KAISER PERMANENTE®

Central Valley Sleep Lab
1779 W. Yosemite Ave, Yosemite Bldg. Suite 101
Manteca, CA 95337
209-824-4200

Patient Name: _____
Medical Record #: _____
Date: _____

Sleep Study Test Information

You have been scheduled for a take home Sleep Study. Please follow the instructions carefully, to ensure the test results are accurate. If you are unable to complete the instructions for your scheduled appointment, please call our department and we can reschedule your appointment for a time that works for you.

Things to know before your Sleep Study Test appointment:

1. You have been scheduled for a **home sleep study.** You will come to your scheduled appointment, learn how to wear the testing equipment, and take the equipment home and wear it for one night while you are sleeping.
2. The test equipment must be returned by 10:30 AM the next business day. If you are unable to do so, please call 209-824-4200 to reschedule the appointment.

Instructions for your Sleep Study Test:

1. No artificial nails/gels and nail polish are allowed on the index finger and ring finger of your non-dominant hand. Example, if you are right handed, it would be your fingers on your left hand that need to be free of artificial nails/nail polish.
2. Please arrive ten minutes before your scheduled appointment. The appointment is 30-45 minutes. If you cannot keep your appointment, call 209-824-4200 to reschedule.
3. Bring the equipment by 10:30 AM the following business day.

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EPWORTH SLEEPINESS SCALE

Complete and bring with you to your appointment. Complete both sides of form.

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations?

Check the most appropriate number for each situation.

Situation	No chance 0	Slight chance 1	Moderate chance 2	High chance 3
Sitting and reading				
Watching television				
Sitting inactive in a public place				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting quietly after lunch without alcohol				
In a car while stopping for traffic				
Sitting and talking to someone				

Please answer a few additional questions:

How many cups of coffee do you drink each day? _____	At what time(s)? _____
How many cans of soda do you drink each day? _____	At what time(s)? _____
How many alcoholic beverages do you drink each day? _____	At what time(s)? _____
How many cups of non-herbal tea do you drink each day? _____	At what time(s)? _____
How many packs of cigarettes do you smoke each day? _____	At what time(s)? _____

Please list any recreational drugs that you may take:_____

Please list any other treatments for sleep problems you have tried in the past:_____

Previously prescribed sleep medications:_____

Current medications:_____

Drug allergies:_____

Current medical conditions:_____

Previous surgical or dental procedures:_____

Family members with sleeping disorders:_____

Have you ever had a sleep study? Yes No If yes, When? _____ Where? _____

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SLEEP BEHAVIOR QUESTIONNAIRE

Patient: Please complete this page yourself based upon what you know about your sleep behaviors. Check any of the following behaviors that patient has been observed doing while he/she were asleep.

Nighttime Symptoms

- ☐ Snoring
- ☐ Pauses in breathing
- ☐ Mouth breather
- ☐ Drink water or keep water at bedside
- ☐ Become sweaty or prefer the room cool
- ☐ Awaken to urinate
- ☐ **Grind Teeth**
- ☐ Heartburn
- ☐ Bed-wetting
- ☐ Unpleasant sensations in legs at bedtime causing restlessness
- ☐ Bed partner complains your legs jerk at night
- ☐ Brief episodes of paralysis as you fall asleep or awaken
- ☐ Hallucinations as you fall asleep or awaken
- ☐ Acting out dreams
- ☐ Sleepwalking, sleep talking, nightmares, or night terrors

Daytime Symptoms

- ☐ Awaken feeling unrefreshed
- ☐ Awaken with headaches
- ☐ Awaken with dry mouth
- ☐ Fatigue
- ☐ Sleepiness
- ☐ Take naps
- ☐ Impotence
- ☐ Driving difficulties: Near misses or accidents due to sleepiness, inability to concentrate, inattention, or hyperactivity
- ☐ Eat caffeinated products (e.g. coffee, tea, soda, chocolate)
- ☐ Experience weakness if you laugh or become angry

How long have you been aware of the sleep behavior(s) checked above? _____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night which it occurs, its frequency during the night, and whether it occurs every night.

_____

_____

If you heard snoring, do you remember hearing short pauses in the snoring or occasional loud “snorts”?____

Please answer the following questions about your sleep schedule:

Average bedtime	_____
Average time to fall asleep	_____
Number of awakenings during night	_____
Primary reason for awakenings	_____
Average time to return to sleep	_____
Average wake-up time	_____
Estimated total sleep time	_____