Patient:

1 Wellness Boulevard, Suite 103
Irmo, South Carolina 29063
Phone: (803) 732-2433
Fax: (803) 732-2624

Study Date: _____ Time: _____

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 out sleep medicine specialist, Dr. Joseph Gabriel.

We look forward to seeing you!

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Primary Care Physician:_____ **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	Intestinal Disease	☐ Yes	☐ No
Lung Disease	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Peptic Ulcer	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Other Heart Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Stomach Disease	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Diabetes (Blood sugar high or low)	☐ Yes	☐ No	Seizures	☐ 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.

	Date	Hospital	Physician
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:

High Blood Pressure	☐ Yes ☐ No	Relation to you: _____
Diabetes (Blood sugar high or low)	☐ Yes ☐ No	Relation to you: _____
Heart Disease	☐ Yes ☐ No	Relation to you: _____
Lung Disease	☐ Yes ☐ No	Relation to you: _____
Sleep Disorder	☐ Yes ☐ No	Relation to you: _____

COMMENTS: (Please explain all "yes" answers) _____

_____

RESPIRATORY

PLEASE CHECK ALL THAT APPLY:

Frequent or severe headaches	☐ Yes ☐ No	Frequent cough	☐ Yes ☐ No
Difficulty breathing through nose	☐ Yes ☐ No	Phlegm or sputum	☐ Yes ☐ No
Chronic nasal discharge	☐ Yes ☐ No	Coughing up blood	☐ Yes ☐ No
Painful sinuses	☐ Yes ☐ No	Frequent pneumonia	☐ Yes ☐ No
Allergies/Hay fever	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Dentures	☐ Yes ☐ No	Unusual shortness of breath	☐ Yes ☐ No

COMMENTS: (Please explain all "yes" answers) _____

_____

CARDIOVASCULAR

PLEASE CHECK ALL THAT APPLY:

Murmur or abnormal heart sound	☐ Yes ☐ No	Smothering spells at night	☐ Yes ☐ No
Bad valve in your heart	☐ Yes ☐ No	Irregular heart beat	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Bad veins	☐ Yes ☐ No
Heart enlargement	☐ Yes ☐ No	Blood clots	☐ Yes ☐ No
Chest pain with exercise	☐ Yes ☐ No	Leg pain, limiting exercise	☐ Yes ☐ No
Swollen legs	☐ Yes ☐ No	Do you sleep on more than one pillow	☐ Yes ☐ No

COMMENTS: (Please explain all "yes" answers) _____

_____

GASTROINTESTINAL/ GENITOURINARY

PLEASE CHECK ALL THAT APPLY:

Difficulty swallowing	☐ Yes ☐ No	Difficulty urinating	☐ Yes ☐ No
Voice changes/ hoarseness	☐ Yes ☐ No	Black or tarry bowel movements	☐ Yes ☐ No
Hiatal hernia	☐ Yes ☐ No	Frequent bladder infections	☐ Yes ☐ No
Abdominal pain	☐ Yes ☐ No	Kidney stones	☐ Yes ☐ No
Blood in bowel movements	☐ Yes ☐ No		

COMMENTS: (Please explain all "yes" answers) _____

_____

ENDOCRINE/REPRODUCTIVE

PLEASE CHECK ALL THAT APPLY:

Goiter or thyroid enlargement	☐ Yes ☐ No	Dizziness when standing	☐ Yes ☐ No
Weight loss	☐ Yes ☐ No	High blood sugar	☐ Yes ☐ No
Weight gain	☐ Yes ☐ No	Abnormal glucose tolerance test	☐ Yes ☐ No
Low blood sugar	☐ Yes ☐ No	High cholesterol or lipids	☐ Yes ☐ No
Poor wound healing	☐ Yes ☐ No	Excessive urination	☐ Yes ☐ No
Easy bruising	☐ Yes ☐ No		

Females: Last menstruation date: _____ Number of pregnancies: _____ GYN problems: _____

COMMENTS: (Please explain all "yes" answers) _____

_____

HEMATOLOGICAL

PLEASE CHECK ALL THAT APPLY:

Patient:

Prolonged or free bleeding	☐ Yes ☐ No	Anemia (low hemoglobin)	☐ Yes ☐ No
Swollen lymph glands	☐ Yes ☐ No	Frequent skin infections or abscesses	☐ Yes ☐ No
Low or high white blood cell count	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No

COMMENTS: (Please explain all "yes" answers) _____

_____

NEURO/PSYCHIATRIC

PLEASE CHECK ALL THAT APPLY:

History of stroke	☐ Yes ☐ No	Personality changes	☐ Yes ☐ No
Memory loss	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Difficulty moving or controlling part of your body	☐ Yes ☐ No	Blue spells	☐ Yes ☐ No
		Suicidal thoughts	☐ Yes ☐ No
Tremors or shakes in your arms or legs	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Drop attacks	☐ Yes ☐ No	Mood swings	☐ Yes ☐ No
Abnormal sensations	☐ Yes ☐ No	Unhappy in current life situation	☐ Yes ☐ No
Difficulty speaking	☐ Yes ☐ No	Do you work over 40 hours per week	☐ Yes ☐ No

COMMENTS: (Please explain all "yes" answers) _____

_____

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 when 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:

	Not at all (None)	Slight (Few Times)	Moderate (Sometimes)	Severe (Always)
Getting to sleep at night	☐	☐	☐	☐
Waking up during the night	☐	☐	☐	☐
Tiredness during the day	☐	☐	☐	☐
Sleepiness during the day	☐	☐	☐	☐

Provide the time that best describes your lifestyle:

During the week:

Bedtime: _____ AM /PM

Wake-up time: _____ AM /PM

Naptime: _____ AM /PM ☐ I don't take naps.

On the weekends (days off work):

Bedtime: _____ AM /PM

Wake-up time: _____ AM /PM

Naptime: _____ AM /PM ☐ I 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 get in a typical night? _____hours
6. How many times do you wake up in a typical night? _____times
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

10. How long is the typical time out of bed during the night? _____hours _____minutes

WHEN FALLING ASLEEP, HOW OFTEN DO YOU:

	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:

	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:

	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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