Bay Area Sleep Center

A Houston Pulmonary Medicine Associates, P. A. Facility
5 Professional Park Drive, Webster, TX 77598
Phone: 281-724-9382 ~ Fax: 281-724-9172

Welcome! Please read the following document carefully as it contains pertinent information regarding your sleep study, interpretation of your study, and billing information.

On behalf of our staff here at The Bay Area Sleep Center, we appreciate your choice of our center to evaluate the cause of your sleep disturbance. We hope that this experience will be as comfortable as possible. Please inform the sleep technician if you have any special needs (e.g., handicapped, extra blankets, fan, etc.) or if you encounter any problems during your stay here.

This field of sleep medicine is highly specialized and requires technical expertise. While you sleep, our technologist will be monitoring you via computer and camera; additionally, they will collect bio-electric signals which will be used to generate information for your physician. This material must be first scored by a technologist, then reviewed by a sleep physician in detail to reach the proper conclusions. The final interpretation of this study is based on these recordings, the technologistôs observations, your history (as provided by the sleep history questionnaire) and your referring physicianôs information.

Please have your bed partner assist you with the enclosed questionnaire and bring it, completed, with you to your scheduled sleep appointment.

Please let us know if we can help you in any other way and do not hesitate to contact our clinical or medical directors if you have any concerns.

Appointment Date: _____ Time: _____

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Patient Preparation Sheet for Sleep Study

On the night of your study:

- Please bring your night/bed attire to change into as well as any toiletries if you'd like to shower the next morning (toothbrush, toothpaste, etc.), medications, favorite pillow etc. We want you to be comfortable, but, for the purpose of the study, we require a top and bottom (shorts or pants) for night attire.
- Please arrive freshly showered with your hair washed and dried. Do not apply make-up, face lotion or hair products such as mousse or gel. Lotions and hair products can interfere with the electrodes during the study. Deodorant is allowed. Please remove fingernail polish as it may interfere with oxygen saturation monitoring.
- For men: Please shave. If you have a beard longer than 2 inches, please trim.
- Please arrive on time for your appointment and please complete the attached paperwork prior to arrival. This will help the set-up process to go more quickly.
- Take your usual medication(s) unless directed by your physician. Patients may bring any medication(s) that they will need that evening, i.e. sleep aid, diabetic needs (insulin), etc.
- Do not take any naps on the day of your scheduled sleep study.
- On the day of your study, limit your caffeine intake for the day, and slow your fluid intake towards the end of the day. Avoid any alcoholic beverages on the day of the study.
- Please understand that your bedtime might be earlier or later than normal. If you have a normal bedtime prior to 9:00 p.m., please inform our schedule coordinator to ensure an 8:00 p.m. appointment.
- Your study will end between the times of 5:30 a.m. and/or 6:00 a.m. If you need to awaken before then, please let us know before your test begins. If you require for someone to provide you transportation, please inform them of these times. The center will close at 7:00 a.m. so please be sure you have your pick up scheduled prior to that time.
- **If you have an allergy to latex, please inform your technician**. To obtain the data for your study, electrodes will be attached to the scalp via a paste that will conduct electrical signals. This paste is very thick and will require warm water and shampoo to remove. Utilizing tape, sensors will be placed on face, neck, chest, and legs. Adhesive residue can be removed with soap and water. Showers are available for clean up after the study.
- Video recording will begin with the application of electrodes.
- Family members nor pets will not be allowed to stay during the test

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Frequently Asked Questions

Q. **What is a polysomnogram?**
A. A polysomnogram is a comprehensive recording of biophysical changes that occur during sleep, such as:

- Brain activity - electrodes attached to the scalp
- Heart rhythm- electrodes attached to chest and abdominal region.
- Eye movements- electrodes attached near the eyes
- Muscle activity ï electrodes attached to the chin and lower legs
- Snore sensor- placed on the neck
- Respiratory effort - elastic belts placed around the chest and abdomen
- Nasal/oral airflow ï probes placed between the upper lip and nose
- Oxygen saturation ï sensor attached to the finger

Q. **Why do a polysomnogram?**
A. To look for behavior that can be harmful to yourself or others. Disrupted sleep can disturb daytime activities such as driving and can cause or exacerbate medical problems which affect basic health, for example diabetes and congestive heart failure.

Q. **How can I sleep with all those sensors on me?**
A. Most people sleep very well. The sensors are applied so that you can turn and move during sleep. The wires are ponytailed together so that entangling does not occur. If a sensor comes off during the study, your technician will come in the room and reattach the sensor. We ask that you move a little more gingerly, but you can sleep in your normal position.

Q. **Will the sensors hurt?**
A. No. The electrodes are placed on the skin to record information, but the recording is non-invasive and is not painful.

Q. **Am I able to use the restroom during the test?**
A. Yes. Prior to your study beginning the technician will ask you to use the restroom. During the night if you wake and need to use the restroom, notify your technician that you need a restroom break. Your technician will disconnect the main cable that will allow you to carry your electrodes to the restroom.

Q. **Is the test covered by my insurance?**
A. The sleep test is covered by most insurance companies including Medicare. However, each patient should check with his/her insurance company about the details. All co-pays and/or deductibles will be collected prior to your study. Please be aware that there is a $50 cancellation fee for cancellations less than 24 hours.

Q. **What happens after my study?**
A. The results are reviewed by a sleep scoring technologist and then interpreted by a sleep physician. A final copy of the report will be sent to your referring physician. Please call your sleep physician within two weeks to schedule a follow-up appointment to discuss your results.

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SLEEP HISTORY
(TO BE COMPLETED BY PATIENT)

Name: _____ Today's Date: _____

Height: _____ Weight: _____ Sex: _____ DOB: _____

Drug Allergies, if any _____

Emergency contact & phone number: _____

CHIEF COMPLAINT

Check any of the following that apply:

- ☐ Loud snoring
- ☐ Breathing or snoring stops for brief periods in my sleep
- ☐ Awaken gasping for breath
- ☐ Difficulty driving due to sleep problem
- ☐ Difficulty at work/school due to sleep problem
- ☐ Do not feel restored upon awakening
- ☐ Become sleepy during the day
- ☐ Become sleepy while sitting
- ☐ Become sleepy while riding
- ☐ Become sleepy while driving
- ☐ Difficulty falling asleep
- ☐ Difficulty remaining asleep
- ☐ Awaken too early

My main sleep problem has bothered me:

- ☐ more than 2 years
- ☐ 1 to 2 years
- ☐ less than a year
- ☐ within the last 3 months
- ☐ within the last month

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MEDICAL HISTORY

Please check if you have had any of the following:

☐ Heart disease ☐ Diabetes ☐ Sinus problems
☐ High blood pressure ☐ Asthma/Emphysema ☐ Reflux
☐ Deviated septum ☐ Anxiety ☐ Seizures
☐ Stroke ☐ Head Injury or brain surgery
☐ Chronic cough ☐ Thyroid condition
☐ Pain which disrupts sleep. The typical location(s) for this pain is/are:
___Headaches ___Neck ___Back ___Chest
___Limb (arm(s) or leg(s) ___Abdominal ___Pelvic ___Joint (arthritis)

☐ Other medical problems which may affect sleep (please list):
_____
_____

MEDICATION

Do you take anything to help you sleep? ☐ Yes ☐ No
If Yes, please list and how often: _____

List current medications and dosages, including both prescriptions and over-the-counter medications:

Name (formal or generic)	Dosage Amount	How often? (once daily / twice daily)

****if more space is needed, please use the back of this sheet.

Are you on supplemental oxygen? ☐ Yes ☐ No If yes, how much? _____(Liters/min)

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SYMPTOMS DURING SLEEP

Indicate ON AVERAGE how often you experience the following symptoms especially when sleeping or trying to sleep:

Times per week

None	1-3	4-6	Daily	Symptom
				My mind races with many thoughts when I try to fall asleep
				I often worry whether or not I will be able to fall asleep
				Fatigue
				Anxiety
				Memory impairment
				Inability to concentrate
				Irritability
				Depression
				Awaken with a dry mouth
				Morning headaches
				Pain which delays or prevents my sleep
				Pain which awakens me from sleep
				Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
				Inability to move as you are trying to go to sleep or wake up
				Sudden weakness or feel your body go limp when you are angry or excited
				Irresistible urge to move legs or arms
				Creeping or crawling sensation in your legs before falling asleep
				Legs or arms jerking during sleep
				Sleep talking
				Sleep walking
				Nightmares
				Fall out of bed
				Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
				Bed wetting
				Frequent urination disrupting sleep
				Teeth grinding
				Wheezing or cough disrupting sleep
				Sinus trouble, nasal congestion or post-nasal drip interfering with sleep
				Shortness of breath disrupting sleep

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SLEEP HABITS

Please answer the following questions as accurately as possible. Indicate AM and PM. If your work and/or sleep schedule changes during the week then indicate your schedule using the ñshift workò column.

Activity	Usual schedule	Weekends	Shift Work
Lights out			
I usually fall asleep in (minutes, hours)			
How many times do you awaken each night?			
Number of times you have difficulty returning to sleep			
The total time I spend awake in bed			
I usually wake up from sleep at			
What time do you usually get out of bed from sleep?			
How many hours of sleep do you get on average?			
Do you take naps and, if so, for how long?			
Begin work time			
End work time			

If you do rotating shift work, or have other work schedule changes and need more space to describe:

_____
_____
_____
_____
_____

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SLEEP TREATMENT

I was previously diagnosed with:

- Sleep apnea When? _____ Where? _____
  My prior treatment included:
  - ☐ CPAP or BiPAP or Bilevel
    - Indicate treatment level (if known): Pressure _____
  - ☐ Oral appliance
  - ☐ Sinus, deviated septum or turbinate reduction
  - ☐ Laser or other procedure on uvula
  - ☐ Uvulopalatopharyngoplasty
  - ☐ Tonsils and/or adenoidectomy
  - ☐ Mandibular surgery

- Restless leg syndrome
  - When? _____ Where? _____
  - Treatment: _____

- Periodic limb movements
  - When? _____ Where? _____
  - Treatment: _____

- Narcolepsy
  - When? _____ Where? _____
  - Treatment: _____

- Insomnia
  - When? _____ Where? _____
  - Treatment: _____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No Did you previously smoke? ☐ Yes ☐ No
How many years of smoking? _____ How much per day? _____
Do you drink alcohol? ☐ Never ☐ Less than 1 per week ☐ 1 ï 5 per week
☐ Other: _____
How much alcohol do you consume within 3 hours of bedtime? _____
How much caffeinated coffee, tea or cola do you drink daily? _____
Have you used stimulant drugs _____Yes _____No
Have you ever used diet pills _____Yes _____No

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ENVIRONMENT

Is your bedroom (loud/quiet) and (light/dark)? (please circle)
Is your mattress (soft/hard/just right)? (please circle)
Do you go to sleep with the television on? ☐ Yes ☐ No
Is your sleep disturbed because of your bed partner or others in your household (Children or Pets)?
☐ Yes ☐ No
Describe briefly:_____

FAMILY HISTORY

Is there a family history of sleep disorders, i.e. apnea, snoring, narcolepsy, insomnia, Restless Leg Syndrome, or other sleep disturbances? If so, please explain.

_____
_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not 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.

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

Situation	*Chance of Dozing*
Sitting and reading é	_____
Watching TVé ..é ...é é é ..	_____
Sitting, inactive, in a public place (e.g., a theater or a meeting) é é é é é é é é	_____
As a passenger in a car for an hour without a break é é é é é é é é é é é ..é	_____
Lying down to rest in the afternoon when circumstances permit é é é é ...é é ..	_____
Sitting and talking with someone é é é é é é é é é é é é é é é é é é ...é é é	_____
Sitting quietly after a lunch without alcohol é é é é é é é é é é é é é ..é .é é	_____
In a car, while stopped for a few minutes in traffic é é é é é é é é é é é ..é é	_____
Total	_____