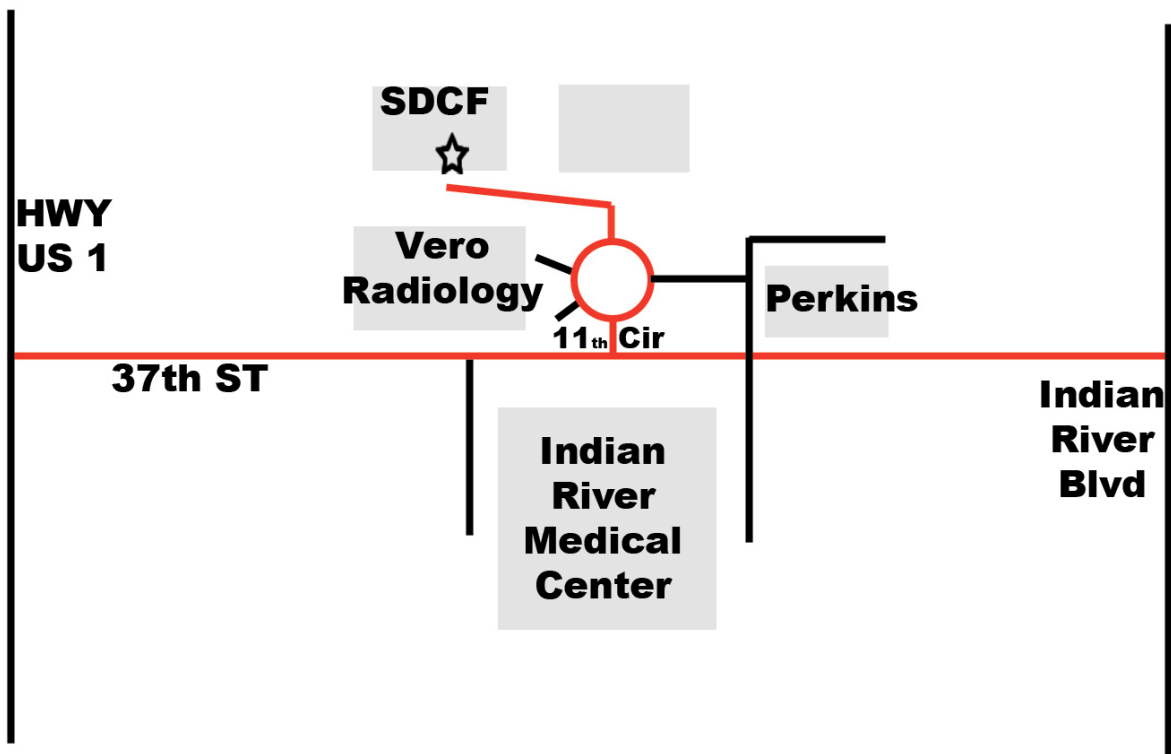


Sleep Disorders Center Florida
3735 11th Circle, Ste 103
Vero Beach, FL 32960



Sleep Disorders Center Florida

3735 11th Cir Suite #103

Vero Beach, FL 32960

(772) 563-2910

Patient Instruction Sheet

- ❖ Bring any medication you may need at bedtime or during the night, this includes such items as antacids, Tylenol or over the counter medicines. You may bring a over the counter sleep aid if you think you may have difficulty falling asleep.
- ❖ Pack as if you are going to stay in a hotel. Items such as toothpaste/ toothbrush, deodorant, razors, hair dryer and products. Spare change of clothes, pajamas are required (you may wear shorts and a tee also). You may also bring your pillow if you wish.
- ❖ Please come with clean, dry hair. Please try not to use any hairspray, gel, or oil in your hair. We use paste to secure electrodes to the scalp and these products make it hard for the electrodes to stick.
- ❖ Please do not use any creams or lotions on your face or legs. This also makes electrodes harder to stick. If wearing make-up you must wash off before set up.
- ❖ **If you need to take a shower before leaving in the morning you must let the receptionist know BEFORE the day of your study** so we can make arrangements for you.
- ❖ **Please do not take any naps on the day of your sleep study.** This will allow you to sleep easier here at the sleep center.
- ❖ **Do not consume any caffeine products after 5pm**, the night of your study. This includes, coffee, soda, tea, and chocolate.
- ❖ Your test will end at 6:00, and you will be able to leave by 7:00. If you need to be awakened before 6:00 please let the technician know before starting the study.
- ❖ We do serve coffee and a light breakfast after your study. You may stay and relax for a bit after awakening.
- ❖ If you have any questions regarding your study please feel free to contact us at (772) 563-2910 We are available 9am-5pm and 7pm to 7am Monday thru Friday, 7pm-7am on Sunday nights.

Appointment Date _____ **Time** _____

Please give us at least 24 hours notice if you can not keep your appointment. Failure to do so will keep another patient from being offered your time. There will be a \$200.00 cancellation fee for cancellations received after 12:00 noon the day of your appointment.

Sleep Disorders Center Florida
Patient Questionnaire

Name: _____ **Age:** _____

Height: _____ **Weight:** _____ **Neck size (inches):** _____

Referring Physician: _____

Please check all that apply to you:

- | | |
|--|---|
| _____ Snore loudly | _____ Snoring can be heard by others |
| _____ Snoring wakes you up | _____ Awaken with snort or gasp |
| _____ Awaken choking | _____ Awaken with heart pounding |
| _____ Snoring followed by long periods of silence | _____ Awaken with sore/ dry throat |
| _____ Fall asleep easily | _____ Others witness not breathing |
| _____ Fall asleep watching TV or reading | _____ Fall asleep driving |
| _____ Sleepiness interferes with social activities or work | _____ Fall asleep having a conversation |
| _____ Legs can't stay still | _____ Experience leg pain, cramps, or creeping feeling in legs. |
| _____ Thoughts keep racing through my mind | _____ Unable to fall asleep |
| _____ Wake up and can't go back to sleep | _____ Unable to relax |

Questionnaire Continued...

What time do you go to bed? _____

How long does it take to fall asleep? _____

How many times do you awaken at night? _____

What do you do when you wake up? _____

How long do you remain in bed after awakening in the morning? _____

How long do you think you sleep at night? _____

Is your sleep different on weekends than weekdays? _____

If so, please explain: _____

Do you work shifts? _____

Do you take naps? _____ how many? _____ how long each? _____

Do you have any of the following medical conditions?: (please check any that apply)

_____ Lung Disease _____ Heart Disease _____ Mental Disorders

_____ Depression _____ Drug addiction _____ Alcohol abuse

_____ Liver /kidney disease _____ Neurologic disorder _____ Diabetes

_____ Hypertension _____ Blood disorders _____ Chronic pain

Do you have a pacemaker or defibrillator? _____

Are you able to get in and out of bed without assistance? _____

Are there any medical conditions not listed that we need to be aware of? _____

If so, please list: _____

Questionnaire Continued...

Please list **all** medications you are taking:

Any allergies to medication?:

The Epworth Sleepiness Scale

Name: _____ Age: _____

Today's Date: _____ Male/ Female (please circle)

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

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 in the afternoon when
Circumstances permit

Sitting and talking to someone

Sitting quietly after lunch without alcohol

In a car, while stopped for a few minutes in traffic

Total:
