

**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 due to any illness or personal emergency, please call our office 24 hours in advance prior to your scheduled sleep study appointment. If your study is scheduled on a Saturday or Sunday, please try to let us know by Friday by noon. We have patients on a cancellation list who are able to come in sooner so if you need to cancel ahead of time, please call us as soon as you can. Your compliance with this policy is greatly appreciated. If you need to cancel your appointment after 5pm Monday through Friday, or on the weekend, please call 602-564-6226 and leave a message to notify the Sleep Technician. Thank you.

**\*A \$100.00 fee will be charged if you do not comply with the above policy.**

**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.
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,

Heather Meiner  
602-564-6257

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

## **Patient Sleep Questionnaire**

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

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

### **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?

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What is your primary sleep complaint?

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

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Y\_\_\_ N\_\_\_ Do you drink caffeinated beverages?

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

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Y\_\_\_ N\_\_\_ Do you drink alcoholic beverages?

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

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**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?  
\*\*\*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:

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**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?

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\_\_\_ Sides Why?

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\_\_\_ Stomach Why?

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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:

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**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:

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**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:

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**Medications**

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

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

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**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