A DIVISION OF ARIZONA
PRIMARY CARE PHYSICIANS, LLC

Patient Scheduled Letter

Thunderbird Internal Medicine Sleep Center
5620 W. Thunderbird Rd., Suite C-1 Glendale, AZ 85306
(602) 938 – 6960

Dear Patient,

Your Doctor has requested you be scheduled for a sleep study. Your appointment has been scheduled for ____.

If you arrive more than 30 minutes before your appointment time the facility may be closed.

Cancellation/No Show Policy*:

If you need to cancel or reschedule your sleep study, please call our office during normal business hours at least 1 business day prior to your scheduled sleep study appointment. If you need to cancel your appointment the night of your scheduled study due to an unforeseen illness or personal emergency, please call our office at 602-938-6960 and leave a message. You may request a call back to reschedule your sleep study. Thank you.

On the day of your sleep study:

1. Please complete the enclosed questionnaire and bring it with you.

2. Please bring your insurance card and photo ID. You will be asked to pay your insurance deductibles and co-pays prior to your Sleep Study.

3. Please bring a list of all your prescription and over the counter medications you currently are taking. You may bring any sleeping pills you normally take.

4. Do not consume any alcohol or caffeinated beverages after 12 noon.

5. Please bring loose and comfortable pajamas to allow for the equipment set-up.

6. Please wash your face and hair to remove make-up oils, and styling products. Please make sure your hair is completely dry before you arrive for your sleep study.

7. Please bring any sleep equipment or devices you normally sleep with, such as a mouth guard, dental devices, neck pillow, CPAP Mask etc. (you do not need to bring the machine portion of your CPAP, just the mask)

What to expect:

1. This is a painless evaluation. Small sensors will be placed on your head, face, neck and legs.

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2. You will meet with your technician to discuss the procedure, answer any of your questions and review your enclosed sleep questionnaire.

3. Please feel free to bring someone to accompany you during your hook-up in preparation for your sleep study. Your guest will be required to leave once the technician begins the study.

4. You will sleep in your own private bedroom. Pillows are provided but feel free to bring your own.

5. We need at least 6.5 hours of your time to complete the study.

6. Please allow 7-9 business days for your physician to receive your sleep study results.

If you have any special needs or requirements or are unable to get in and out of bed or walk without assistance please notify us immediately so we may be appropriately staffed to assist you. If you have any questions regarding your study or for directions, please do not hesitate to call us at 602.938.6960

Thank you,

Staff

DIRECTIONS: Our Sleep Center is Located by our 5620 W. Thunderbird office in Suite C-1

*****Please leave all valuable and personal property at home as Thunderbird Internal Medicine is not responsible for any personal property that is lost or damaged.**

Thank you

Patient Sleep Questionnaire

****Bring this portion with you to your Sleep Study****

Thunderbird Internal Medicine
A Division Of Arizona Primary Care Physicians, LLC

Life and Work Habits

Y___ N___ Do you smoke or use other forms of tobacco?

If yes what? ____________________ How much? _______________

Y___ N___ Do you exercise?
If yes, how often?
___ Seldom ____ Often ____Daily

Describe your type of work and your work hours?
____
____
____
____

What is your primary sleep complaint?
____
____
____
____

What was the reason your physician sent you for this sleep study?
____
____
____
____

Y___ N___ Do you drink caffeinated beverages?

If yes, what caffeinated beverages do you drink and how much per day?
____
____
____
____

Y___ N___ Do you drink alcoholic beverages?
**If yes, what alcoholic beverages do you drink and how much per day? (Wine, mixed drinks, beer)
____
____
____

Problems Falling Asleep

Y___ N___ Do you have trouble relaxing and feeling ready to go to sleep?
Y___ N___ Do you hear, see or feel things that may not be real as you're falling asleep?

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For example, hearing voices or feeling someone is in the room

Y___ N___ Do you often have trouble falling asleep due to racing thoughts?
Y___ N___ Do you often have trouble falling asleep because of pain or discomfort?

Elaborate if necessary:
____
____
____

__Sleep Hygiene (check all that apply)__

Do you perform the following in bed?

___Watch TV
___Read
___Worry
___Have arguments in bed
___Write
___Eat
___Check the clock
___NONE

When is your normal bedtime (whether it is on the couch, on a recliner, in a bed, etc?)
___ A.M. ___P.M.

When is your normal wake time?
___ A.M. ___ P.M.

__Sleep Habits__
How long does it take you to fall asleep? _______ Hours _______ Minutes
How many hours on average do you sleep per night? _______ Hours _______ Minutes
Please check all of the positions you are UNABLE to sleep in.

___Back Why?
____

___Sides Why?
____

___Stomach Why?
____

Y___ N___ Are you having trouble remembering misplaced items or events?
Y___ N___ Have you ever had the sensation of weakness while you were laughing, angry, or feeling sad?
**For example, laughing very hard at a joke and feeling weak in your legs.
Y___ N___ Do you usually need to nap during the day?
Y___ N___ Do you usually find your naps refreshing?
Elaborate when necessary:
____

Problems During Sleep

Y___ N___ Do you wake up during sleep and have trouble falling back to sleep?
Y___ N___ Do you wake up too early and have trouble falling back to sleep?
Y___ N___ Do you frequently check the clock?
Y___ N___ Do you have difficulty sleeping due to discomfort in legs or arms?
Y___ N___ Have you ever walked in your sleep?
Y___ N___ Do you have nightmares?
Y___ N___ Do you have a history of wetting the bed?
**If yes, when? Child___ Adult ___
Y___ N___ Do you grind your teeth?
Y___ N___ If yes, do you use a mouth device to prevent this?
Y___ N___ Have you ever thrashed, thrown covers off or fallen out of bed?

Problems During Sleep (cont.)

Y___ N___ Have you ever hit or kicked your bed partner, or injured yourself during sleep?
Y___ N___ Have you ever awakened screaming?
Y___ N___ Do you snore?
Y___ N___ Has anyone ever said you stop breathing while sleeping?

Problems after waking up

Y___ N___ Do you normally wake up with headaches?
Y___ N___ Have you ever awakened confused or disoriented?
Y___ N___ Have you ever awakened feeling like you're awake but can not move?
Y___ N___ Do you feel tired when you wake up?

Daytime Sleepiness
0- Would never fall asleep
1- Slight chance of dozing
2- Moderate chance of dozing
3- High chance of dozing

Situation (for the list below, use the scale above to rate how easy it is for you to fall asleep in each situation)
___ Sitting and reading
___ Watching TV
___ Sitting inactive in a public place (ex: Theatre)
___ As a passenger in a car for an hour without a break
___ Lying down to rest in the afternoon
___ Sitting and talking to someone
___ Sitting quietly after lunch (when you've had no alcohol)
___ In a car, while stopped in traffic

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

___None ___ Choking or gasping for air

___Sinus or cold symptoms ___ Leg discomfort

___Frightening dreams ___Need to urinate

___ Indigestion ___ Pain

___Hunger ___Bed Partner

___Pets ___Asthma

___Cough ___ Children

___Headaches ___ Nausea

___Thirst ___Noise

___ Stress ___ Shortness of Breath

Please list any other symptoms that disturb your sleep not listed here:

____
____
____

Other medical history (check all that apply)

___ None ___High blood pressure

___Nasal/sinus problems ___Claustrophobia

___Panic Attacks ___Other nose or throat surgery

___Heart Disease ___Depression

___Lung Disease ___ Gerd

___ Diabetes ___Thyroid disease

___Stroke ___Seizures

Y ___ N___ Have you ever had surgery for Sleep Apnea?

Family Sleep Disorder History

Please list any diagnosed sleep disorders in your family. If you do not know the diagnosis, describe the symptoms:

____
____
____

Medications

Please list all PRESCRIBED MEDICATIONS you are currently taking. (dosage not required)

____
____
____
____

Please list all NON-PRESCRIPTION MEDICATIONS you have taken in the last 48 hours before your sleep study. (Over the counter, herbal, homeopathic, etc.)

____
____
____
____

Sleep Disorder Awareness

How did you become aware that you might have a sleep disorder and may need a sleep study? Check all that apply:

___Your physician ___ Media (radio, TV, newspaper, magazine)

___Website/Internet ___ Family/Friend