

## SLEEP HISTORY/LIFE HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

Phone (s) \_\_\_\_\_ Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_ Highest Grade Completed \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

Doctor's Address \_\_\_\_\_ SS # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Medicare Policy No. \_\_\_\_\_ Medicaid Policy No. \_\_\_\_\_

It is important for you to be accurate in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. This information will be held in the STRICKEST CONFIDENCE.

1. In the space provided below, please describe your main problem (s) in your own words, including when and how this began and what treatments you have received for this in the past:

\_\_\_\_\_

\_\_\_\_\_

2. Has it been a continuous or intermittent problem?  
 almost every night       for periods of at least one week  
 irregularly  
 other \_\_\_\_\_
3. How long has this problem bothered you?  
 longer than 2 years       1 to 2 years       several years  
 within the last 3 months       within the last month
4. On the scale below, please estimate the severity of your problem (s):  
 mildly upsetting     moderately severe     extremely severe  
 totally incapacitating
5. How strongly do you want help with your problem?  
 very much     much       moderately     could do without it

6. How do you describe your sleep problem? Check all that apply
- difficult falling asleep
  - wake up during the night
  - wake up early in the morning
  - excessive daytime sleepiness
  - difficulty awakening

7. Do any members of your family have sleep problems? Please explain.

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8. Circle any of the following that apply to you:

- Headaches   Dizziness   Palpations   Stomach problems   Bowel disturbances  
 Take sedatives   Fatigue   Feel panicky   Feel tense   Nightmares   Take sedatives  
 Depressed   Unable to relax   Sexual problems   Don't like weekends   Insomnia  
 Tremors   Financial problems   Fainting spells   Alcoholism   Shy with people  
 Bad home conditions   Unable to have a good time   Can't make decisions

9. Is your present work situation satisfactory?

10. Does your sleep problem disturb your sex life? (Provide information about any significant relationships)

11. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity?

List any medications that you are taking at this time:

Name of Drug	Dose	How long have you been taking this medication?
1.		
2.		
3.		
4.		
5.		

If additional medications, please list on back.

Medical/ Surgical History:

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In case of an emergency, list contact person:

\_\_\_\_\_ Phone number: \_\_\_\_\_

Patient/Family Signature: \_\_\_\_\_ Date \_\_\_\_\_

## GENERAL SLEEP HABITS

1. How many hours of sleep do you usually get per night?  
\_\_\_\_\_
2. What time do you usually go to bed on WEEKDAYS? \_\_\_\_\_  
WEEKEND? \_\_\_\_\_
3. How long does it take you to fall asleep?  
\_\_\_\_\_
4. How many times do you typically wake up at night?  
\_\_\_\_\_
5. What time do you usually awaken in the morning on WEEKDAYS? \_\_\_\_\_  
WEEKEND? \_\_\_\_\_
6. On average, how long do you stay in bed after waking up in the morning?  
\_\_\_\_\_
7. Do you usually: (check all that apply to you)  
 sleep with someone else in your bed  
 sleep with someone in your room  
 provide assistance to someone during the night (child, invalid, bed partner, animal)
8. Is your sleep often disturbed by:  
 heat                       light  
 cold                         bed partner  
 noise                       not being in your usual bed  
 other - please explain  
\_\_\_\_\_  
\_\_\_\_\_
9. Are your sleep habits on weekends different from the rest of the week?  
 no               yes –please explain  
\_\_\_\_\_  
\_\_\_\_\_

10. With whom are you now living? (wife, husband, children, parents, etc. and their ages?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Do you work split shifts or rotating (variable) shifts? \_\_\_\_\_  
If so, what is your schedule? \_\_\_\_\_

12. Do you usually drink coffee or tea within 2 hours before you go to bed?  
 yes  no

13. Do you do physical exercises before you go to bed?  
 yes  no

14. Do you read before falling asleep?  
 yes  no

15. Do you take naps during the afternoon or evening?  
 never  seldom  frequently – If so, for how long? \_\_\_\_\_

16. Do you feel refreshed after a short (10– 5 minute) nap?  
 yes  no

17. How do you feel after an average night of sleep?  
 usually I feel drowsy and/or tired  
If so for how long  1 hour  2 hours  3 hours  4 hours  
 most of the time, I feel good

18. Do you feel better during  
 morning  afternoon  evening

19. List your daily consumption of the following:  
Coffee \_\_\_\_\_ Tea \_\_\_\_\_  
Chocolate \_\_\_\_\_ Alcohol \_\_\_\_\_  
Other Drugs \_\_\_\_\_ Over the counter drugs \_\_\_\_\_  
Colas \_\_\_\_\_ Nicotine \_\_\_\_\_

20. What is your personal interpretation as to why you have you particular sleep/wake problem?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**GULF COAST SLEEP CENTER  
7777 HENNESSY BLVD. Ste. 216  
BATON ROUGE, LA 70809  
(225) 362-6240**

**SLEEP DISORDER PROGRAM**

**PATIENT INFORMATION**

1. The sleep test consists of monitoring with specialized equipment while you sleep.
2. In order to obtain the best results from your test, it is essential that you sleep. Prepare or sleep in the same manner that you would do in your home.
3. Please bring clothing you normally sleep in, as well as slippers. Try to avoid wearing silk or satin sleepwear.
4. Avoid caffienated beverages and limit water consumption after 6:00 p.m. on the day of the sleep study.
5. Take you routine medications. If you have medicine for sleep, anxiety or nerves that you take occasionally, avoid taking those medications the night of your sleep testing.
6. You need to arrive at Gulf Coast at 8:00 p.m.
7. You will be in a private room for your testing, with access to bathroom facilities.
8. The test will be completed between 5:00 a.m. and 5:30 a.m. We require 6 hours of recorded time for the study.
9. Please be sure hair is washed and free of all creams and oils.
10. You will want to plan on going straight home after the study to remove any unwanted gel or paste remaining in your hair.

*If you have any problems with this date, please contact us immediately.*

## **GULF COAST SLEEP CENTER**

### **SLEEP LAB CANCELLATION POLICY**

**This letter serves to inform you that Gulf Coast Sleep Center has a strict cancellation policy of which must be adhered to in order to avoid a \$150.00 cancellation fee.**

**“Any cancellations or requests to reschedule an appointment in the Sleep Lab must be completed within 48 hours of the scheduled appointment. In the event a scheduled appointment is missed, a \$150.00 cancellation fee will be processed and collected from the patient.”**

**Should you need to cancel or reschedule an appointment, please contact Missy Archer at (225) 362-6240**

**We look forward to providing you with a pleasant experience and quality sleep study at Gulf Coast Sleep Center.**

**Thank you for your cooperation and the opportunity to work with you.**

**Sincerely,**

**Missy Archer**

## **SLEEP LAB DISCHARGE INSTRUCTIONS**

**As you were informed in the pre-admissions packet, you will have several electrodes placed throughout your scalp when preparing for the sleep study. Both a preparatory gel and paste may be used in placing these electrodes. In order to avoid any (adverse reactions?) skin irritations, please follow the discharge instructions listed below upon completion of your sleep study:**

- Use the wash cloth and towel provided to remove as much of the paste in your hair as possible. If you need assistance, we will gladly help you.**
- Avoid getting any paste in your eyes. It may cause irritations.**
- As soon as you get home, wash hair to remove remaining paste. It may take more than one shampoo to completely remove electrode gel and paste.**
- Thank you for choosing Gulf Coast Sleep Center**

**If you have any further questions, please contact Missy Archer at (225) 362-6240**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES\***

**Gulf Coast Sleep Diagnostic will use and disclose your personal health information to treat you. To receive payment for the care we provide, and for other health care operations, healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution.**

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**Please Print Name**

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**Signature**

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**Date**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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**YOU ARE ENTITLED TO A COPY OF THIS CONCENT AFTER YOU SIGN IT**

**Include completed consent in the patient's Medical Record and Business Office Chart**

## The Epworth Sleepiness Scale

How likely are you to doze or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these this 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	CHANCE OF DOZING
Sitting and Reading	_____
Watching TV	_____
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 and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Date: \_\_\_\_\_ Male/ Female

Medications: \_\_\_\_\_

\_\_\_\_\_

WEIGHT: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

# LakeJointEffort

*A Total Approach to Joint Replacement*

## Sleep Apnea Syndrome Assessment

Compute Weight & Height to give a BMI measure.

Stated Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_

### Body mass Index (BMI) Scale

Height...H-factor	Height...H-factor	Height...H-factor
4'7"..... 0.232	5'3"..... 0.177	5'11".....0.139
4'8"..... 0.224	5'4"..... 0.172	6'0"..... 0.136
4'9"..... 0.216	5'5".... 0.166	6'1".... 0.137
4'10".... 0.209	5'6".... 0.161	6'2"..... 0.128
4'11".... 0.202	5'7".... 0.157	6'3".... 0.125
5'0"..... 0.195	5'8".... 0.152	6'4".... 0.122
5'1".... 0.189	5'9".... 0.148	6'5".... 0.119
5'2".... 0.183	5'10"....0.143	6'6".... 0.116

### BMI Categories:

- Underweight = <18.5
- Normal weight = 18.5-24.9
- Overweight = 25-29.9
- **Obesity = BMI of 30 or greater**

Q1. Do you have sleep apnea? Yes No

Q2. If yes, do you have a CPAP machine? Yes No

**\* Instruct patient to bring into the hospital on admit\***

### If patient answers no to the above questions, continue interview:

Q3. Do you Snore? Yes No

Q4. Do you ever fall asleep easily and or sometimes inappropriately? Yes No

Q5. Do you feel tired or have excessive daytime sleepiness? Yes No

Q6. Are you groggy on awakening? Yes No