EASTERN CONNECTICUT CARDIOLOGY ASSOCIATES, LLC
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PAITENT APPOINTMENT FOR OVERNIGHT SLEEP STUDY

Patient Name: ______________________________________ **Test date & time:** __________________

Preparing for your sleep study

To ensure the most accurate results of your sleep study please remember the day of:

- Take any prescription medication that you typically take unless you have consulted with your physician to do otherwise.
- Bring any medications you will need during your stay, we will not administer any medications.
- Avoid all caffeine and alcohol.
- Refrain from using unnecessary hair products.
- Pack and overnight bag including your own pillow if you'd like. Extra clothing and anything else you may need. Pack as if you were staying overnight at a hotel.
- Notify your doctor or the sleep technologist of any medications, supplements, over-the-counter drugs or vitamins that you are taking, as this can affect the results of your study. It would be helpful to bring a list.
- If you are on oxygen, please bring in your oxygen and notify the sleep technologist.
- Please arrive promptly at your scheduled appointment date and time of your study.
- We need verbal confirmation or cancellation by 10:00am the morning of your sleep study or your appointment will be cancelled and filled with another patient. For Saturday and Sunday appointments, the verbal confirmations needs to be Friday at 1-:00am or your appointment will be cancelled. If you do not give proper notice, you will be charged $350.00 for the appointment.

You can confirm your appointment by text or call to (860) 500-6094

Location of your sleep study

Your overnight sleep study test will be located at 153 main street suit 15 in Manchester, CT, 06040. If you are running late or cannot make your appointment, you must contact the number below depending on the time of day.

860-500-6094 To confirm your sleep study appointment from 7:00am – 4:00pm or text anytime.

860-646-4722 If you are running late or cannot make it from 7:00pm – 6:30am (Sleep Lab)

860-647-9494 For any questions or to cancel from 9:00am – 5:00pm (Eastern CT cardiology)

If it is not between the times listed, you may call Eastern Connecticut Cardiology's answering service at 860-647-9494 and leave a detailed message with the answering service.

After you arrive and change into your pajamas, the sleep technologist will begin placing electrodes, with a sticky backing, connected to light weight wires, on your forehead, ears, head, chin, chest and legs, they will then place an elastic belt around your abdomen and rib cage. This belt is used to measure your breaking throughout the study. The last piece of equipment used is an oximeter probe which will be placed at the tip of your finger to measure the oxygen in your blood. The sleep technologist will arrange the study equipment so you are comfortable, most patients do not have a problem falling asleep.

Each room is closely monitored by closed-circuit televisions allowing the sleep technologist to monitor your breathing, heart rate, and changed in sleep pattern throughout your sleep study. If you have any questions before, during, or after your sleep study, please do not hesitate to ask your sleep technologist, they will be more than happy to assist you.

Thank you.

Patient name: ____ **D.O.B:** _________________________

What is the main sleep problem you have? (chief complaint):

____

____

Please tell us about your sleep by circling one number after the following questions. Do the best you can to pick the one that most describes yourself. At the end fo the questions, you can write in anything you want us to know.

Circle one: **1= never, 2= rarely, 3= occasionally, 4= frequently, or 5= always.**

MY SLEEP HISTORY

1: does your best time vary every night?	1 2 3 4 5
2: Do you have difficulties going to sleep at bedtime?	1 2 3 4 5
3: Do you have difficulty maintaining sleep?	1 2 3 4 5
4: Does the need to urinate prevent you from staying asleep?	1 2 3 4 5
5: Does anxiety prevent you from staying asleep?	1 2 3 4 5
6: Does acid reflux prevent you from staying asleep?	1 2 3 4 5
7: Does pain prevent you from staying asleep?	1 2 3 4 5
8: Did anyone ever tell you that you snore?	1 2 3 4 5
9: Have there ever been reports of a pause in breathing during your sleep?	1 2 3 4 5
10: Do you ever feel tired while you're awake?	1 2 3 4 5
11: When you wake up, do you feel refreshed?	1 2 3 4 5
12: Have you ever fallen asleep while driving?	1 2 3 4 5
13: Do you experience trouble concentrating while being awake?	1 2 3 4 5
14: Do you notice yourself dosing off?	1 2 3 4 5
15: Does being tired cause problems for you at work?	1 2 3 4 5
16: Do you wake up with a headache?	1 2 3 4 5
17: Do you have problems breathing through your nose throughout the year?	1 2 3 4 5
18: Do you wake up from nightmares?	1 2 3 4 5

19: Do you walk in your sleep?	1 2 3 4 5
20: Do you have trouble going to sleep because your legs ache?	1 2 3 4 5
21: Do you jerk your legs when you sleep?	1 2 3 4 5
22: Do you feel more irritated lately?	1 2 3 4 5
23: Do you have vivid or distinct dreams when you sleep?	1 2 3 4 5
24: Did you ever wake up feeling like you're paralyzed?	1 2 3 4 5
25: Have you ever felt sudden weakness after laughing?	1 2 3 4 5
26: Do you drink alcohol to help you sleep at night?	1 2 3 4 5
27: Do you ever wake up too early and are unable to fall back asleep?	1 2 3 4 5
28: Do you take medications to help you sleep at night?	1 2 3 4 5
29: Does surrounding noise keep you from sleeping at night?	1 2 3 4 5
30: Do you wake up gasping for air?	1 2 3 4 5
31: Do you read, watch tv or use the computer before you go to sleep?	1 2 3 4 5
32: Do you wake up gasping for air?	1 2 3 4 5
33: Do you wake up choking?	1 2 3 4 5
34: Do you wake up with pressure, or chest tightness?	1 2 3 4 5
35: Do you ever have irregular or fast heart rate?	1 2 3 4 5
36: Do you wake up coughing?	1 2 3 4 5
37: Do you wake up wheezing?	1 2 3 4 5
38: Are you a restless sleeper?	1 2 3 4 5
39: Do you feel that you can sleep better away from home?	1 2 3 4 5
40: Do you feel that you think too much to go to sleep?	1 2 3 4 5
41: Do you wake up hungry, needed a snack to go back to sleep?	1 2 3 4 5
42: Did you have trouble staying awake in school as a child?	1 2 3 4 5
43: have you had thoughts of suicide this past year?	1 2 3 4 5
44: Have you ever had an accident due to drowsiness?	YES ______ NO ______
45: Do you drink energy drinks during the day?	YES ______ NO ______
46: Do you feel discomfort in your legs while you're trying to sleep?	YES ______ NO ______

47: Do you have the urge to move your legs while trying to relax? YES______ NO ______

48: Does stretching make your legs feel better? YES ______ NO ______

49: Are your legs worse at night time? YES ______ NO ______

50: Do you grind your teeth? YES ______ NO ______

51: Have you told your dentist that you grind your teeth? YES ______ NO ______

52: Have you ever had an evaluation for a sleep study? YES ______ NO ______

If so, when and where did it take place? ____

____

53: Do you use a CPAP? YES ______ NO ______

If yes, what is the pressure? ____

54: Do you use oxygen? YES ______ NO ______

During the day? YES ______ NO ______ At night? YES ______ NO ______ Flow rate? _____________

Please write anything that you would like us to know: ____

____

____

MEDICATIONS: (PLEASE INCLUDE HOW OFTEN AND HOW MUCH)

____
____
____
____

OVER THE COUNTER OR VITAMINS:

____
____
____

ALLERGIES AND REACTIONS:

____
____
____

PAST MEDICAL HISTORY: (Any medical problems) Please check any that you have or have had in the past.

_____ Allergies affecting your nose.

_____ Sinus problems

_____ Asthma

_____ Heart disease (coronary artery disease)

_____ Heart irregularity such as Atrial Fibrillation

_____ Pulmonary hypertension

_____ Neuromuscular disease

_____ Fibromyalgia

_____ Heart attack or heart failure

_____ Emphysema or chronic bronchitis

_____ High blood pressure

_____ Hiatal hernia or reflux

_____ Epilepsy or seizures

_____ Arthritis

_____ Chronic back pain

_____ Thyroid problems

_____ Blood problems

_____ Kidney dialysis

_____ Psychiatric problems (not including depression)

_____ Obesity

_____ Diabetes

_____ Water retention

_____ Depression

_____ Kidney disease

SURGICAL HISTORY:

____

____

SOCIAL HISTORY:

1: Do you currently or have you ever smoked cigarettes? YES _____ NO _____

2: How old were you when you started smoking? YES _____ NO _____

3: How many cigarettes did you smoke in a day? __________

4: Did you quit? YES _____ NO _____

5: When did you quit? __________

6: Do you drink alcohol? YES _____ NO _____

7: How much do you drink? __________

8: Have you used street drugs within the last two years? YES _____ NO _____

9: Do you drink coffee, tea or caffeinated beverages? YES _____ NO _____

10: How much/may per day? __________

11: Do you exercise? YES _____ NO _____

12: How much exercise and what type or exercise?

____

____

13: Are you having any problems with the people that you live with? YES ____ NO _____

14: Do you work? YES _____ NO _____

15: What is your occupation? ____

16: Does your job cause you a lot of stress? YES _____ NO _____

17: Describe your work hours. ____

18: Do you work evening shifts? YES _____ NO _____

19: Do you have any pets? YES _____ NO_____

20: Do you pets give you any allergies? YES _____ NO _____

21: Do your pets sleep in your room? YES _____ NO _____

22: Do your pets sleep in your bed? YES _____ NO _____

23: Do you sleep with a feather pillow or down comforter? YES _____ NO _____

24: If you don't sleep in a bed, what do you sleep on? YES _____ NO _____

25: Does pain keep you awake at night? YES _____ NO _____

26: If so, what type of pain? ____

27: What is your normal bedtime? ____

28: What is your normal waking time? ____

29: How many hours do you sleep most nights? ____

30: How long does is usually take you to fall asleep? ______________________________________

31: Ho long have you had problems with sleep? _______ Weeks _______ months ______ years

32: How many times do you wake during the night? ____

33: How man naps do you take during the week? ____

34: What do you do if you cannot fall asleep? ____

FAMILY HISTORY

Any Family history of sleep apnea, narcolepsy or other sleep disorders? YES _____ NO ____

If yes, please describe:

____
____

If your parents are still living, please describe their age and health:

____
____

If your parents are not living please describe cause of death:

____
____

If any family members have heart of lung disease please describe their relationship to you:

____

Any additional family health information:

____

REVIEW OF SYSTEMS Circle all that apply:

Eyes, nose, throat:	Itchy, watery eyes	Runny nose	Stuffy nose	
Glands:	abnormal blood sugar	Thyroid problems		
Lungs:	Wheezing	Coughing	Shortness of breath	
Heart:	Chest pain	Palpitations	Chest pressure	
Stomach:	Heartburn	Nausea		
Bladder/ Kidneys:	Frequent urination	Bedwetting		
Muscle/Joints:	Neck pain	Joint pain	Muscle stiffness	
Brain/ Nerves:	Forgetful	Migraines and headaches	Numbness of hands and feet	
Psychology:	Anxious	Panic attack	Claustrophobia	Depression
Skin:	Bluish fingernails	Cold hands/feet	Numbness of hands/feet	