POST SLEEP STUDY QUESTIONNAIRE

Please mark your answers and fill in the blanks where applicable.

1. How long did it take you to fall asleep last night?
   ☑ Immediately ☐ Few minutes ☐ Hours ☐ Did not fall asleep
2. How does this compare to the time it usually takes you to fall asleep?
   ☐ Same ☑ Shorter time ☐ Longer time
3. How many hours of sleep do you feel you got? 8-9
4. How does this compare to the amount of sleep you normally get?
   ☐ Same ☐ Less than normal ☑ More than normal
5. Did you dream? ☑ Yes ☐ No
6. How much dreaming do you remember?
   ☐ None ☐ Less than usual ☑ More than usual
7. Did you wake up?
   ☐ More than usual ☑ Same ☐ Less than usual
8. How many times do you remember waking up before the end of the study? None
   Why did you wake up? _____
9. How did you feel immediately after you woke up?
   ☐ Sleepy ☑ Somewhat alert ☐ Wide awake
10. How did you feel 10 to 15 minutes after waking up?
    ☐ Sleepy ☐ Somewhat alert ☑ Wide awake
11. In general, how did you sleep?
    ☐ Poorly ☐ Same as usual ☑ Better

Please answer questions 12-16 if you used CPAP/BiPAP.

12. How did you tolerate the mask and pressure?
    ☐ Poorly ☐ Well ☑ Very well
13. Do you feel rested? ☑ Yes ☐ No
14. How did you sleep with CPAP?
    ☑ Better ☐ Same as usual ☐ Worse
15. Please explain any problems you had with the CPAP therapy: _____

Thank you for completing this questionnaire.

Please remember to make an appointment with your physician to discuss the results of your sleep study.

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

Discharge Time: 6:05 am

Reference #3007 Sleep Lab

List current medication	Dosage	How often	What for	Prescribed by
Metformin				
HCTZ				
Lisinopril				
Norvasc				
omeprazole				

(yes) no Do you drink alcohol? How much? not very much - helps me fall asleep

(yes) no Do you drink caffeinated beverages, such as coffee, tea, or soft drinks?

Lots Ounces – (How many ounces per day? (4 ounces = 1 cup)

at bedtime Hours before bedtime – last caffeine for the day

(yes) no Do you smoke – or have you ever smoked on a regular basis? 2 Packs per day?

35 years you have smoked

_____ years ago–How long ago did you stop smoking (if you have stopped smoking)

Check" any of the following symptoms which you have recently experienced.

- ___ Loss of appetite
- ✓ Loss of energy
- ✓ Weight Gain
- ___ Weight loss
- ___ Change in vision
- ___ Hearing loss
- ___ Dizziness
- ✓ Throat pain
- ___ Nose bleeds
- ___ Chest pain
- ___ Irregular heartbeat
- ✓ Legs swelling sitting long period
- ___ Cough
- ✓ Shortness of breath doctor says due to allergies + overweight
- ___ Abdominal pain
- ✓ Indigestion
- ___ Difficulty with urination
- ___ Joint pain
- ___ Neck Pain
- ___ Back pain
- ✓ Headaches
- ___ Numbness
- ___ Nervousness
- ✓ Trouble concentrating
- ___ Irritability
- ✓ Sad mood

Do you (circle the answer)	Never	Rarely	Sometimes	Frequently
Snore?	1	2	3	4
Have morning headaches?	1	2	3	4
Sweat a great deal at night?	1	2	3	4
Stop breathing at night?	1	2	3	4
Have problems breathing through your nose	1	2	3	4
Sleep on your back?	1	2	3	4
Have pain or discomfort that keeps you awake?	1	2	3	4
Have jerking of your legs during the night?	1	2	3	4
Feel that your legs ache before you fall asleep or during the night?	1	2	3	4
Feel a need to move your legs while in bed in order to relieve discomfort or tension?	1	2	3	4
When you become angry, sad, or very happy do you ever feel your knees buckle, your arms get weak, or your jaw drop open?	1	2	3	4
When you are about to fall asleep or when you are just waking up, have you ever felt paralyzed? (as if you could not move)	1	2	3	4
When just falling asleep or just waking up, have you felt like you were still "dreaming?"	1	2	3	4
Do you become sleepy while driving?	1	2	3	4

___ yes ___ no Have you ever had a motor vehicle accident due to drowsy driving?

Place a check mark if you have any of the following conditions?

___ Heart Disease
___ Stroke or mini-stroke
✓ High blood pressure
✓ Diabetes
___ Thyroid problems
___ Cancer
✓ Reflux
___ Seizures
___ Arthritis
___ Lung disease
___ Depression
___ Other health problems:

Most Recent Blood Tests – when? Which doctor?

Previous surgeries - include tonsillectomy or nose surgery - starting with the most recent

List nose sprays you use (include over the counter ones). Afrin
Please list allergies

"Check" any of these conditions which are present in one of your family members

___ heart disease ✓ loud snoring ✓ sleep apnea brothers
___ stroke ✓ high blood pressure ___ other sleep disorders
Other

Coulter Sleep Center

Questionnaire for new patients

Height 5'10"
Weight 417

Name C.W. McCall Age 50 Date 1.6.09

Circle one Single (Married) Divorced Widowed

Occupation? truck driver
Who referred you to see Dr. Goza/Gibson family doc
Primary Care Physician?
Describe your sleep problem — Why are you seeing me today? Snoring, tired all the time
Have you had a sleep study or seen a sleep specialist? When? NO
Doctor / Location
On Weekdays, (or days / nights when you work or go to school)

2. What time is bed time? 30min-1½hr Hours it takes you to fall asleep
What time do you get up? 6 hrs How much sleep do you get?
Yes Do you nap during the day? 2 hrs How long do you nap?
Several How many times do you awaken during the night?
How do you feel when you get up in the morning? ____ well rested X Not well rested

On Weekends, (days / nights when you are off work or out of school)

What time is bed time? Hours it takes you to fall asleep
Sam What time do you get up? Sam How much sleep do you get?
Do you nap during the day? How long do you nap?
How many times do you awaken during the night?
How do you feel when you get up in the morning? ____ well rested ____ not well rested

Please place a check beside any of these situations which give you trouble.

✓ Getting to sleep at night ✓ Waking during the night
Waking to early in the morning? ✓ Getting too little sleep at night
✓ Being too sleepy during the day Unusual behavior during sleep?

How likely are you to doze off or fall asleep in the following situations , in contrast to just feeling tired? This refers to your usual way of life in recent times. 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.

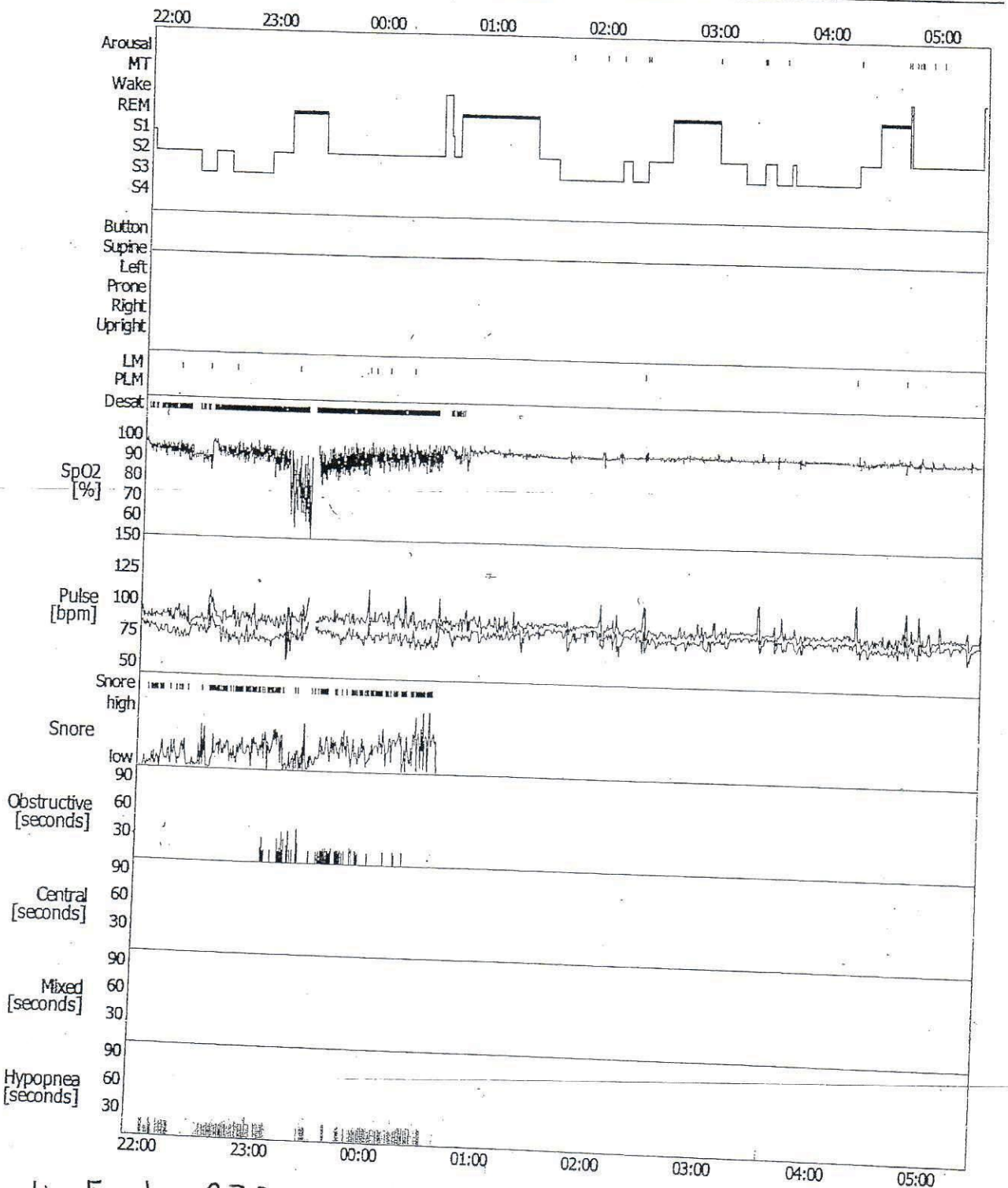
0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

SITUATION:

2 Sitting and reading?
3 Watching T.V?
2 Sitting, inactive in a public place (ex: theater or meeting)?
3 As a passenger in a car for an hour without a break?
3 Lying down to rest in the afternoon when circumstances permit?
2 Sitting and talking to someone?
2 Sitting quietly after lunch without alcohol?
2 In a car, while stopped for a few minutes in traffic?

Total 19 (add points from above questions)

Summary Graph



Obstructive Events = 278 AHI = 103.6

2. SAT Awake = 96%
Lowest = 49%