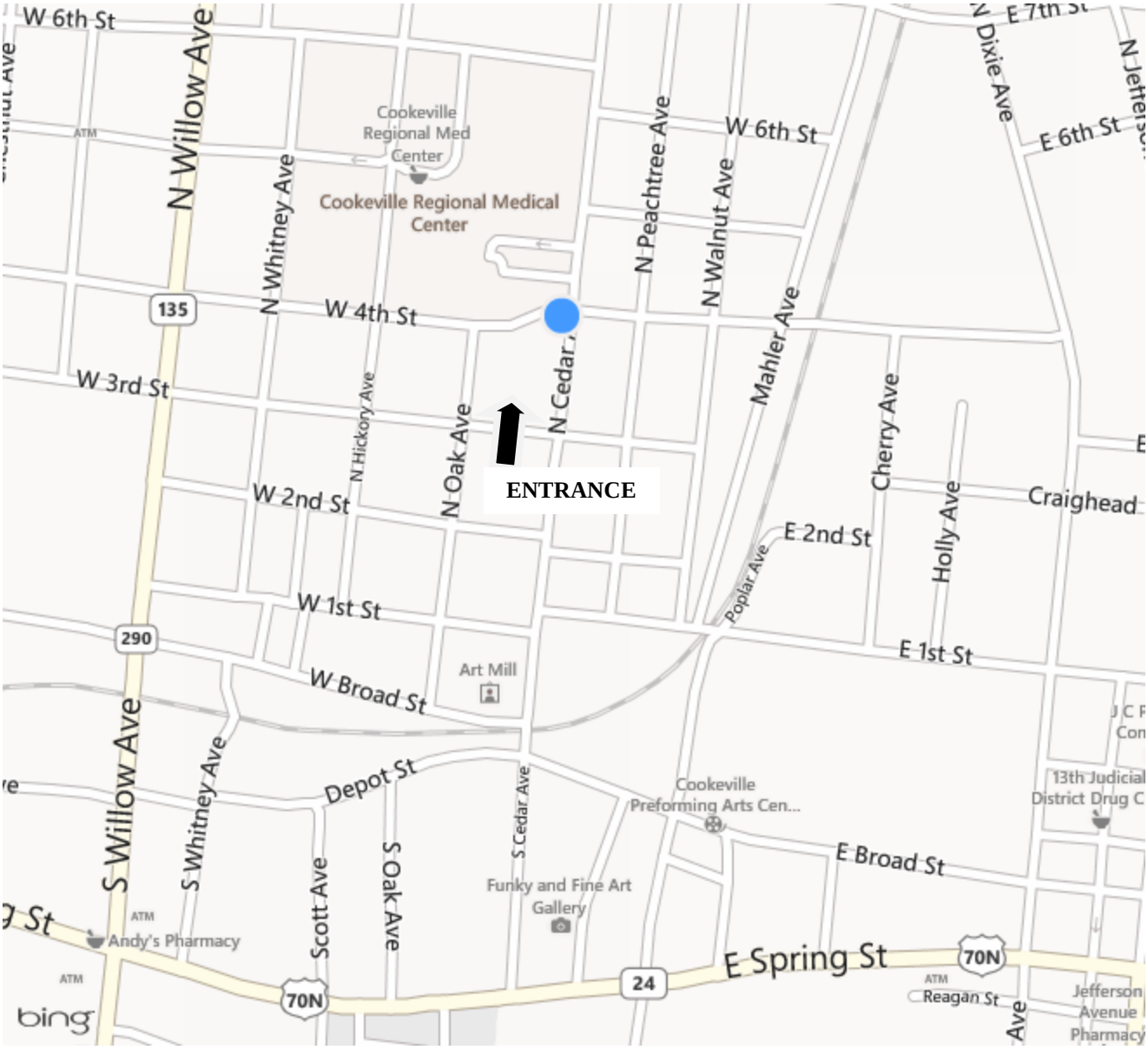
The SLEEP CENTER at COOKEVILLE REGIONAL
The Proven Choice

100 West Fourth Street, Suite 350
Cookeville, TN 38501
(931) 783-2753 • Fax: (931) 783-2036

Patient Name: _____

Appointment Date: _____ Time: Sleep Study 8:00 PM

We are located at the corner of 4th Street and Cedar Ave or 4th Street and Oak Ave. We are at the back of the Upper Cumberland Ear Nose & Throat building, the same entrance as the Allergy, Asthma and Sinus Center. Take the elevator to the 3rd floor.



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Instructions for your test:

1. **Patients who require assistance with mobility, personal care, medications or other special needs during the night must bring a caregiver who can stay throughout the test to provide the needed assistance. Please call in advance to inform us if the patient has special needs.**
2. Avoid taking naps, if possible.
3. Make sure your hair and skin are clean and oil free. Please remove braids, hairpieces and extensions.
4. No caffeine after 2:00 P.M.
5. Bring all medications with you. We do not dispense any medications. Do not take night time medications before you arrive.
6. Make sure your hair and skin are clean, dry and oil and product free. Please remove braids, hairpieces and extensions. For male patients: if you are usually clean-shaven, please shave before you arrive.
7. Bring comfortable and loose fitting clothes to sleep in. Try to avoid silky-type garments. (Two-piece pajamas or shorts and shirt are best)
8. You may bring your own pillow, however, one will be provided.
9. You may eat dinner. Try not to overfill. No caffeine or chocolate.

REMINDERS:

- If you consulted the clinic for excessive daytime sleepiness, make sure that someone drives you to the clinic and back home in the morning. Excessive daytime sleepiness may be dangerous when you drive.
- Please complete this paperwork and bring it with you to your appointment. Bring your insurance cards and an identification card. We will need to make a copy for each appointment. If you have any questions, you anticipate being late or cannot make this appointment, please contact us at 931-783-2753.

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General Questionnaire

Date: _____

Full Name: DOB: SSN:

Address:_____ City _____State_____

Home Phone:_____ Alternate number:_____

Occupation:_____ Employer: _____ Employer Address: _____

Disabled: Yes No (Circle) Retired: Yes No (circle) Year Retired: _____

Age:____ Height:_____ Weight:_____Weight 6 months ago:_____ At age 20:_____ At your heaviest:_____

Referring Physician:_____ Family Physician:_____

1. What is the reason you (or your doctor) contacted the Sleep Center?

   _____

   _____

2. How long have you had this problem?

   _____

3. Has anyone in your family had any type of sleep disorder?

   _____

4. What time do you usually try to fall asleep? _____

5. What time do you usually try to get out of bed? _____

6. Do these times vary? _____ If yes, please explain: _____

7. How much time do you sleep at night? _____

8. How many times do you usually awaken each night? _____ Do you have difficulty returning to sleep? _____

9. How long are you awake altogether during the night? _____

10. How often do you:

(when you are trying to fall asleep)	never	sometimes	occasionally	often
▪ have difficulty falling asleep?	☐	☐	☐	☐
▪ have thoughts racing through your mind?	☐	☐	☐	☐
▪ feel sad or depressed?	☐	☐	☐	☐
▪ have anxiety?	☐	☐	☐	☐
▪ worry about not being able to sleep?	☐	☐	☐	☐
▪ worry you won't return to sleep after awakening?	☐	☐	☐	☐
(just prior to or during sleep)				
▪ have creeping, crawling or aching feeling in your legs?	☐	☐	☐	☐
▪ kick or twitch your legs?	☐	☐	☐	☐
▪ have unusual movements while asleep?	☐	☐	☐	☐
▪ wake up frequently?	☐	☐	☐	☐
▪ have trouble waking up in the a.m.?	☐	☐	☐	☐
▪ have restless or disturbed sleep?	☐	☐	☐	☐
▪ feel muscular tension?	☐	☐	☐	☐
▪ have any kind of pain or discomfort?	☐	☐	☐	☐
▪ wake up with chest pain?	☐	☐	☐	☐
▪ feel alert and energetic all day?	☐	☐	☐	☐
▪ snore loudly?	☐	☐	☐	☐
▪ wake up gasping for breath?	☐	☐	☐	☐
▪ sweat a lot during the night?	☐	☐	☐	☐
▪ wake up with a headache?	☐	☐	☐	☐
▪ wake up with a dry mouth?	☐	☐	☐	☐
▪ wake up sick to your stomach?	☐	☐	☐	☐
▪ walk in your sleep?	☐	☐	☐	☐
▪ fall out of bed while asleep?	☐	☐	☐	☐
▪ wake up screaming, violent or confused?	☐	☐	☐	☐
▪ wet the bed?	☐	☐	☐	☐
▪ grind your teeth while sleeping?	☐	☐	☐	☐

11. Have you ever had vivid dream-like scenes just as you are falling asleep? _____
If yes, briefly explain: _____

12. Have you every felt paralyzed (could not move) just as you were falling asleep or waking up? _____ If yes, please explain: _____

13. How many naps do you take in a usual week? _____ length of naps? _____ Are they refreshing? _____

14. Do you have episodes of sudden muscular weakness when laughing, angry or in an emotional situation? _____ If yes, please explain: _____

15. Have you had your tonsils or adenoids removed? _____

16. Can you breathe easily through your nose? _____

17. Have you ever had your nose broken or a facial fracture? _____

18. Do you have a problem with job performance due to sleepiness? _____

19. Do you have a problem driving due to sleepiness? _____

20. My sleep is frequently disturbed by: (check all that apply)

☐heat	☐choking	☐shortness of breath
☐cold	☐indigestion or heartburn	☐frightening dreams
☐light	☐hunger	☐cough
☐noise	☐thirst	☐chest pain
☐bed partner	☐children	☐pets
☐need to urinate	☐phone	☐asthma
☐creeping, crawling feelings in legs		

21. How much of the following fluids do you drink?

		During a typical day	Within 2 hrs of bedtime
Coffee:	caffeinated	_____ cups	_____ cups
	decaffeinated	_____ cups	_____ cups
Tea		_____ cups	_____ cups
Soda		_____ glasses	_____ glasses
Alcohol		_____ drinks	_____ drinks

22. How much tobacco do you smoke during a 24 hour period?
Cigarettes? _____
Cigars? _____
Pipe bowls? _____

23. Do you use any type of illicit drugs? _____ If so, what? _____

24. Please list the name and dosage of all medications you take NOW or have taken in the last 30 days, including over the counter (non-prescription) medications.

25. Please list any allergies or write NONE. _____

26. Please check any problem or illness you have now or have had in the past.

☐heart disease	☐headaches	☐depression	☐eye trouble
☐low blood pressure	☐fainting	☐mental problems	☐hearing trouble
☐high blood pressure	☐ringing of the ears	☐muscle cramps	☐pneumonia
☐heart attack	☐black outs	☐thyroid condition	☐heartburn
☐pacemaker	☐ulcers	☐meningitis	☐erectile dysfunction
☐hernia	☐dizziness	☐prostate trouble	☐cancer
☐back trouble	☐gout	☐kidney trouble	☐TB
☐asthma	☐allergies	☐bladder trouble	☐Diabetes- Type I or II?
☐bronchitis	☐seizures	☐arthritis	☐Stroke
☐COPD	☐Parkinson's		

27. Please list any illness not listed above, hospitalizations or surgeries you have had:

28. Do you wear CPAP or BiPAP at home? _____ if yes, what company are you currently using for CPAP/BiPAP supplies? _____

29. Do you use oxygen at home? _____ if yes how many hours daily do you use it?

Anything you would like to add:

_____
_____
_____
_____

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Patient Name: _____ Date: _____

Sleep Facts

Do you have a history of snoring?
_____ Never
_____ Rarely – only once or a few times
_____ Sometimes – occasionally or under special circumstances
_____ Every night or almost every night
_____ Don't know

Has your bed partner ever moved, temporarily or permanently to another bedroom (or had you move to another room) due to snoring or restless sleep? **YES NO**

Have you ever been told you seem to have momentary periods during sleep when you stop breathing or breathe abnormally? **YES NO**

Do you ever gasp for air during the night? **YES NO**

Have you ever been told you kick or make disruptive movements during sleep?
YES NO

Do you have a family history of sleep apnea? **YES NO**

Epworth Sleepiness Scale

How likely are you to fall asleep in the following situations? In contrast to just feeling tired, this refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to determine how the situation would affect you.

0 = never doze 1 = slight chance 2 = moderate chance 3 = high chance

Situation:	**Chance of dozing:**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting passive in a public place (ex. Theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

TOTAL _____

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Bed-Partner Questionnaire

Patient Name: _____ Date: _____

I have observed this person's sleep (circle one)

Never One or twice Often Every night

Check any of the following behaviors that you have observed this person doing while asleep
Circle those that you consider severe problems

__ Light snorer
__ Occasional loud snorts
__ Pauses in breathing
__ Sleep talking
__ Bed-wetting
__ Awakening with pain
__ Getting out of bed not awake
__ Becoming very rigid and shaking
__ Apparently sleeping even if he/she says otherwise

_____ Loud snorer
_____ Choking
_____ Twitching or kicking of legs
_____ Grinding teeth
_____ Sitting up in bed not awake
_____ Head rocking or banging
_____ Biting tongue
_____ Crying out
Other _____
_____
_____

If this person snores, what makes it worse?

__ Sleeping on his/her back
__ Sleeping on his/her side

_____ Alcohol
_____ Fatigue

Describe the sleep behaviors checked in more detail. Describe the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night

_____

_____

Has this person even fallen asleep during normal daytime activities or in dangerous situations?

Yes / No

If yes, please explain _____

Does this person use sleeping pills? Yes / No What kind? _____
How often?

Signed: _____ Relationship to person: _____