINA OR CHEST PAINS
____ DEVIATED NASAL SEPTUM
____ ASTHMA
____ ACID REFLUX
____ ANXIETY
____ CHRONIC FATIGUE SYNDROME

Does anyone in your immediate family have any of the above problems? **Yes / No** If yes, who and what disorder?
____

Have you been diagnosed with cancer? **Yes or No** Type? : ________________________Current status? ____________________

Please list any other significant medical conditions:____

Please list all surgeries you have had:

____

____

MEDICATION

Please list all of the medication you are currently taking

Medication	Dosage	Medication	Dosage	Medication	Dosage

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Sleep Hygiene

Describe your routine on weekdays: ____

Weekends: ____

Do you work shifts: Yes or No If yes to shift work, what shifts do you work? ________________________

WEEKDAY SCHEDULE

How many hours of sleep do you think you are getting a night? ___________ What time do you actually get into bed? __________________

Do you doze off before getting into bed? **Yes or No**

How long does it take to fall asleep once in bed? _________________ Do you feel this is long, short, or normal? ______________________

How many times do you wake up during the night? _______________ Do you feel this is normal? Yes or No

Why do you wake up during the night? __________________________________Do you have difficulty going back to sleep? ___________

What time do you wake up in the morning? ______________________________ What time do you get out of bed? ________

DOES YOUR SLEEP SCHEDULE CHANGE ON THE WEEKENDS? If yes, please answer the following questions. IF NO, CROSS THROUGH THE NEXT SET OF QUESTIONS.

How many hours of sleep do you think you are getting a night? ___________ What time do you actually get into bed? __________________

Do you doze off before getting into bed? **Yes or No**

How long does it take to fall asleep once in bed? _________________ Do you feel this is long, short, or normal? ______________________

How many times do you wake up during the night? _______________ Do you feel this is normal? Yes or No

Why do you wake up during the night? __________________________________Do you have difficulty going back to sleep? ___________

What time do you wake up in the morning? ______________________________ What time do you get out of bed? ________

NAPS:

Do you nap or doze off during the day? **Yes or No**

Do you take naps? __________ If yes, how many days per week and how long are the naps? ______________________________________

What time of the day do you feel sleepy most? _______________________ Do you feel alert after these naps? **Yes or No**

Per Day Answers:

Do you drink Reg/Decaf coffee?	**Yes or No**	if yes, how many: ___________
Reg/Decaf Tea?	**Yes or No**	if yes, how many: ___________
Do you drink REG or NO caffeine soft drinks?	**Yes or No**	if yes, how many: ___________
Do you eat chocolate?	**Yes or No**	if yes, how much: ___________
Do you smoke/ chew/ dip tobacco?	**Yes or No**	if yes, how much: ___________
Do you drink alcohol?	**Yes or No**	if yes, how much: ___________
Do you exercise regularly?	**Yes or No**	if yes how often: _____________

If not, Why? ____

Sleep Environment

Is your bedroom quiet? **Yes or No**

Is your bedroom dark? **Yes or No** **If no, why?**____

Circle if you have any of the following on while you are going to sleep? Radio, Stereo system, TV, White noise, Sound machine, iPod.

Does the above device stay on all night? **Yes or No** **If no, how long?**____

Do you eat in bed? **Yes or No** Do you read in bed? **Yes or No** Do you work in bed? **Yes or No**

Do you write in bed? **Yes or No**

Are there any pets in the house? **Yes or No** Do they stay in the bedroom with you? **Yes or No**

Do you currently have a special bedtime routine? ____

____

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If you *do not* sleep alone at night, please have your bed partner answer the following questions.

Check all that apply that you have witnessed the patient doing while asleep or have noticed about the patient's sleep routine or sleep problem.

_____ Pauses in breathing
_____ Snores
_____ Moves or kicks legs/feet a lot
_____ Talks in their sleep
_____ Sleep Walks
_____ Becomes rigid and / or shakes
_____ Sits up in bed while still asleep
_____ Grinds their teeth while asleep
_____ Nocturia (bedwetting)
_____ Is very restless while sleeping (tossing and turning)
_____ Has a lot of nightmares
_____ Gets up a lot during the night
_____ Has trouble going to sleep
_____ Wakes up a lot at night, but does not seem to have trouble going back to sleep
_____ Wakes up a lot at night, but does have trouble going back to sleep
_____ Falls asleep quite often at inappropriate times (i.e., watching T.V., reading, having conversations with others, riding as a passenger in a car, etc.)
_____ Takes naps (even cat naps). How many times? _________ in any given day

Is there anything else that you feel is important that we have not asked?

____

____

____

____

____

____

____

Bed Partner Name: ____ Date: ______________________

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