Sleep Study Information

Metroplex Hospital Sleep Center
2111 S. Clear Creek Rd. | Killeen, TX 76549
(254) 519-8452

- Report to sleep lab at your scheduled appointment time, do not arrive before this time.
- Bring insurance card to appointment with you.
- If you would like to be put on a cancellation list, please call the Sleep Lab.
- Due to the preparation time for this study, we need a minimum of 24 hours notice if you cannot make your appointment. If you need to reschedule your appointment please call our Scheduling department at (254) 519-8500.
- If you have a history of seizures or are a shift worker, please inform us prior to your appointment.
- No naps the day of the test.
- No caffeine after 12 noon the day of test (tea, coffee, soda, chocolate, etc).
- Shower/bathe prior to test. No lotions, makeup, etc. Shampoo hair prior to test. No creams, oils, gels, sprays, etc. If you have any type of artificial hair, please contact the Sleep Lab.
- Remove fingernail polish.
- Men should shave chin area prior to test. If you have a beard or goatee, there is no need to shave these off.
- Take all medications as prescribed by your physician. Bring list of medications being taken with you. If you take a sleep aid you may take it.
- Bring comfortable 2-piece sleep attire (no silk). T-shirt and shorts, pajamas, but nothing tight around the ankles.
- You may bring your own pillow to sleep on.
- No one can stay overnight with the patient unless other arrangements have been made by the sleep lab personnel. Spouse/family may stay with patient for the hook-up procedure. However, if the patient is under 18 years old a parent MUST stay with the child.
- Wake up time is 6:00AM. If patient is being picked up, please make arrangements for someone to be here at this time.
- Please eat a meal before reporting for your appointment. The Sleep Lab does not provide meals.
- Sleep lab is located at 2111 S. Clear Creek Rd. next to Metroplex Hospital. Coming from Hwy. 190 take the first entrance into the hospital, as soon as you turn in there will be 3 office buildings in a U-shape on your right. Turn into that parking lot and we are located in the office on the left. Ring the door bell and technician will be right with you.

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

Total _____

Name:_____ Age:_____

Date of Birth:_____ Sex: □ M □ F Weight:_____ Height:_____

Home Telephone # (_____)_____ Work Telephone # (_____)_____

Marital Status:_____

Referring Physician:_____

Spouse and /or Emergency Contact(s)

_____

Name Relationship Phone # ( )

_____

Name Relationship Phone # ( )

Occupation:_____Years in this job?_____

Are you a shift worker? □ YES □ NO

SLEEP AND WAKE BEHAVIOR ASSESSMENT

1. What are your major complaints related to sleep and wakefulness?

_____

_____

_____

2. How long have you had them?_____

SLEEPINESS ASSESSMENT

1. Are you excessively sleepy during the day? □ YES □ NO

2. Do you fall asleep or have to fight sleep under the following conditions?

Sitting quietly	□ YES	□ NO
Driving	□ YES	□ NO
Riding	□ YES	□ NO
Talking	□ YES	□ NO
Eating	□ YES	□ NO
Standing	□ YES	□ NO
Talking on the telephone	□ YES	□ NO

3. Do you take scheduled naps during the day? □ YES □ NO

_____

Printed Name of Physician Signature

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SYMPTOMS DURING SLEEP ASSESSMENT

1. Check any of the following symptoms that you currently have when sleeping or trying to sleep:

□ Toss & turn	□ Fall out of bed	□ Bed wetting
□ Heartburn	□ Sour belches	□ Pain
□ Regurgitation	□ Night Sweats	□ Teeth grinding
□ Cold feet	□ Sleep walking	□ Sleep talking
□ Nightmares	□ Leg jerking	□ Irresistible urge to move legs

2. Check any of the following that you experience during sleep:

□ Choking	□ Making whistling sounds	□ Gasping for air
□ Loud snoring	□ Struggling to breathe	□ Stop breathing
□ Snorting	□ Sleeping while mouth open	
□ Waking yourself with snoring	□ Waking with a dry mouth	

3. Do you snore in all positions? □ YES □ NO

4. If not what positions do you snore in?_____

SLEEP HABITS ASSESSMENT

1. What time do you usually go to bed?_____

2. How long does it usually take you to fall asleep?_____

3. How many times do you awaken at night?_____

4. Why do you awaken at night?_____

5. Do you have trouble returning to sleep? □ YES □ NO

6. What time do you usually get wake up in the morning?_____

7. How do you wake up in the morning? (i.e., alarm clock, etc.)_____

8. What time do you usually get up in the morning?_____

9. Do you usually sleep longer when you don't have to get up? □ YES □ NO How long?_____

10. How many hours of actual sleep time do you think you get each night on the average?_____

11. Upon awakening in the morning, do you feel:

Completely rested	□ YES	□ NO
Partially rested	□ YES	□ NO
Not rested at all	□ YES	□ NO

12. Do you frequently have a headache during the night and morning? □ YES □ NO

13. Do you take anything to aid in sleep? □ YES □ NO What?_____

NARCOLEPSY ASSESSMENT

1. As you fall asleep or wake up, do you have vivid or lifelike visions (people in the room, etc.) ? □ YES □ NO

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2. When you are angry or excited, do you have sudden weakness or have any part of your body go limp. (head drop, knees buckle, etc.) □ YES □ NO

3. As you are trying to go to sleep or wake up, do you ever have an inability to move? □ YES □ NO

4. Have you ever driven or traveled somewhere and did not remember how you got there? □ YES □ NO

PREVIOUS TREATMENT ASSESSMENT

1. Have you ever been treated for your sleep problems? □ YES □ NO
2. Explain:_____

_____

_____

_____

PSYCHOLOGICAL ASSESSMENT

1. Check any of the following symptoms that you have to an excessive degree:

□ Fatigue
□ Anxiety
□ Suicidal
□ Change in personality
□ Inability to concentrate
□ Depression
□ Family Problems
□ Memory Impairment
□ Irritability
□ Loss of appetite

MEDICAL HISTORY ASSESSMENT

1. Do you have high blood pressure? □ YES □ NO
2. Have you ever had problems with or surgery on your tonsils, adenoids, nose or throat? □ YES □ NO
   If yes, please explain:_____
   _____
3. Do you have a thyroid condition? □ YES □ NO
4. List any chronic medical condition that you have:

   A._____ B._____
   C._____ D._____
   E._____ F._____

5. List any surgery or injuries and dates that you have had:

   A._____ B._____
   C._____ D._____
   E._____ F._____

6. List any medication to which you are allergic to:

   A._____ B._____
   C._____ D._____
   E._____ F._____

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7. List any medications and dosages that you take on a regular basis. Please include over the counter medications and/or herbs.

_____

_____

_____

_____

8. When was your last complete physical examination?_____

by whom?_____

9. Was blood work performed? □ YES □ NO

10. Have you had thyroid function studies performed? □ YES □ NO

11. Has your weight changed recently? □ YES □ NO

If yes, please explain:_____

SOCIAL AND FAMILY HISTORY ASSESSMENT

1. Do you currently smoke? □ YES □ NO
   If yes, how long?_____

2. Did you previously smoke? □ YES □ NO
   If yes, how long?_____

3. Do you drink alcohol? □ YES □ NO
   If yes, how long?_____

4. How much coffee, tea or cola beverages do you drink per day?_____

5. How many people live in your home? _____

   Relationships to you:_____

6. Does any family member (parent, brother, sister, child, etc) have a sleep problem or snore loudly? □ YES □ NO
   Please Describe:

_____

_____

_____

_____

_____

7. Last grade of school completed. □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12 □ 13 □ 14 □ 15 □ 16

_____

Patient/Guardian/Power of Attorney/Patient Representative Signature (Please state relationship)

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Please Read Me!
Sleep Hygiene Guidelines

If you are here chances are that you may have a sleep problem. Sleep problems often have two parts: first, the medical or anatomical portion of your sleep problem and second, problems regarding your sleep environment and sleep habits. These guidelines are called "Sleep Hygiene" and are very important to improve your sleep.

The Sleep Disorder Center recommends good sleep hygiene practices and wants to teach you how to achieve better sleep.

1) It is best to avoid reading, watching TV, eating, listening to the radio, etc. in bed. The bed is to be used for sleep and sex only . If not, we associate the bed with other activates and often it becomes difficult to fall asleep.

2) Minimize noise, light, and temperature extremes during the sleep period with ear plugs, window blinds, or electrics blanket or air conditioner. Both noise and light have been shown to disrupt falling asleep. Interestingly, if your room is too hot (above 75 degrees) or too cold (below 54 degrees) it can affect your sleep as well.

3) Try not to drink fluids after 8:00pm. This may reduce awakenings due to urination.

4) Nicotine is a stimulant and should be avoided near bedtime and upon night awakenings. Thus, having a smoke before bed, although it fells relaxing, is actually putting a stimulant into your blood stream. WE ARE NOT RECOMMENDING SMOKING. IF YOU MUST, FOLLOW THESE SUGGESTIONS: cut back before bed, during the 4 hours before bed have fewer cigarettes, and none 30-45 minutes before bed.

5) Caffeine is also a stimulant and should be discontinued 4-6 hours before bedtime. Caffeine is in coffee (100-200mg), soda (50-75 mg), iced tea, chocolate, and various over the counter medications. Caffeine stays in your systems for up to 12 hours!!! Thus try not to have any past lunch time, and decaffeinated coffee after dinner. BE CAREFUL if you consume large amount of caffeine and you cut yourself off too quickly . YOU WILL GET HEADACHES which, of course, will keep you awake.

6) Alcohol is a depressant; although it may help you fall asleep, it causes awakenings later in the night. As alcohol is digested your body goes into withdrawal from the alcohol causing nighttime awakenings, and often nightmares. Excessive alcohol use can lead to dependence and the withdrawal from alcohol dependence leads to poor sleep.

7) A light snack may be sleep inducing, but a heavy meal too close to bedtime interferes with sleep. Stay away from protein and stick to carbohydrates, or dairy products. Milk contains the amino acid L–Tryptophan which has been shown in research to help people go to sleep. So milk and cookie or crackers (without chocolate) may be useful and taste good as well.

8) Do not exercise vigorously just before bed. If you are the type of person who is aroused by exercise, it may be best to exercise late in the afternoon (preferably an aerobic workout, like running, or walking). Some studies have shown that exercise right before bed is not as bad as once thought, unless you are the type of person that becomes more alert with exercise.

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