San Leandro Sleep Disorder Center

13939 East 14th Street, Suite 180, San Leandro, CA. 94578
Phone: (510) 614-7728 Fax: (510) 614-7738

Patient Name: _____ Physician: _____

Sleep Study Date: _____

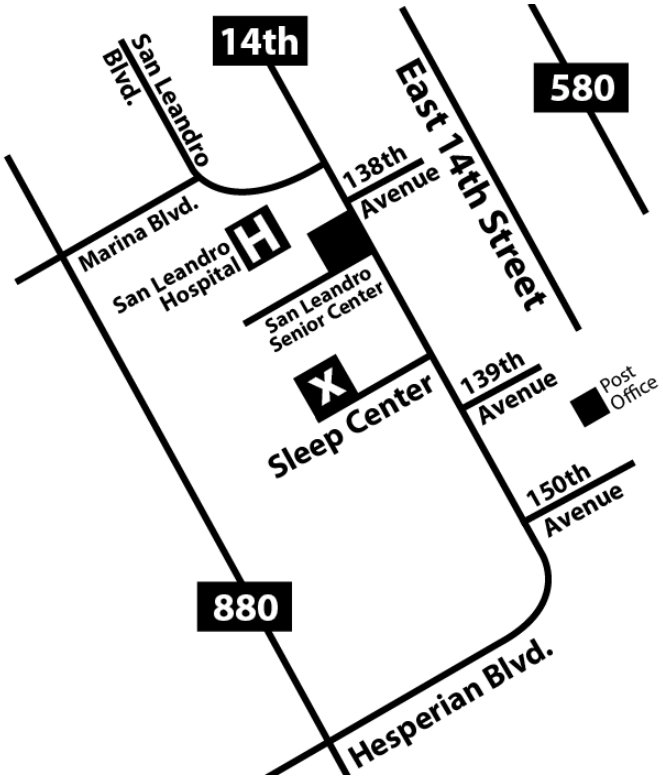
Check-in Time: 8:00 pm – 8:30 pm **Check-out Time: 5:30 am – 6:00 am**
*********<u>***No later than 6:00 am.***</u>

If you do not <u>*SHOW UP*</u> or <u>*CANCEL within 48 hours*</u>, you will be assessed with <u>*a $250 cancellation/no-show fee*</u>.

PLEASE CALL TO CONFIRM YOUR SLEEP STUDY APPOINTMENT*

If you need to <u>CHANGE or CANCEL</u> your appointment; if you have concerns or any further questions, please contact the sleep center at **(510) 614-7728**.

<u>Bring your INSURANCE CARD , A GOVERNMENT ISSUED PHOTO ID, a list of your medications and the COMPLETED sleep forms to your sleep study appointment.</u>



WE ARE <u>NOT</u> AT THE HOSPITAL.

The sleep center (13939 East 14th Street) is located ***<u>BESIDE</u>*** the San Leandro Hospital and the San Leandro Senior Center.

From <u>HW 580 westbound</u>, exit at 150th ave.. fairmont and turn RIGHT on East 14th street. The sleep center will be on your LEFT side.

From <u>HW 880 northbound</u>, exit HESPERIAN AVE. From **HESPERIAN AVE.,** turn left on East 14th street. The Sleep Center will be on your LEFT side.

From <u>HW 880 southbound</u>, exit MARINA EAST. When you reach **SAN LEANDRO BLVD.,** turn right on East 14th street. The Sleep Center will be on your RIGHT side.

This is a medical facility. There is absolutely <u>NO SMOKING</u>

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NO PETS ALLOWED (SERVICE DOGS ARE WELCOME!)

Techs leave at exactly 6:00 am. If you need to stay longer, you can wait at the coffee shop, seven-11 store (both located across the sleep center) or at hospital lobby (located beside the sleep center). The technicians appreciate your consideration to this matter.

<u>Instructions for Sleep Study Patients</u>

- Please plan to arrive between **8:00pm - 8:30 pm.**
- **Pls. have your forms COMPLETED**
- Try to avoid naps during the day so that going to sleep will be easier during your study.
- ***Wash and dry hair before going to the clinic. Do not apply sprays, conditioners, gels, or oils to your hair. IF YOU HAVE A WEAVE OR WEAR A WIG (or anything on your hair) please notify the center AHEAD OF TIME.***
- It is ideal to take a shower prior to coming.
- Facial Hair: Please make sure that you are clean shaven. If you have a beard, you **do not** have to shave it off.
- Have your evening meal **2-3 hours** prior to showing up for your study.
- Avoid drinking anything with caffeine or alchohol **4-6 hours** before your study. If possible, avoid both after your lunch.
- Bring a government issued PHOTO ID and your insurance card
- Bring your regular prescribed medications according to your physician's instructions
- Sleeping clothes such as pajamas or shorts and a t-shirt. Although your comfort is very important, **clothing must be worn at all times.**
- A favorite pillow or blanket, if desired.
- Any other specialty items you may need for sleep or will need first thing in the morning such as toiletries, toothpaste, toothbrush, etc.
- Clothes to go home in; or clothes for work, if heading to your job in the morning
- Small snacks are okay to bring.
- PARKING is available for free (well lit at night)
- The center is both BART and BUS accessible. Please contact BART or AC Transit for direction.

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13939 East 14th Street, Suite 180 San Leandro, CA 94578
Scheduling - 1-866-363-7535 tel. (510) 614-7728 fax. (510) 614-7738 www.slsleep.com

Bedroom

Bedroom with TV

Private Washroom

Shower Facility

NAME: _____ Date of Birth _____

Height _____ Weight _____ (lbs) Neck Size _____

Please answer the questions below.

_____ I snore

_____ I have had a stroke

_____ I have diabetes

_____ I have pulmonary problems

_____ I have high blood pressure

_____ I sometimes get short of breath

_____ I am overweight

_____ I sometimes have morning headaches

_____ I have problems sleeping

_____ I use Oxygen

_____ I feel sleepy and/or tired during the day

_____ I am depressed

_____ I have been told that I stopped breathing at night

_____**YES**, **please have the doctor assess my sleep as well**

_____ **I use CPAP/Bi-PAP unit. Please re-evaluate my use of this device.**

How likely are you to doze off or fall asleep in the following situations?

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

	Situation
0 1 2 3	Sitting and reading
0 1 2 3	Watching TV
0 1 2 3	Sitting, inactive in a public place (e.g. a theater or a 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 the circumstances permit
0 1 2 3	Sitting and talking to someone
0 1 2 3	Sitting quietly after a lunch without alcohol
0 1 2 3	In a car, while stopped for a few minutes in traffic

Date:

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

NAME *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other	
Race: ☐ Black ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Native American/Alaskan Native ☐ Other	
Previous or referring doctor:	**Date of last physical exam:**

ACUTE SLEEP SYMPTOMS	
What is your main sleep problem?:	
How long has this been a problem?:	☐ last 3 months ☐ last 6 months ☐ last year ☐ more than 1 yr ☐ I don't remember
Is this problem:	☐ getting worse ☐ getting better ☐ staying the same

CLINICAL DATA QUESTIONS		
Are you currently taking any blood pressure medications? ☐ Yes ☐ No		
If "Yes", how many? ☐ 1 ☐ 2 ☐ 3 ☐ 4		
Have you ever taken a sleeping pill (prescription or OTC)? ☐ Yes ☐ No		
If yes, what and when:		
Do you use tobacco? ☐ Yes ☐ No		
Are you on any pain medications?	**☐ Yes**	**☐ No**

Have you ever been diagnosed with the following?:

☐ Coronar Artery Disease	**☐ Atrial Fibrillation**	**☐ Pacemaker**
☐ Congestive Heart Failure	**☐ Diabetes**	**☐ Internal Defibrillator**
☐ Stroke	**☐ TIA (mini stroke)**	

PERSONAL HEALTH HISTORY

Allergies: (Please list any food, medication or environmental allergies AND the reaction you had.)

Physical Information:	Height (inches)		Weight (lbs)		Neck Size (inches)	
How would you currently describe your health:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor					

Have you been diagnosed with any of the following conditions? ☐ Yes ☐ No

☐ Alcoholism	☐ Depression	☐ Obesity
☐ Allergies	☐ Drug addiction	☐ Overweight
☐ Anxiety	☐ Edema, pedal	☐ Post-MI
☐ Arthritic pain	☐ Fainting	☐ Postural hypertension
☐ Asthma	☐ Head trauma	☐ Reflux / heartburn
☐ Attention deficit disorder	☐ Heart problems	☐ Retroagnathia
☐ Back problems	☐ High cholesterol	☐ Shortness of breath
☐ Chronic hypercapnea / hypoxemia	☐ Hormonal problems	☐ Sinus problems
☐ Cold extremities	☐ Hypertension	☐ Temporo-mandibular joint problems (TMJ)
☐ COPD	☐ Impotence	☐ Tonsillectomy
☐ Cor pulmonale	☐ Menses	☐ Unexplained episode
☐ Dental - braces or orthodontics	☐ Nasal obstruction	☐ Upper respiratory infections, recurring
☐ Dental - wisdom teeth removed	☐ Neck problems	

Please list ANY past SURGERIES or HOSPITALIZATIONS within the last 5 years

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

SLEEP HISTORY AND CURRENT SLEEP HABITS

During your sleep, do you currently have or in the last 6 months have had any of the following problems? (Please check all that apply)

☐ Stop breathing in your sleep	☐ Frequent arousals from sleep	☐ Dry mouth at night|
☐ Difficulty initiating / maintaining sleep	☐ Drooling at night	☐ Morning headaches
☐ Excessive daytime sleepiness	☐ Morning fatigue	☐ Nightmares/Night terrors
☐ Leg discomfort before falling asleep	☐ Leg cramps while asleep	☐ Shortness of breath when lying down
☐ Frequent trips to the bathroom	☐ Loud snoring	☐ Restless sleeper
☐ Palpitations at awakening	☐ Sleep walking/talking	☐ Night sweats
☐ Heartburn /gas pains	☐ Gasping/Choking sensation	☐ Cold extremities

What is your usual bed time?		
What is your usual rise time?		
Have you ever hurt yourself during sleep? ☐ Yes ☐ No		
Have your movements during sleep ever hurt others? ☐ Yes ☐ No		
Have you ever had a sleep study?	☐ Yes	☐ No
If yes, where and when:		
Do you sleep alone?	☐ Yes	☐ No
If no, who sleeps in bed with you: (Choose all that apply)	☐ Spouse ☐ Significant Other ☐ Child/Parent ☐ Pet	
How would you describe your sleep?	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor	
How would you describe your bed partners sleeping?:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor	
How regular are your sleep habits?:	☐ Very Regular ☐ Somewhat Regular ☐ Somewhat Irregular ☐ Very Irregular	
How long does it usually take you to fall asleep?	☐ 0-10 min ☐ 11-20 min ☐ 21-30 min ☐ 31-60 min ☐ more than 60 min	
How many times do you wake up during an average night?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5	
When you wake up during the night, how long does it usually take you to fall back to sleep?	☐n/a ☐ 0-10 min ☐ 11-20 min ☐ 21-30 min ☐ 31-60 min ☐ more than 60 min	
How long does it usually take you to fall asleep?	☐ 0-10 min ☐ 11-20 min ☐ 21-30 min ☐ 31-60 min ☐ more than 60 min	
If you can't fall back to sleep do you get out of bed? ☐ Yes ☐ No		
Do you watch television or listen to music to help you fall asleep? ☐ Yes ☐ No		
How many hours of sleep do you get each night on the average?	☐ 5hrs or less ☐ 6 hrs ☐ 7 hrs ☐ 8 hrs ☐ 9 hrs ☐ more than 9 hrs	
Do you keep the same schedule on weekends or days off work? ☐ Yes ☐ No		
How often is your sleep disrupted by discomfort or pain?	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ more than 5	
Please describe your normal work hours.		
If you do shift work, how often does your shift change?		

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)
	☐ Mild exercise (1 to 2 / week)
	☐ Occasional vigorous exercise (3 -4 / week)
	☐ Regular vigorous exercise (> 4 / week)

Diet	Are you dieting? ☐ Yes ☐ No		
	If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No		
	# of meals you eat in an average day?		

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ more than 4				
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ more than 8				
Tobacco	Do you use tobacco? ☐ Quit ☐ Yes ☐ No			☐ Yes	☐ No
	If "yes", what kind>? ☐ Cigarettes	☐ Chew	☐ Pipe	☐ Cigars	
		_____ number of packs/day	_____ year quit		

DAYTIME FUNCTIONING			
Do you feel FATIGUE (tiredness, exhaustion, lethargy) in the daytime even when you are not sleepy?	☐ No ☐ Infrequently ☐ Occasionally ☐ Often ☐ Always		
Do you feel SLEEPY (or struggle to stay awake) in the daytime?	☐ No ☐ Infrequently ☐ Occasionally ☐ Often ☐ Always		
If so under what circumstances do you fall asleep easily? (check all that apply)	☐ Driving ☐ After Meals ☐ Meetings/Class/Church ☐ Reading/Watching TV ☐ Other		
Does your daytime sleepiness interfere with your daytime activities (school, chores, job, relationship)	☐ Yes ☐ No		
Have you ever had an accident or near miss from falling asleep while driving? ☐ Yes ☐ No			
How often do you feel alert and energetic for an entire day?	☐ Never ☐ Sometimes ☐ Most of the time ☐ All the time		
Do you take naps (intentional or unintentional) during the day? ☐ Yes ☐ No			
If "Yes", how often and for how long?			
Do you feel refreshed after naps? ☐ Yes ☐ No			
How often do you feel refreshed after naps? ☐ Never ☐ Sometimes ☐ Most of the time ☐ All the time			
Has your memory been getting worse lately? ☐ Yes ☐ No			
Have you had difficulty concentrating lately? ☐ Yes ☐ No			
Have you been felling more irritable lately? ☐ Yes ☐ No			

MOOD AND COGNITION			
Have you ever been treated for anxiety, depression or severe stress? ☐ Yes ☐ No			
Please explain:			
Have you been feeling more depressed lately? ☐ Yes ☐ No			
How much stress would you say you are under right now?	☐ More than usual ☐ Less than usual ☐ the same		
Is your stress related to: (Please check all that apply)	☐ Work ☐ Personal ☐ Other		
Have you felt:	☐ Hopeless ☐ Helpless ☐ Worthless ☐ Useless		
How is your appetite?	☐ Worse than usual ☐ Better than usual ☐ the same		
Have you had any suicidal thoughts lately? ☐ Yes ☐ No			
In response to intense emotion (laughter, anger, surprise) have you felt sudden muscle weakness in your legs, neck or other extremities?		☐ Yes	☐ No
Please explain:			
Before you are fully asleep, do you have vivid, sometimes frightening dream like hallucinations? ☐ Yes ☐ No			
Please explain:			
Have you ever wakened from sleep and felt like your body was "paralyzed" and you could not move even though you could see and breathe?		☐ Yes	☐ No
Do you ever have difficulty falling asleep do to pain, cramping, twitching or a crawling sensation in your legs?		☐ Yes	☐ No