Frontier Neurosciences Sleep Lab @ 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 appointment time. 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 your sleep test:

1. Please wear pajamas with a top and a bottom. This can be sweat pants and a t-shirt if you would like.
2. Please bring any night time medications that you may need to 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 IPADI 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
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.
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 in our sleep lab for your study. Please feel free to contact the office prior to your study if you have any further questions or concerns.

Name________________________ DOB_________ Height________ Weight _______

How would you rate your over-all health? Excellent Good Fair Poor

Please list ***major surgery's*** you have had including operations such as tonsillectomy & adenoidectomy (T&A)

Operation	Date

Please list all ***medications*** that you are taking also note "As Needed" in the time per day box

Medication	Dose	Time per day	Medication	Dose	Times per day

Family history of sleep disorders? i.e: sleep apnea, narcolepsy, restless leg syndrome, insomnia, etc.

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Review of systems

1. Have you gained weight in the past 12 months? No Yes Lost _______ Gained______
2. Do you regularly have a problem breathing through your nose? 0 1 2 3 4 5 Never Severe
3. Do you have difficulties with physical exertion such as unusual shortness of breath, difficulty breathing or chest discomfort? No yes
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 chests tightness? No Yes
7. I-lave you had persistent swelling of your ankles or feet? No Yes
8. Do you have any difficulty with swallowing food, indigestion, heartburn or regurgitating of acid back into your chests or mouth? No Yes
9. Have you had any change in your unusual bowel habits recently, such as constipation or change in shape, color, etc.? No Yes
10. Do you have any difficulty passing you're 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:

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General questions pertaining to sleep habits.

What is the usual time you get in to bed? _________ PM/AM Out of bed__________ AM/PM

Please circle one per question that best describes you. If you have any comments, write them on the questionnaire.

Are you more irritable than in the past? A.No B.A little bit more C. Quite a bit more D. A lot more E Constantly irritated	Compared to the past, your interest in sex is? A. Increased B. About the same C. A little less D. Much less E. No interest at all
If you have problems with your sleep how long (Years)? A. Less than 1 year B.1-2yrs C. 2-5 yrs. D. 5-10yrs E. 10 or more yrs.	If you snored in the past, was it usually….. A. Light or quiet (barely audible in bedroom) B. Average (easily heard in the bedroom, but not disruptive) C. Moderate loud (Disturbs my bed partner) D. Extremely loud (can be heard by people outside of my bedroom) E. Beyond loud (Offends the neighbors)
Have you ever had loud snoring? No, skip below Yes Combined all the years, how many years have you snored? A.0-1 B. 1-2 C.2-5 D. 5-10 E 10 or more When I sleep A. I never move B. I rarely change positions C. I occasionally change positions but generally don't move much D. I am restless, change positions frequently and am easily disrupted E. I never sleep	When you snore currently, it is usually……. A. Light or quiet (barely in bedroom) B. Average (easily heard, but not disruptive) C. Moderate loud (Disturbs my bed partner) D. Extremely loud (can be heard by people outside of my bedroom) E. Beyond loud (Offends the neighbors) How many times during sleep do you typically wake up for more than 3-5 min? A. 0-2 B. 3-4 C. 5-8 D. 9-12 E. more than 12

When I sleep	As far as either you or your bed partner know your breathing during sleep is?
A. I never dream or can't recall dreaming B. I dream occasionally C. I have vivid dreams which are bizarre but generally pleasant D. I have vivid dreams (Or nightmares) but remain quiet in bed. E. I have vivid dreams which I sometimes seem to act out.	A. Normal or I don't know B. B. Rarely interrupted C. Sometimes interrupted D. Frequently interrupted by long pauses E. Continuously interrupted by pauses
Have you ever or do you now use any kind of stimulants because of excessive sleepiness? A. Never B. Rarely C. Occasionally D. Frequently E. Almost every night	If I use stimulants, my symptoms excessive sleepiness are A. Never improved B. Rarely improved C. Slightly better D. Much better E. Completely gone
How many times do you awaken from sleep and go to the bathroom to urinate? A. 0-1 B. 1-2 C. 2-3 D. 3-4 E. more than 4	How many times do you awaken from sleep and feel hungry? A. 0-1 B. 1-2 C. 2-3 D. 3-4 E. more than 4

Questions	0 Never	1 Rarely	2 Occasionally Once a month or less	3 Frequently 1-2 times per week	4 Almost always nearly every night
How often do you have problems with excessive daytime sleepiness?					
If yes to question above for how long (years)					
How often does your bedtime vary from night to night?					
How often do you have difficulty going to sleep at night?					
How often do you have trouble staying asleep?					

When trying to fall asleep, how often do you experience crawling or aching sensations in your legs, and inability to keep your legs still?					
Do you use alcohol before bedtime to help you sleep?					
How often do you use sleeping medications or tranquilizers to help you sleep?					
How often do you make loud and disruptive noises (not snoring) when you are breathing during sleep?					
How often do you sleep on your back?					
How often do you experience stomach acid coming up in your throat or mouth during sleep?					
How often do you awaken with choking or the sensation of not breathing?					
How often do you awaken with heartburn?					
How often do you awaken with night sweats?					
How often do you awaken and experience heart palpations or feel your heart racing at night?					
When you finally get out of bed in the morning, do you feel refreshed and ready to start the day?					
How often do you awaken from sleep or in the morning with a headache?					
How often do you have a problem throughout the day due to tiredness and fatigue?					
Following your usual night sleep, do you have difficulty with becoming drowsy when not physically active (for example: while reading, watching television, at movies)?					
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.)?					
If you have excessive daytime sleepiness, do you feel refreshed after a nap?					
Do you have difficulty concentrating and focusing attention during the day because of drowsiness?					
If you work how often have you had difficulty during your job because of sleepiness?					
Do you experience vivid dream-like images while falling asleep (either daytime naps or sleep at night)					
Do you awaken from sleep or a nap with the feeling that you are unable to move or are paralyzed?					
Do you experience sudden muscular weakness or "weak knees" with emotional situations, especially laughter?					

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)

Situation	Chance of dozing (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place; 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	

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

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Signature_______________________________

Date__________________