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.

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,

Staff

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

*****Please leave all valuables 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

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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?

_____
_____
_____
_____

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?
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