Observer’s Name: _____________________   Relationship to Patient: _____________  Date: ________

Frequency of observations: □ Once or twice  □ Often  □ Almost every night

Check any of the following behaviors observed while watching person sleep. Circle behaviors that you consider severe problems for this person.

- □ Light snoring
- □ Loud snoring
- □ Loud snorts
- □ Pause in breathing (How long? ____seconds)
- □ Choking
- □ Gasping for air
- □ Twitching, moving or kicking of legs
- □ Twitching or flinging of arms
- □ Grinding teeth
- □ Apparently sleeping even if person behaves otherwise
- □ Other __________________________________________________________________

If person snores, what makes snoring worse?

- □ Sleeping on back  □ Sleeping on side  □ Alcohol  □ Fatigue

Does snoring sometimes require you or your partner to sleep separately?  □ Yes  □ No

Does this person drink alcohol or use street drugs?  □ Yes  □ No
SCHEDULED APPOINTMENTS

1st Study  Date reserved: _____________  Time reserved: ____________  AM  PM
2nd Study  Date reserved: _____________  Time reserved: ____________  AM  PM

We have reserved a room, testing equipment, and a sleep technician for your scheduled study. Please afford us the courtesy of 24-hour advance notice for any appointment change. In the event that you need to cancel or reschedule your appointment, please notify our office at least 24 hours in advance of the scheduled date and time in order to avoid the cancellation fee. If you do not cancel and do not show up for your appointment, a charge of $150.00 may be billed to you for which you may be personally responsible. Kindly call our office during normal business hours, Monday through Friday 8:30 AM to 5:00 PM and speak directly to office personnel at the front desk. Messages left on the voice machine cannot be guaranteed as received.

OVERVIEW OF SLEEP STUDIES

- The diagnostic sleep study is a noninvasive, pain-free procedure performed by a sleep technician who will monitor more than 20 different aspects of your sleep including sleep quality, breathing, oxygen level, pulse, eye movements, and muscle tone. All functions are monitored through the use of sensors placed on your body.

- The CPAP or oral appliance titration sleep study is similar to the diagnostic study. The same measurements of the dimensions of your sleep are monitored and recorded; however, during this sleep study you will be sleeping with the CPAP device or oral appliance in place. This study allows us to measure how well you sleep with continual airflow and assess by trial and error what device measurements are optimally therapeutic for you.

- You will be able to leave the facility at 6:00 AM. If someone is picking you up, please have him/her arrive no later than 6:30 AM.
NIGHT-TIME SLEEP STUDY INSTRUCTIONS

- Please be on time for your scheduled study.
- No tobacco products may be used during the course of the sleep study.
- Only patients are allowed in the building during the sleep study. For privacy and security reasons, family and friends are not allowed to stay the night unless they are the designated caregiver.
- For security purposes, once patients are checked in for their sleep study, they are not allowed to leave the building at any time.

PREPARING FOR THE SLEEP STUDY

- After 12 noon on the day of the sleep study, do not consume any products with caffeine, alcohol and/or stimulants, including chocolate.
- Avoid taking naps
- Skin must be free of lotions and any other type of moisturizer; remove all nail polish.
- If you normally shave your face in the morning, please shave that afternoon or evening. If you have a beard, mustache or goatee, you do not need to shave it off.
- Hair must be free of gels, conditioners and hair spray. Please wash your hair on the day of your scheduled study.
- Please eat dinner prior to arriving for the sleep study.
- If you need transportation, please make arrangements prior to your scheduled study.

ITEMS TO BRING

- Please wear loose, comfortable pajamas.
- Bring all of your night-time medications with you. Upon arrival, take medications as you normally would unless otherwise instructed by your physician.
- You may also bring your own pillow or any item that may help you feel comfortable during the study.

FREQUENTLY ASKED QUESTIONS

Question: What happens if I need to get up during the night?
Answer: You will be able to get up as needed.

Question: How will I be able to sleep with sensors and wires attached to my body?
Answer: It generally takes no more than 30 minutes to become accustomed to the equipment. The vast majority of patients have little difficulty falling asleep.

Question: What should I bring with me?
Answer: You should bring your normal bedtime attire. If you would like to shower in the morning, you may want to bring your own toiletries. All patients are required to sleep in regular pajamas—not silk pajamas, T-shirts and shorts, or sweats. Nude sleeping is prohibited. For women, pajamas are preferred in lieu of nightgowns.
SLEEP QUESTIONNAIRE

MEDICAL HISTORY

Name: _________________________________    SSN: ________________      Date: ______________

Age: ____      Height: ______  Weight: _______      □ Male  □ Female

Primary MD: _______________________________   Referring MD: ___________________________

This questionnaire is designed to assist us in understanding the nature of your sleep-related problem. Please take your time and answer each question as completely and accurately as possible.

SLEEP QUESTIONNAIRE

CHIEF COMPLAINT(S)

□ Difficulty falling asleep   □ Difficulty staying asleep   □ Fatigue despite adequate sleep   □ Snoring
□ Significant daytime drowsiness   □ Witnessed apnea   □ Gasping / choking upon awakening
□ Sleep walking / talking   □ Night terrors   □ Acting out dreams   □ Legs kick / move while sleeping
□ Morning headaches   □ Insomnia   □ Other: _____________________________________________

HISTORY OF PRESENT ILLNESS

1.  How long have you had this problem?  □ < 1 month   □ 1-6 months   □ 6 months-2 years   □ >2 years
2.  Rate the severity of your problem. □ Mild  □ Moderate  □ Severe  □ Problem only for others
3.  Is your sleep-related problem getting worse?      □ Yes      □ No
4.  What factors aggravate your symptoms?
5.  Does your problem have a negative impact on your ……… work performance       □ Yes      □ No
    ……… sex life                        □ Yes      □ No
    ……… quality of life                 □ Yes      □ No
    ……… social activities               □ Yes      □ No

6.  Do you use any medications or other substances to help you sleep?      □ Yes      □ No
    If yes, please list drug/substance(s), dose, frequency, and length of usage.

7.  Do any members of your family have significant sleep-related problems?      □ Yes      □ No
    If yes, please explain:

8.  Have you discussed your sleep-related problems with another doctor?      □ Yes      □ No
    Doctor’s Name: ___________________________  Diagnosis: ___________________________
    Current treatment: ___________________________  Prior treatment: ___________________________
<table>
<thead>
<tr>
<th><strong>Please rate how often you or others note that you:</strong></th>
<th>Never</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snore</td>
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<tr>
<td>Snore loudly enough for others to complain</td>
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<tr>
<td>Awaken from sleep feeling short of breath, gasping, or choking</td>
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<td>Hold your breath or stop breathing while asleep</td>
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<tr>
<td>Experience other breathing problems at night</td>
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<tr>
<td>Wake up with a headache that improves in less than 2 hours</td>
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<tr>
<td>Have dry mouth upon awakening</td>
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<tr>
<td>Sweat excessively at night</td>
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<tr>
<td>Experience heart pounding or irregular heart beats during night</td>
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<td>__________________________________________________________________________________________</td>
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<tr>
<td>Feel sleepy or tired during the day</td>
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<tr>
<td>Awaken feeling unrested or unrefreshed</td>
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<tr>
<td>Become drowsy while driving</td>
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<td>Have motor vehicle accidents due to sleepiness</td>
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<td>Have trouble at school or work because of sleepiness</td>
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<tr>
<td>Become irritable or crabby</td>
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<tr>
<td>Have difficulty concentrating; experience memory impairment</td>
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<td>__________________________________________________________________________________________</td>
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<tr>
<td>Fall asleep involuntarily, suddenly or in an awkward situation</td>
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<tr>
<td>Experience sudden weakness, knees buckling, or jaw drop when laughing, scared, angry or crying</td>
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<td>Feel unable to move (paralyzed) when waking or falling asleep</td>
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<tr>
<td>Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep similar to hallucinations</td>
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<tr>
<td>Perform complex tasks of which you are totally unaware such as driving or navigating without conscious awareness</td>
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<tr>
<td>__________________________________________________________________________________________</td>
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<tr>
<td>Have nightmares or night terrors</td>
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<tr>
<td>Act out dreams by yelling and swinging arms and legs</td>
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<tr>
<td>Walk or talk while asleep</td>
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<tr>
<td>Do anything else considered “unusual” while asleep</td>
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<td>__________________________________________________________________________________________</td>
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<tr>
<td>Move, twitch or jerk your legs while asleep</td>
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<tr>
<td>Feel leg restlessness, agitation or discomfort at or before bedtime</td>
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<tr>
<td>If yes: Do you feel an overwhelming urge to move your legs? □ Yes □ No</td>
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<tr>
<td>Does it happen only in the evening? □ Yes □ No</td>
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<tr>
<td>Does it only happen when you are relaxed? □ Yes □ No</td>
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<tr>
<td>Does it get better if you move around or walk? □ Yes □ No</td>
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<tr>
<td>Does it disturb your sleep or sleep onset? □ Yes □ No</td>
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<tr>
<td>How often do you experience this feeling? ___________________________________________</td>
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</table>
SLEEP HYGIENE

1. Do you often have anxiety around bedtime? □ Yes □ No
2. Do you have thoughts racing through your mind while trying to fall asleep? □ Yes □ No
3. Do you sleep better away from home than in your own bed? □ Yes □ No
4. Are you anxious or upset if you have difficulty falling asleep? □ Yes □ No
5. Do you usually take coffee, tea, or chocolate within 2 hours of your bedtime? □ Yes □ No
6. Do you exercise within 2 hours of your bedtime? □ Yes □ No
7. Do you watch TV or read in bed before falling asleep? □ Yes □ No
8. Do you ever nap or rest during the awake portion of your day? □ Yes □ No
   If yes: How often? __________ times per day; __________ times per week
   How long is your nap / rest? □ < one hour □ ≥ one hour
   After the nap / rest, do you still feel tired? □ Yes □ No
9. Check conditions that routinely apply to you: □ Sleep alone □ Sleep with someone else in bed
    □ Sleep with pet in room/bed □ Provide assistance during night to child, invalid, bed partner, animal
10. Check factors that generally disturb your sleep: □ Heat □ Cold □ Light □ Noise □ Bed Partner
    Other: ______________________________

SLEEP HABITS

1. When do you feel your very best? □ Morning □ Afternoon □ Evening
2. Approximately, how many hours do you actually sleep per night? __________________________
3. What time do you usually go to bed? Workdays: __________ Non-Workdays: __________
4. What time do you usually rise from bed? Workdays: __________ Non-Workdays: __________
5. How long does it usually take for you to fall asleep? _____________________________
6. How many hours of sleep do you need to feel your very best? __________________________
7. In an perfect world, what would be the ideal hour for you to go to bed? __________________
8. In an perfect world, what would be the ideal hour for you to awaken? __________________
9. What usually prevents you from quickly falling asleep? _____________________________
10. How many times do you typically wake up during the night? _________________________
11. What generally causes you to wake up during the night? ____________________________
12. If you wake up during the night, how long do you typically stay awake? ______________
13. If you wake up during the night, when do you typically wake up?
   □ Soon after falling asleep □ In the middle of the night □ Near the end of the sleeping period
14. What do you usually do when you awaken during the night? _________________________
MEDICAL HISTORY

Please check conditions for which you have been diagnosed:

- □ Angina
- □ Congestive heart failure
- □ Coronary artery disease
- □ Arteriosclerosis
- □ Heart murmur
- □ Rheumatic heart disease
- □ Arrhythmia
- □ Hypertension
- □ Stroke
- □ Peripheral artery disease
- □ Other cardiovascular disorders ________
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Sinusitis
- □ Other respiratory disorders ________
- □ Acid reflux
- □ Diverticulitis
- □ Hiatal hernia
- □ Swallowing disorder
- □ Stomach ulcers
- □ Other gastrointestinal disorders ________
- □ Arthritis
- □ Back pain
- □ Osteoporosis
- □ Chronic fatigue syndrome
- □ Fibromyalgia
- □ Autoimmune disorder
- □ Neuromuscular disorder
- □ Diabetes
- □ Sickle cell anemia
- □ Thyroid disease
- □ Cancer
- □ Migraines
- □ Seizures / Epilepsy
- □ Brain injury
- □ Spinal infection
- □ Spinal injury
- □ Nerve injury
- □ Other neurologic disorders
- □ Acid reflux
- □ Diverticulitis
- □ Hiatal hernia
- □ Swallowing disorder
- □ Stomach ulcers
- □ Other gastrointestinal disorders ________
- □ Arthritis
- □ Back pain
- □ Osteoporosis
- □ Chronic fatigue syndrome
- □ Fibromyalgia
- □ Autoimmune disorder
- □ Neuromuscular disorder
- □ Diabetes
- □ Sickle cell anemia
- □ Thyroid disease
- □ Cancer
- □ Migraines
- □ Seizures / Epilepsy
- □ Brain injury
- □ Spinal infection
- □ Spinal injury
- □ Nerve injury
- □ Other neurologic disorders
- □ Acid reflux
- □ Diverticulitis
- □ Hiatal hernia
- □ Swallowing disorder
- □ Stomach ulcers
- □ Other gastrointestinal disorders ________
- □ Arthritis
- □ Back pain
- □ Osteoporosis
- □ Chronic fatigue syndrome
- □ Fibromyalgia
- □ Autoimmune disorder
- □ Neuromuscular disorder
- □ Diabetes
- □ Sickle cell anemia
- □ Thyroid disease
- □ Cancer
- □ Migraines
- □ Seizures / Epilepsy
- □ Brain injury
- □ Spinal infection
- □ Spinal injury
- □ Nerve injury
- □ Other neurologic disorders

CURRENT MEDICATIONS: Please list all medications that you are currently taking and their dosages:

____________________________________________________________________________________
____________________________________________________________________________________

DRUG ALLERGIES: Are you allergic to any drugs? □ Yes  □ No  If yes, please list:

____________________________________________________________________________________

PAST SURGERIES: Please list all operations and the approximate date of the procedure. ________________

FAMILY HISTORY: Has anyone in your blood-related family been afflicted with the following conditions:

- □ Hypertension □ Diabetes □ Heart disease □ Stroke □ Cancer
- □ Sleep apnea □ Narcolepsy □ Restless legs syndrome □ Sleep walking / talking □ Parasomnias

OCCUPATIONAL HISTORY: Occupation: ________________  Are you a shift worker? □ Yes  □ No  If yes, please describe work schedule: ________________

SOCIAL HISTORY

Marital Status: □ Single  □ Married  □ Divorced  □ Widowed
Children living at home: □ No □ Yes  Ages of children: ________________
Others living at home: □ No □ Yes □ Spouse □ Parents / Grandparents □ Friend
Alcohol consumption: □ Never □ Rarely □ Occasionally □ Frequently □ Alcoholic
Tobacco use □ No □ Yes  If yes, Type: ________  Frequency: ________
Recreational drug use □ No □ Yes  If yes, Type: ________  Frequency: ________
# REVIEW OF SYSTEMS

Please check any of the following symptoms which you currently or recently have experienced.

## General
- □ Fatigue
- □ Malaise / lethargy
- □ Generalized weakness
- □ Loss of appetite
- □ Weight loss
- □ Weight gain
- □ Night sweats
- □ Fever / chills

## Ears, Nose, Throat and Mouth
- □ Earache
- □ Ringing in the ears
- □ Allergies
- □ Frequent colds
- □ Nasal congestion
- □ Nosebleeds
- □ Sinusitis
- □ Toothache
- □ Oral ulcers
- □ Dry mouth
- □ Facial pain
- □ Jaw pain
- □ Hoarse voice
- □ Sore throat
- □ Difficulty swallowing
- □ Swollen glands

## Cardiovascular System
- □ Chest pain
- □ Pain in arm, shoulder, jaw, neck or back
- □ Rapid heart rate
- □ Irregular heartbeat
- □ Dizziness
- □ Pain in leg when walking
- □ Ankle / leg swelling

## Eyes
- □ Vision changes
- □ Double vision
- □ Discharge
- □ Pain
- □ Sensitivity to light

## Lungs
- □ Chronic cough
- □ Shortness of breath with mild exertion
- □ Difficulty breathing
- □ Wheezing
- □ Bloody sputum

## Gastrointestinal System
- □ Nausea / vomiting
- □ Indigestion
- □ Acid reflux
- □ Diarrhea
- □ Constipation
- □ Cramps
- □ Bloating
- □ Vomiting blood
- □ Blood in stool
- □ Abdominal pain
- □ Abdominal swelling
- □ Rectal pain
- □ Rectal bleeding

## Genitourinary System
- □ Frequent urination
- □ Painful urination
- □ Urinary incontinence
- □ Blood in urine
- □ Pelvic / groin pain
- □ Genital ulcers
- □ Male:
  - Erectile dysfunction
- □ Testicular pain / swelling
- □ Female:
  - Irregular periods
- □ Hot flashes
- □ Vaginal discharge

## Musculoskeletal System
- □ Joint pain / swelling
- □ Back pain
- □ Muscle pain / weakness
- □ Leg cramps

## Nervous System
- □ Headaches / migraines
- □ Dizziness / fainting
- □ Seizures
- □ Tremors
- □ Disorientation
- □ Lack of coordination
- □ Numbness / paralysis
- □ Memory loss / impairment

## Psychiatric Symptoms
- □ Depression
- □ Anxiety / panic attacks
- □ Hallucinations
- □ Delirium
- □ Dementia
- □ Suicidal ideation

## Endocrine System
- □ Heat intolerance
- □ Cold intolerance
- □ Excessive thirst
- □ Sexual dysfunction
- □ Hair loss
- □ Excessive sweating

## Skin
- □ Rashes
- □ Bruises
- □ Hives
- □ Lesions

Patient Signature ______________________________________   Date ___________________
How likely are you to doze off or 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 haven’t done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

<table>
<thead>
<tr>
<th>CHANCE OF DOZING (0-3)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Would never doze</td>
</tr>
<tr>
<td>1</td>
<td>Slight chance of dozing</td>
</tr>
<tr>
<td>2</td>
<td>Moderate chance of dozing</td>
</tr>
<tr>
<td>3</td>
<td>High chance of dozing</td>
</tr>
</tbody>
</table>

*It is important that you answer each question as best you can.*

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING (0-3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching TV</td>
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</tr>
<tr>
<td>Sitting, inactive in a public place (e.g., a theater or a meeting)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking to someone</td>
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<tr>
<td>Sitting quietly after a lunch without alcohol</td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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</tbody>
</table>

Total score: ____