FRONTIER NEUROSCIENCES
The Healing Space
702 Platinum Ave.
Cody, WY
Phone: (307) 578-1985 Fax: (307) 578-1938

Sleep Study Instructions

Please arrive to your appointment 15 minutes prior to your sleep test. If the tech is not waiting for you at the front, please take a seat and they will be out to get you promptly. Please have your sleep packet filled out and ready to present to the tech. Please refer to the following list of instructions for sleep test:

1. Please DO come with pajamas with a top and a bottom. These can be sweat pants and a t-shirt if you would like.

2. Please DO bring any night time medications that you may take.

3. You may bring your own blanket and pillow if you wish.

4. The sleep rooms do not have TV's, but you may bring an IPAD or electronic device to read or stream movies.

5. DO NOT drink caffeine 12 hours prior to your sleep study.

6. DO NOT drink alcoholic beverages at least 24 hours prior to your sleep study.

7. Please DO NOT use any lotions prior to your sleep study as they can cause the leads to not stick to the skin.

8. Please do not wear nail polish during your sleep study.

9. We do require a 24-hour notice of cancellation. If we do not receive this, you may be charged a fee of 200.00.

We want you to be as comfortable as possible while you are performing your study. Please feel free to contact the office prior to your study if you have further questions or concerns.

Date: _____

Name: _____
Last First Middle

Address: _____
Street

_____
City State Zip

Telephone: (___) _____ (home) Date of Birth: _____

(___) _____ (work) Sex: _____ Age: _____

(___) _____ (cell) Email Address: _____

Current Marital Status: Married___ Cohabit___ Single ___ Divorced ___ Widow/Widower ___

Occupation: _____ Working Hours: From _____ to _____

Family MD: _____ Referring MD: _____

Social Security # _____ Insurance: _____

Birthplace: _____ _____
City State (or Country)

Ethnicity: Caucasian ___ Black ___ Hispanic ___ Am Indian ___ Asian or Pacific Islander ___Mixed ___

PRESENT ILLNESS:

What is the PRIMARY reason for this examination? _____

_____

Please describe your problem in your own words. If possible, specify how long you have had trouble and what has been done about it so far. How has it affected the quality of your life?

_____

_____

_____

_____

_____

PERSONAL HABITS:

Cigarette Smoking:	Have you ever smoked cigarettes regularly?	No Yes (If no, go to next section)
	If yes, how many years altogether have you smoked? _____	
	Overall, how many cigarettes a day would you typically smoke? _____	
	Do you smoke presently?	No Yes
	If yes, about how many cigarettes a day do you average? _____	
	If you smoked previously, when did you quit? _____	
Caffeine Use:	Do you drink caffeinated beverages?	No Yes coffee ___ tea ___ cola ___
	What is your typical consumption in a 24 hour period? _____	
Alcohol Use:	Do you drink alcohol?	No Yes
	If yes, what is your typical consumption in a 24/hr period	_____
	Do you drink alcohol daily?	Yes No
	Did you drink alcohol in the past and now abstain?	Yes No
Exercise Program:	Please describe any exercise you perform beyond what you do at work or with ordinary activities.	

FAMILY HISTORY:

	Living ?	Age (or Age at Death)	Health Problems or Cause of Death
Father	Y N	_____	_____
Mother	Y N	_____	_____

	Number	Ages (or Age at Death)	Health Problems or Cause of Death
Sisters	_____	_____	_____
Brothers	_____	_____	_____
Children	_____	_____	_____

Please circle illnesses which have occurred in your BLOOD relatives:

Sleep abnormalities (any kind)
Narcolepsy
Problems with staying awake
Sleep Apnea
Allergies (asthma, hayfever, or eczema)
Strokes
Hypertension
Diabetes
Cardiac Disease _____
Breast Cancer _____
Other significant conditions _____

_____

_____

_____

_____

_____

MEDICAL HISTORY:

Height _____ Weight _____

How would you rate your over-all health?

excellent good fair poor

Have you ever been diagnosed or treated for any of the following conditions?

If yes, when		If yes, when	
_____	Hypertension (high blood pressure)	_____	Hiatal Hernia
		_____	Gastric Reflux
_____	Cardiac Arrhythmia (heart irregularities)	_____	Hypothyroidism (low thyroid)
		_____	Nasal polyps
_____	Coronary Artery Disease (hardening of arteries)	_____	Hay Fever or Allergic Rhinitis
		_____	Deviated Nasal Septum
_____	Stroke	_____	Vocal Cord Disease
_____	Myocardial Infarction (heart attack)	_____	Chronic Lung Disease (any kind)
		_____	Asthma
_____	Congestive Heart Failure	_____	Bronchitis
_____	Pulmonary Hypertension	_____	Emphysema
_____	Polycythemia (excessive red blood cells)	_____	Depression
		_____	Diabetes
_____	Edema (water retention)	_____	Sleep Apnea
		___	

List the major surgeries you have had including operations such as tonsillectomy & adenoidectomy (T & A), etc.

Operation	Date	Operation	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications, including non-prescription items (i.e., over-the-counter) that you take on a **regular** basis.

Medication	Dosage	Times /day	Medication	Dosage	Times /day
a.			e.		
b.			f.		
c.			g.		
d.			h.		

List those medications you have taken occasionally but do not take routinely.

Medication	Dosage	Times /day	Medication	Dosage	Times /day
a.			d.		
b.			e.		
c.			f.		

List any other serious or chronic medical illnesses you have or for which you have been treated. Also list any hospitalizations and reasons:

_____

_____

_____

REVIEW OF SYMPTOMS:

1.	Have you gained or lost weight in the past 12 months?	No Yes Gained_____ Lost_____
2.	Do you regularly have a problem breathing through your nose?	0 1 2 3 4 5 Never Severe
3.	Do you have any difficulties with physical exertion such as unusual shortness of breath, difficulty breathing or chest discomfort?	No Yes 0 1 2 3 4 5 Never Severe
4.	Do you have a chronic or persistent cough?	No Yes
5.	Do you have excessive phlegm or sputum?	No Yes

6.	Do you have episodes of wheezing or chest tightness?	No Yes
7.	Have you had persistent swelling of your ankles or feet?	No Yes
8.	Do you have any difficulty with swallowing food, indigestion, heartburn or regurgitation of acid back into your chest or mouth?	No Yes
9.	Have you had any change in your usual bowel habits recently, such as constipation or change in shape, color, etc.?	No Yes
10.	Do you have any difficulty passing your urine such as burning, blood, or poor stream?	No Yes
11.	If you are a male, have you had problems with impotency?	No Yes
12.	Have you experienced any neurologic problem such as persistent loss of sensation, loss of muscle strength, poor coordination, clumsiness, balance difficulty or memory loss?	No Yes
13.	Do you have any persistent arthritis, joint pains, or other musculoskeletal discomfort?	No Yes
14.	Do have excessively dry skin?	No Yes

Please describe positive answers to questions above and elaborate on any other persistent symptom(s) which seem important to you:

GENERAL QUESTIONS PERTAINING TO SLEEP HABITS

Select and circle **ONLY ONE answer per question that best describes you.** If you have any comments, please write them on the questionnaire.

What is the usual time you get –

in to bed?_____

out of bed? _____

1 How often do you have any problems with your sleep?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

2 If yes, for how long (years)?

0 less than 1 year
1 1-2
2 2-5
3 5-10
4 10 or more

3 When I sleep

0 I never move.
1 I rarely change positions.
2 I occasionally change positions but generally do not move very much
3 I am restless, change positions frequently and am easily disrupted
4 I never sleep

4 When I sleep

0 I never dream or can't recall dreaming
1 I dream occasionally
2 I have vivid dreams which are bizarre but generally pleasant
3 I have vivid dreams (or nightmares) but remain quiet in bed.
4 I have vivid dreams which I sometimes seem to act out.

5 How often do you have problems with excessive daytime sleepiness?

0 never (go to question 7)
1 rarely
2 occasionally
3 frequently
4 almost always

6 If yes, for how long (years)?

0 less than 1 year
1 1-2
2 2-5
3 5-10
4 10 or more

7 How many hours do you usually **sleep** at night (or day if on shift work)?

less 4 5 6 7 8 9 10 more

8 How often does your bedtime vary from night to night?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

9 How often do you have difficulty going to sleep at night?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

10 How often do you have trouble staying asleep?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

Select and circle **ONLY ONE answer per question that best describes you.**

11 How many times during sleep do you typically wake up for more than 3-5 minutes?

0 0-2
1 3-4
2 5-8
3 9-12
4 more than 12

12 How many times do you awaken from sleep and go to the bathroom to urinate?

0 0-1
1 1-2
2 2-3
3 3-4
4 more than 4

13 Do you use alcohol before bedtime to help you sleep?

0 never
1 rarely
2 occasionally (once a month or less)
3 frequently (1-2 times a week)
4 almost always (nearly every day)

14 How often do you use sleeping medications or tranquilizers to help you sleep?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

15 When you sleep, do you have persistent twitching or jerking of your arms or legs?

0 never or don't know
1 rarely
2 occasionally
3 frequently
4 almost always

16 When trying to fall asleep, how often do you experience crawling or aching sensations in your legs, and inability to keep your legs still?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

17 Have you ever had loud snoring?

no Go to question 22
yes Go to next question

18 All together, how many years have you snored?

0 0-1
1 1-2
2 2-5
3 5-10
4 10 or more

19 At the present time, how often do you snore?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

20 When you now snore, it is usually ....

0 light or quiet (barely audible in the bedroom)
1 average (easily heard in the bedroom, but not disruptive)
2 moderately loud (disturbs my bed partner)
3 extremely loud (can be heard by people outside of my bedroom)
4 beyond loud (offends my neighbors)

Select and circle **ONLY ONE answer per question that best describes you.**

21 If you snored in the past, was it usually

0 light or quiet
1 average
2 moderately loud
3 extremely loud
4 beyond loud (see above)

22 How often do you make loud and disruptive noises (not snoring) when you breathe during sleep?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

23 How often do you sleep on your back?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

24 As far as either you or your bed partner know, your breathing during sleep is ...

0 normal or I don't know
1 rarely interrupted
2 sometimes interrupted by long pauses
3 frequently interrupted by long pauses
4 continuously interrupted by pauses

25 How often do you awaken with choking or the sensation of not breathing?

0 never
1 rarely
2 occasionally
3 frequently
4 almost every night

26 How often do you awaken with heartburn?

0 never
1 rarely
2 occasionally
3 frequently
4 almost every night

27 How often do you experience stomach acid coming up into your throat or mouth during sleep?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

28 How often do you awaken with night sweats?

0 never
1 rarely
2 occasionally
3 frequently
4 almost every night

29 How often do you awaken and experience heart palpitations or feel your heart racing at night?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

30 When you finally get out of bed in the morning, do you feel refreshed and ready to start the day?

0 almost always
1 rarely
2 frequently
3 occasionally
4 never

Select and circle **ONLY ONE answer per question that best describes you.**

31 How often do you awaken from sleep or in the morning with a headache?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

32 How often do you have a problem throughout the day due to tiredness and fatigue?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

33 Following your usual night's sleep, do you have difficulty with becoming drowsy when not physically active (for example: while reading, watching television, at movies)?

0 never
1 rarely
2 occasionally (such as after lunch)
3 frequently
4 almost always

34 Following your usual night's sleep, do you have difficulty with sleepiness when physically active and may even unintentionally fall asleep for short periods (for example: while in conversation with other people, driving a car, working, during sexual intercourse, etc.)?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

35 If you have excessive daytime sleepiness, do you feel refreshed after a nap?

0 never
1 occasionally
2 frequently
3 almost always
4 I rarely nap or not applicable

36 Have you ever or do you now use any kind of stimulants because of excessive sleepiness?

0 never (go to question 38)
1 rarely
2 occasionally
3 frequently
4 almost every day

37 When I use stimulants, my symptoms of excessive sleepiness are

0 never improved
1 rarely improved
2 slightly better
3 much better
4 completely gone

38 Do you have difficulty concentrating and focusing attention during the day because of drowsiness?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

39 If you work, how often have you had difficulty doing your job because of sleepiness?

0 never or not applicable
1 rarely
2 occasionally
3 frequently
4 almost always

40 Compared to the past, your interest in sex is?

0 increased
1 about the same
2 a little less
3 much less
4 no interest at all

Select and circle **ONLY ONE answer per question that best describes you.**

41 Are you more irritable than in the past?

0 no
1 a little more
2 quite a bit
3 a lot more
4 constantly irritated

42 Do you experience depression?

0 no
1 a little more
2 quite a bit
3 a lot more
4 I have considered suicide recently

43 Do you experience vivid dream-like images while falling asleep (either daytime naps or sleep at night)?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

44 Do you awaken from sleep or a nap with the feeling that you are unable to move or are paralyzed?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

45 Do you experience sudden muscular weakness or "weak knees" with emotional situations, especially laughter?

0 never
1 rarely
2 occasionally
3 frequently
4 almost always

INSTRUCTIONS: Rate the chance that you would doze off or fall asleep during different, routine, daytime situations. How likely are you to fall asleep in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation. Then add the numbers for the total score.

ESS Scale: 0 = Would ***never*** dose.
1 = ***Slight*** chance of dozing.
2 = ***Moderate*** chance of dozing.
3 = ***High*** chance of dozing.

	Chance of dozing (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place; e.g., a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch	
In a car, while stopped in traffic	
Total	

Select and circle **ONLY ONE answer per question that best describes you.**

I hereby give permission for the reports of my sleep studies be sent to the following doctors and/or insurance companies:

_____

_____

_____

_____

Signature _____ Date _____