WHAT IS A SLEEP STUDY?
A sleep study, or polysomnogram, is a recording that includes various measurements used to help identify and diagnose sleep disorders. Sleep is a vital part of your life, and without it your body cannot perform and function productively during the day. Sleep disorders can disrupt sleep causing fatigue, sleepiness, and difficulty concentrating; as well as affecting your overall health.

HOW TO PREPARE FOR THE TEST
Prior to your sleep study, it is important that you prepare appropriately. Please call Amber (732-2433) with any questions, concerns or important information so we can meet all of your needs when you arrive. Brenda is here during the day, Monday through Friday, to answer any questions and address any concerns you may have.

If you need to reschedule or cancel your sleep study appointment, you must notify our office at least 24 hours in advance to avoid being charged $150.00. Please respect our sleep technicians’ time and travel by complying with these guidelines.

SLEEP LAB’S GUIDELINES:
• DO NOT consume caffeine (coffee, tea, cola, chocolate, etc.) after 12:00 noon the day of your study.
• DO NOT use lotions or creams on your body or face.
• Try to get a good night’s sleep the night before and avoid taking naps the day of your study.
• Please shower, shave and shampoo your hair the day of your sleep study. AVOID excessive hair sprays, oils, creams and gels.

MEDICATIONS: Please bring a list of your current medications. It is important for Dr. Gabriel to know if you are taking any prescribed or over-the-counter medications. Certain medications can affect sleep and the interpretation of a sleep study. Please contact your primary care physician if any of your medications need to be discontinued prior to your sleep study appointment.

OVERNIGHT BAG: You should pack an overnight bag, as you would for an overnight stay at a hotel or a friend’s house, to cover your needs for the night and in the morning (your pillow, personal toiletries, a book, snacks and a change of clothes). It is important to bring something comfortable to sleep in. Pajamas, nightgown or sleeping shorts and a t-shirt are suitable. Avoid clothing that will make you hot and sweaty. Bring your medications if you will need them while you are away from home - no medications are given or supplied by the sleep lab.

*If you are returning for a CPAP trial, please bring your hose and mask (do not bring your machine).
Patient:

WHAT TO EXPECT

When you arrive to the Sleep Lab of Columbia, you will be shown to a private bedroom. The rooms are similar to a comfortable, residential bedroom with a nearby restroom. You will be given the opportunity to freshen up after the study and resume your normal daily activities at 5:00AM.

The rooms are specially equipped to monitor and record your sleep activity. The technician will apply adhesive electrodes, sensors and other monitoring devices to the skin of your head and body. These devices are designed to be as comfortable as possible and will be used to painlessly record breathing through your mouth and nose, heart rate, oxygen levels, brain wave activity, and muscle, eye and leg movements during sleep. Flexible elastic belts around your chest and abdomen measure your breathing. A clip on your finger or earlobe monitors the level of oxygen in your blood and your heart rate. You may read, do crossword puzzles or another relaxing activity prior to bedtime. We ask that you be asleep by 11:00PM. A family member can accompany you to the lab and they are permitted to stay in your room.

A camera is used to observe your sleep throughout the night. This provides useful diagnostic information and also acts as a safety feature. An intercom is on at all times to enable you to speak to the technician in an adjacent central monitoring room. The technician will monitor you during the entire night by means of computers, video and printouts of your recorded activity.

WHERE TO GO FOR THE SLEEP STUDY

Please report directly to the Sleep Lab of Columbia located on the first floor of Irmo Professional Center on Wellness Boulevard, in Suite 103. We are across the street from Lexington Urgent Care-Irmo on St. Andrews Road. Please go to the left side of the building and ring the doorbell to alert our staff of your arrival.

OBTAINING YOUR RESULTS

A follow-up appointment will be scheduled for you at the same time your sleep study appointment is scheduled. Please make every effort to keep this follow up appointment, as this is the time you will discuss your test results with our sleep medicine specialist, Dr. Joseph Gabriel.

We look forward to seeing you!
Patient: ____________________________  Referring Physician: ____________________________

Sleep Complaint: ____________________________

PAST MEDICAL HISTORY

Please answer all questions to the best of your ability.

DO YOU NOW OR HAVE YOU EVER HAD:

- Tuberculosis (TB) □ Yes □ No
- Lung Disease □ Yes □ No
- Cancer □ Yes □ No
- Thyroid Disease □ Yes □ No
- High Blood Pressure □ Yes □ No
- Stomach Disease □ Yes □ No
- Diabetes (Blood sugar high or low) □ Yes □ No
- Intestinal Disease □ Yes □ No
- Heart Attack □ Yes □ No
- Peptic Ulcer □ Yes □ No
- Other Heart Disease □ Yes □ No
- Liver Disease □ Yes □ No
- Kidney Disease □ Yes □ No
- Other Heart Disease □ Yes □ No
- High Blood Pressure □ Yes □ No
- Diabetes (Blood sugar high or low) □ Yes □ No

Please explain all “Yes” answers:
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

HABITS

DO YOU NOW OR HAVE YOU EVER USED:

1. Tobacco (smoke cigarettes, chew tobacco, etc.) □ Yes □ No IF YES: amount per day: ________ How long? ________ years
   Have you quit? □ Yes □ No IF YES: when? ________

2. Alcohol (beer, liquor, wine, etc.) □ Yes □ No IF YES: amount per day: ________ How long? ________ years
   Have you quit? □ Yes □ No IF YES: when? ________

3. Caffeinated beverages (soda, coffee, tea, etc.) □ Yes □ No IF YES: amount per day: ________ How long? ________ years
   Have you quit? □ Yes □ No IF YES: when? ________

MEDICATIONS:

Please list all current medications. (If you brought a list with you, please provide a copy for Dr. Gabriel.)
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

Please list all medication allergies:
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

OPERATIONS:

Please provide the information for each of the following operations. If they do not apply to you, please write “N/A” in the blank.

<table>
<thead>
<tr>
<th>Date</th>
<th>Hospital</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Tonsillectomy: ____________________________
Gallbladder: ____________________________
UPPP: ____________________________
Other: ____________________________

ARE YOU CURRENTLY IN GOOD HEALTH? □ Yes □ No If no, please describe your current health conditions/illnesses:
_________________________________________________________________________________________________________
_________________________________________________________________________________________________________

FAMILY MEDICAL HISTORY
Patient:

**PLEASE CHECK ALL THAT APPLY TO YOU IMMEDIATE FAMILY MEMBERS:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relation to you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes (Blood sugar high or low)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Lung Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:** (Please explain all “yes” answers)

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**RESPIRATORY**

**PLEASE CHECK ALL THAT APPLY:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relation to you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent or severe headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty breathing through nose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic nasal discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful sinuses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies/Hay fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:** (Please explain all “yes” answers)

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**CARDIOVASCULAR**

**PLEASE CHECK ALL THAT APPLY:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relation to you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murmur or abnormal heart sound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bad valve in your heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart enlargement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain with exercise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swollen legs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:** (Please explain all “yes” answers)

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**GASTROINTESTINAL / GENITOURINARY**

**PLEASE CHECK ALL THAT APPLY:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relation to you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty swallowing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voice changes/ hoarseness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hiatal hernia</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in bowel movements</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:** (Please explain all “yes” answers)

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**ENDOCRINE/REPRODUCTIVE**

**PLEASE CHECK ALL THAT APPLY:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Relation to you:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goiter or thyroid enlargement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight gain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low blood sugar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor wound healing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy bruising</td>
<td></td>
<td></td>
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</tbody>
</table>

**Females:** Last menstruation date: __________ Number of pregnancies: _______ GYN problems: __________

**COMMENTS:** (Please explain all “yes” answers)

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**HEMATOLOGICAL**

**PLEASE CHECK ALL THAT APPLY:**
### Sleep Assessment

- The following will help us to obtain an understanding of your sleeping problems. It is extremely important that you answer each question completely and to the best of your knowledge. Your bed partner or room-mate may be helpful with some the questions.

- As you read each question, it is recommended you answer with your first impression.

- Answer all questions by considering the past six months, unless otherwise specified.

- If you are engaged in shift work or other unusual sleep/wake schedule, refer to “daytime” as the times you would normally be awake and “nighttime” as the times you would be sleeping.

**Do you feel you get too much sleep at night (☐) OR do you feel you do not get enough sleep at night (☐)?**

Please rate each of the following problems that best describes you:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all (None)</th>
<th>Slight (Few Times)</th>
<th>Moderate (Sometimes)</th>
<th>Severe (Always)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting to sleep at night</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Waking up during the night</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tiredness during the day</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sleepiness during the day</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Provide the time that best describes your lifestyle:

**During the week:**

Bedtime: ____________ AM /PM
Wake-up time: ____________ AM /PM
Naptime: ____________ AM /PM

**On the weekends (days off work):**

Bedtime: ____________ AM /PM
Wake-up time: ____________ AM /PM
Naptime: ____________ AM /PM

If you don’t take naps.

1. Do you watch TV or read in bed before going to sleep? ☐ Yes ☐ No If yes, how long? ________________
2. Do you use sleeping aids or medicine? ☐ Yes ☐ No
   If yes, please list: ____________________________________ Frequency? ___________________
3. How long are you in bed before deciding to go to sleep? _______hours _______minutes
4. How long does it take you to fall asleep after you have decided to? _______hours _______minutes
5. How many hours of sleep do you get in a typical night? _______hours _______minutes
6. How many times do you wake up in a typical night? _______times _______hours _______minutes
7. How long is a typical wake time? _______hours _______minutes
8. If you do awaken during your sleep, which part(s) of the night is it likely to happen? ☐ First third ☐ Second third ☐ Last third
9. How many times do you get out of bed in a typical night? _______times
Patient:

10. How long is the typical time out of bed during the night? _____ hours _____ minutes

**WHEN FALLING ASLEEP, HOW OFTEN DO YOU:**

[Checkboxes for frequency: Not at all/None, Slight/Few Times, Moderate/Sometimes, Severe/Always]

1. Have thoughts racing through your mind
2. Have anxiety, or worry about things
3. Feel muscular tension
4. Feel afraid of not being able to go to sleep
5. Feel unable to move or paralyzed
6. Notice parts of your body startle or jerk
7. Experience restlessness in your legs (crawling or aching / unable to keep your legs still)
8. Experience vivid, dreamlike scenes or hallucinations when awaken
9. Experience pain or discomfort

**DURING THE NIGHT, HOW OFTEN DO YOU:**

[Checkboxes for frequency: Not at all/None, Slight/Few Times, Moderate/Sometimes, Severe/Always]

10. Sleep with someone else in your room
11. Sleep with someone else in your bed
12. Sleep on a special surface
13. Have a restless, disturbed sleep
14. Disturb the sleep of your bed partner
15. Provide assistance to someone or something else
16. Have nasal congestion
17. Use nasal spray or other medication to deal w/ nasal congestion
18. Snore
19. Hold your breath or stop breathing
20. Wake up gasping for air or feeling you can’t breath
21. Wake with a choking sensation
22. Have some other breathing problem
23. Sweat excessively
24. Sleep walk
25. Sleep talk
26. Grind your teeth
27. Have leg twitching or jerking during your sleep
28. Have other unusual movements during sleep
29. Eat during the night after you go to sleep

**DURING THE NIGHT, HOW OFTEN IS YOUR SLEEP DISTURBED DUE TO:**

[Checkboxes for frequency: Not at all/None, Slight/Few Times, Moderate/Sometimes, Severe/Always]

30. Stomach or abdominal pains
31. Leg cramps
32. Paresthesia (pins and needles sensation) in your arms and legs
33. Itching sensations
34. Feeling short of breath in a flat position
35. “Gas” in your stomach, or indigestion
36. Awakening with regurgitation, or burning in your throat
37. Hunger
38. Thirst
39. Awakening with the urgent need to urinate
40. Intense heart pain
41. Other chest pains
42. Asthma
43. Persistent coughing
44. How often do you feel extremely alert and energetic all day
45. How long does it take you to “get going” in the morning _______ minutes

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Sleep Lab of Columbia

1 Wellness Boulevard, Suite 103
Irmo, South Carolina 29063
Phone: (803) 732-2433