These questions are necessary for the physician to evaluate your test and must be filled out prior to your appointment. If you are not sure how to answer a question it can be discussed with the technician at the time of your test. Do not alter your normal routine or make any adjustments in medications that you have been using for sedation, sleep or to maintain wakefulness. Please do not consume alcohol or caffeine on the day of your test.

NAME: __________________________________________________________  DOB: _______________AGE: _______

ADDRESS: _______________________________________________________  PHONE: ________________________

Emergency Contact: ________________________________________________  PHONE: ________________________

Referring MD:_____________________________________________________  PHONE: ________________________

Reason for Study__________________________________________________________________________________

Patient Occupation_____________________________   Shift Day   Evening   Night   Rotating

SEX______  HEIGHT______ Feet. _____Inches  WEIGHT______lbs   NECK SIZE________Inches

What was your weight: 6 months ago _____   2 years ago________   At age 20 _________

What was your heaviest weight _____________

MEDICAL CONDITIONS (check if present):

____High Blood Pressure   _____Heart Disease   _____Heart Attack

____Congestive Heart Failure   _____Kidney Disease   _____Asthma

____Emphysema   _____Bronchitis   _____Diabetes

____Thyroid Dysfunction   _____Seizures   _____Stomach Problems

____Chronic Headaches   _____Depression   _____COPD

____Obesity (Mild/Moderate/Severe)   _____Ear, Nose, Sinus or Throat Problems

____Deviated Septum   _____Clausrophobic

Other __________________________________________________________________________________________________________

MEDICATIONS:

1._____________________   2.________________  3.________________   4._______________

Frequency:      ________________      ________________      ________________     _______________

Dosage:      ________________      ________________      ________________      _______________

Use back of page for additional meds.

ALLERGIES ______________________________________________________________________________________________________

1.  Have you ever had a Sleep Study done?   YES ______  NO ______

If YES, where and when was it performed? ____________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

2.  What positions do you tend to sleep in?

On right side____  On left side____  On back____  On stomach____

3.  How many pillows do you sleep with?  1_____  2_____ 3______  More______
4. Do you use any breathing aid for sleep? 
   a. Do you use a CPAP or BIPAP breathing machine when you sleep? 
   b. If yes, what is the setting? __________________ 
   c. Do you use oxygen at home? 
   d. If yes, what is the setting? __________________ 

5. Do you have any problems with: 
   a. Nasal Congestion 
   b. Nasal Obstruction 
   c. Nasal discharge 
   d. Nasal Polyps 
   e. Sinuses 
   f. Tonsils 
   g. Adenoids 

6. Have you ever had any of the following surgeries: 
   a. Tonsillectomy 
   b. Adenoidectomy 
   c. Nasal Surgery 
   d. Sinus Surgery 
   e. Vocal Cord Surgery 

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PARTNER QUESTIONNAIRE

Please check the appropriate box regarding your relationship to the patient
SPouse □  Partner □  RoomMate □  Parent □

Please check which of the following behaviors you have observed the patient doing while asleep

- Loud Snoring □  Light Snoring □
- Flailing of arms and legs □  Twitching of legs and feet □
- Breathing pauses (10 sec or more) □  Grinding teeth □
- Sleep talking □  Sleepwalking □
- Bed Wetting □  Sitting up in bed while asleep □
- Rocking or banging of head □  Getting out of bed while asleep □
- Tongue biting □  Becoming very rigid and/or shaking □

How long have you been aware of these sleep behaviors? _______________________________________________

Please describe in further detail these observed sleep behaviors: __________________________________________
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 activities. 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

**PATIENT** (please complete)

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and Reading</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting, inactive, in a public place</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon</td>
<td></td>
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<td></td>
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<tr>
<td>Sitting and talking to someone</td>
<td></td>
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<td></td>
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<tr>
<td>Sitting quietly after lunch with no alcohol</td>
<td></td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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</tbody>
</table>
The purpose of this form is to provide us with your typical sleep habits. Please start filling it out daily, a week prior to your scheduled sleep study. If your study is less than a week away, give us as many days as you can. This will aid us in the diagnosis of your condition.

Complete the top box each evening prior to bed, and complete the bottom box each morning when you get up. If there is an unusual event on a given night (e.g. illness, emergency, phone calls) make a note of it in the “Unusual Events” row.

- Are you a shift worker YES □ NO □ If yes, what hours do you work? _______
- How many pillows do you usually sleep with? _______

<table>
<thead>
<tr>
<th>DATE</th>
<th>Example 9/30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each nap time if any</td>
<td>11am 3pm</td>
</tr>
<tr>
<td>Total sleep during Each nap time</td>
<td>15min 1 hr</td>
</tr>
<tr>
<td>Meds or alcohol taken as a Sleep aid at bed time (Y or N)</td>
<td>Y</td>
</tr>
<tr>
<td>Bedtime</td>
<td>11pm</td>
</tr>
</tbody>
</table>

| How long did it take you to Go to sleep? | 1 hr |
| Rise time | 6am |
| Total sleep during night | 5hrs |
| Number of Night-time Awakenings | 4 |
| Duration of each Awakening | 5, 15, and 25 mins |
| When I awake, I feel: 1 = exhausted – 5 = refreshed | 3 |
| My sleep last night was: 1 = very restless – 5 = refreshed | 2 |
| Unusual Events | Phone call at 1am |