HEARTSTRONG sleep centers

9450 Grogan's Mill RD. #150
The Woodlands, TX 77380
Phone: 832-770-3200 Fax: 832-442-5505
www.heartstrongsleep.com

Dear Heartstrong Sleep Study Patient,

Thank you for allowing Heartstrong Sleep Centers to provide your sleep study as requested by your physician. Included with this document are a few questionnaires as well as a list of the "do's and don'ts" pertaining to the sleep study. Also included is a map of our location.

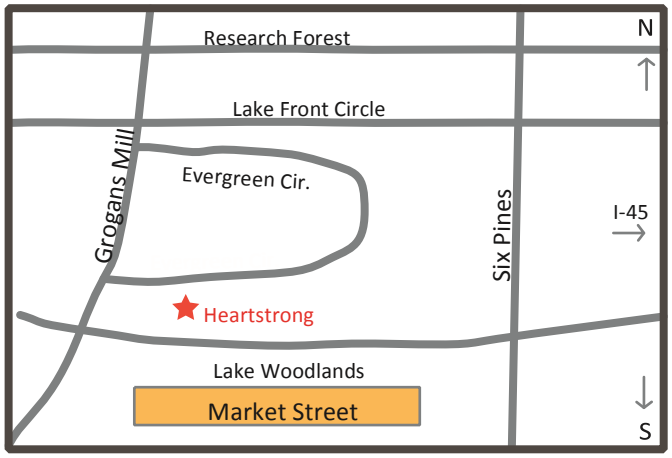
You should plan on arriving for your study at **8:30 pm**. Your study will last until 5:00 am the following morning, unless specifically requested otherwise. If you have any questions about the instructions, information or questionnaires, please don't hesitate to call us.

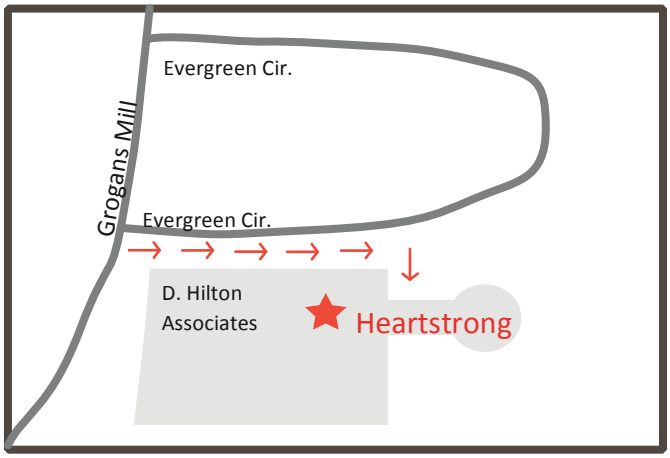
We look forward to seeing you soon and to beginning the process that will lead to the successful treatment of your sleep disorder.

Sincerely,

Heartstrong Sleep Center of The Woodlands

<u>You must turn on Evergreen Circle to access parking</u>. Second entrance on right where sign is - 9450 Grogans Mill Rd (circle drive in back of the building; park under turn around awning.)





THE DAY OF TESTING:

DO NOTS:

- Please do not take any naps.
- Please do not drink caffeinated beverages after 4:00 p.m.
- Please do not sleep past 9:00 a.m. on the day of your test.

DO'S:

- Eat dinner before arrival.
- Bring a list of all your medications.
- Continue to take all your medications according to your doctor's instructions.
- Bring any medications that you need to take during your stay.
- Bring your own sleepwear (No silk clothing as this will interfere with monitoring equipment.)You may bring your own pillow if you wish. Plan for comfort.

PREPARATION FOR TESTING:

- Please wash your hair the night before or the morning of your study and avoid using hair products the day of the study. Please arrive without make-up, if possible. If this is not practical, please wash your face to remove make-up when you arrive. Unless you have a beard, please be clean-shaven. If you have a beard, we can work around it, but beard stubble is very difficult to work with.
- Hairpieces and wigs must be removed in order to reach your scalp.
- No lotions or oils on body the day of testing

GOING HOME:

- You will be awakened at 5:00 a.m. the next morning and you may leave as soon as you are ready to go. Checkout time is at 6:00 a.m. at the latest, unless previous arrangements have been made.

GUESTS:

- Adult family members are welcome and encouraged to be present for the educational portion of the study. However, we do discourage anyone from staying over-night unless scheduled for a study. If you require the help of a personal care assistant due to a medical disability, we are happy to have your PCA stay with you.

- If you feel it is necessary to have someone stay with you, please call us at
- IF YOU NEED TO RESCHEDULE OR CANCEL YOUR STUDY:
- If you need to cancel or reschedule your appointment please call us at 832-770-3200. You may leave a message on voicemail if outside of normal business hours. If you do not show up for your scheduled appointment or cancel within 24 hours of your scheduled appointment,
  YOU WILL BE CHARGED A $300.00 NO-SHOW FEE.

WHEN:

- Please report to the sleep lab at 8:30PM unless told otherwise.
- Park in front of building. (see map attached map)
- Please feel free to call 832-770-3200 if you have any questions about your sleep study.

1. PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____

Preferred Contact #:_____ Secondary #:_____

Emergency Contact Name and Number:_____

AGE: _____ HEIGHT: _____ WEIGHT: _____ D.O.B.: _____

Please describe your sleep problem(s) and be as specific as you can. Input from family and your bed partner is also helpful. **Please check the below statements that apply** and write in any extra comments that you feel may be helpful.

When did your sleep problem(s) begin? _____

Have you ever been told that you snore?	□ **YES**	□ **NO**
Have you ever been told that you stop breathing while asleep?	□ **YES**	□ **NO**
Do you awaken choking or with difficulty breathing?	□ **YES**	□ **NO**
Do you ever awaken suddenly feeling short of breath?	□ **YES**	□ **NO**
Do you awaken with a headache?	□ **YES**	□ **NO**
Have you ever been told that you kick/move your legs repeatedly during sleep?	□ **YES**	□ **NO**
Do you ever feel a strong sensation of discomfort in your legs when you relax or lay down?	□ **YES**	□ **NO**
Do you awaken with indigestion or heartburn?	□ **YES**	□ **NO**
Do you nap during the day or in the evening before going to bed? If YES, how often?____ How long is your typical nap?_____	□ **YES**	□ **NO**
Do you feel refreshed following a nap?	□ **YES**	□ **NO**
Do you work night or rotating shifts? If YES, what shifts do you work? _____	□ **YES**	□ **NO**

Please provide any additional information in reference to your breathing while you sleep that you feel is important.

_____

How many caffeinated beverages do you consume in a day? (Coffee, tea, cola etc.) _____

Have you recently gained weight? If so, How much? _____	□ **YES**	□ **NO**
Do you consume alcoholic beverages? If so, How much? _____	□ **YES**	□ **NO**
Do you smoke? If so, how many packs per day? _____	□ **YES**	□ **NO**

2. TYPICAL SLEEP HABITS

Usual Sleep Schedule:	Weekdays	Weekends
a. What time do you usually go to bed?	_____	_____
b. What time do you usually wake up?	_____	_____
c. Do you feel refreshed when you awaken?	□ YES	□ NO

d. How long does it take you to fall asleep? _____

How often do you wake during the night? _____ Why? _____

3. REM INTRUSION SYMPTOMS

Do you experience dreams just as you are falling asleep?	☐ **YES**	☐ **NO**
When you are falling asleep, do you ever see vivid, life-like images?	☐ **YES**	☐ **NO**
Have you ever had a sudden muscle weakness that made it difficult to stand or maintain control of your extremities?	☐ **YES**	☐ **NO**
If yes, was this sudden weakness associated with any particular event or emotional state? (Laughing, anger, fear)?	☐ **YES**	☐ **NO**
Have you ever felt paralyzed as you were falling asleep?	☐ **YES**	☐ **NO**

4. PRIOR SLEEP STUDIES AND/OR TREATMENT

Have you ever had a sleep study before? If yes, when and where? _____	☐ **YES**	☐ **NO**
Have you ever been treated for a sleep disorder? If yes, describe the disorder and the treatment given, if any:	☐ **YES**	☐ **NO**

_____

5. DAYTIME SLEEPINESS

Please indicate how likely you would be to doze off or fall asleep in the following situations, in contrast to just feeling tired. These situations refer to your usual way of life in recent times. Even if you have never done or have not recently done some of these things try to work out how they would have affected you.

SITUATIONS (Please check **ONLY ONE** number for each situation)	0 Never	1 Slight	2 Moderate	3 High
Sitting and reading?				
Watching TV?				
Sitting inactive in a meeting, seminar or theater, etc.?				
As a passenger in a car for one hour?				
Lying down to rest in the afternoon?				
While having a relaxed conversation?				
In a car while stopping at a traffic light?				
			TOTAL POINTS:	

6. MEDICAL HISTORY

☐ Heart Disease	☐ Stroke	☐ Acid Reflux / Heartburn	☐ Menopause
☐ Irregular Heartbeat	☐ High Cholesterol	☐ Diabetes	☐ Cancer
☐ High Blood Pressure	☐ Congestive Heart Failure (CHF)	☐ Thyroid Disease	☐ Epilepsy / Seizures
☐ Angina	☐ COPD / Emphysema	☐ Anxiety Disorder	☐ Post-Traumatic Stress Disorder
☐ Heart Attack	☐ Asthma	☐ Depression	

Please list any other health problems: _____

Please list any other surgical procedures and give an approximate date:

_____

_____

7. MEDICATIONS

Please list all medications that you are currently taking, prescription and over the counter.
If you have a printed list we can make a copy for you

Name of Medication	Amount	How Often	Reason Prescribed or Taken