

**SLEEP DISORDERS CENTER AT TRINITAS
210 WILLIAMSON STREET
ELIZABETH, NEW JERSEY 07202
PHONE: (908) 994-8694
FAX: (908) 994-8697**

**VIPIN GARG, MD,FCCP,FAASM
DIPLOMATE OF AMERICAN
BOARD OF SLEEP MEDICINE**

Dear _____,

This is to confirm your appointment for a sleep study on: _____

(Sun.Mon.Tue.Wed.Thu.Fri.Sat)

Please report to the Admitting Department registration area, located in the main Medical Center building, to the right of the Main Lobby, by 7:30 PM. If you are using the Parking Garage, please have your parking ticket validated at the Lobby Information Desk. If your parking card is not validated, there will be a fee for parking. Present your insurance information and identification card(s) to the registrar. The registrar will give you a form. After Admitting has registered you please come to the Sleep Center located across the street.

- ❖ Please complete the enclosed questionnaire and bring it with you on the night of the study
- ❖ Bring your insurance information and identification card(s)
- ❖ Bring the prescription from your physician for this test

Your sleep study requires an overnight stay. We provide a private shower facility. Your sleep study will be completed by 7:00 AM. Trinitas will provide you with complimentary continental breakfast in the cafeteria, located in the main building of the medical center, starting at 7:00 AM. The Sleep Technician will give you the necessary voucher.

No family members or friends will be allowed to wait in the Sleep Center building during your test. The only exception made will be for children; in that case, one parent can remain for the night. Also, the only food that can be eaten in the Sleep Center would be a bedtime snack that is prescribed by your physician for a medical reason. All other food must be eaten before you arrive at the Sleep Center. If there are special needs, please let us know before your test date.

We will be calling your home a few days before your exam to remind you of your appointment. If you are not at home, we will leave that message with a household member or on your answering machine, if available. If that is unacceptable to you, please let us know upon receipt of this letter.

Should you have any questions prior to your arrival, please call us at our main office number: (908) 994-8694 prior to 3:00 PM, Monday through Friday or call the main Trinitas number: (908) 994-5000 and ask the operator to page the Charge Respiratory Therapist.

Thank you for choosing the Sleep Disorders Center at Trinitas Regional Medical Center.

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On The Day of Your Sleep Study

We are very pleased that you have chosen Trinitas Regional Medical Center for your Sleep Study. The Sleep Disorders Center is looking forward to making your visit a pleasant and comfortable experience. The suite has private sleeping quarters and shower/bathroom accommodations.

Here is a checklist of things to do before you arrive at the Sleep Center

- ▶ Please limit the amount of fluid intake 2-3 hours before coming to the Sleep Center
- ▶ No alcohol on the day of your study
- ▶ No coffee on the day of your study after 12 noon
- ▶ You may eat your normal dinner meal
- ▶ Please take all non-sleep related medications at the regular time. If you have been prescribed medication for sleep, that you regularly take at bedtime, you may bring that medication with you to take prior to going to sleep.
- ▶ Limit cigarette smoking after 12 noon, nicotine will affect the test
- ▶ Shower or bathe. Shampoo hair; Dry Hair completely - a **clean scalp** is imperative for a good test.

Please **DO NOT** use any of the following:

**Conditioners
Hair Treatments
Hair Sprays
Hair Gels
Hair Crèmes
Hair Rollers**

- ▶ Remove hairpieces, sections, wigs and toupee
- ▶ Dry and brush or comb your hair, **the hair must not be wet or damp** when you arrive
- ▶ No Perfumes or Colognes
- ▶ Necklaces and earrings (except studs) to be taken off
- ▶ Avoid all facial and body crèmes or treatments for this test
- ▶ Bring cotton or cotton/rayon pajamas (we do have hospital gowns)
- ▶ Avoid satin, nylon, and silk because of static electrical build-up
- ▶ Change of clothes
- ▶ Personal toiletries (for the morning)
- ▶ Personal hygiene products you require

If you have any questions, please feel free to call 908-994-8694

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SLEEP QUESTIONNAIRE

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____

CITY: _____ STATE _____ ZIP CODE _____

HOME PHONE: _____ WORK PHONE _____

CELL PHONE: _____

AT WHAT DAYTIME PHONE NUMBER MAY OUR PHYSICIAN DIRECTOR CONTACT YOU TO DISCUSS YOUR TEST RESULTS? _____

DATE OF BIRTH: _____ SEX (circle) ___ M ___ F

EMERGENCY CONTACT: _____ RELATIONSHIP _____

EMERGENCY CONTACT PHONE NUMBER: _____

PLACE OF EMPLOYMENT: _____ OCCUPATION: _____

NAME OF PHYSICIAN/INDIVIDUAL REFERRING YOU TO SLEEP CENTER:

PRIMARY MEDICAL PHYSICIAN: _____

MARITAL STATUS: (circle) ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED

WHAT IS THE MAIN REASON FOR YOUR VISIT TO THE SLEEP CENTER?

HOW LONG HAS THIS PROBLEM AFFECTED YOU? _____

HOW SERIOUS IS THIS PROBLEM FOR YOU? (circle one below)

(VERY SERIOUS) (MODERATELY SERIOUS) (MILDLY SERIOUS) (NOT SERIOUS)

HOW DID YOU FIRST HEAR ABOUT OUR SLEEP CENTER?

___ PHYSICIAN ___ RELATIVE ___ FRIEND

___ NEWSPAPER ___ PHONE BOOK ___ RADIO

___ TELEVISION ___ MAGAZINE ___ INTERNET

OTHER (please list) _____

HAVE YOU EVER HAD A SLEEP STUDY BEFORE? YES NO

IF YES, WHAT WERE THE RESULTS? _____

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SLEEP PATTERNS

	<u>WORK DAYS</u>	<u>OFF DAYS</u>
ACTIVITY PRIOR TO TURNING LIGHT OFF TO SLEEP	_____	_____
TYPICAL BEDTIME (e.g. 10 PM)	_____	_____
TYPICAL TIME IT TAKES TO FALL ASLEEP (e.g. 15 minutes)	_____	_____
TYPICAL NUMBER OF AWAKENINGS	_____	_____
ACTIVITIES DURING AWAKENING (e.g. WATCHING TV, READING)	_____	_____
TYPICAL AMOUNT OF TIME NEEDED TO FALL BACK ASLEEP	_____	_____
TYPICAL WAKE UP TIME	_____	_____
DESIRED WAKE UP TIME	_____	_____
HOW DO YOU USUALLY AWAKEN? (e.g. ALARM CLOCK)	_____	_____
TOTAL AMOUNT OF SLEEP	_____	_____
NUMBER OF NAPS PER DAY	_____	_____
TYPICAL LENGTH OF NAP	_____	_____
DO YOU FEEL YOU GET TOO MUCH SLEEP AT NIGHT?	YES	NO
DO YOU FEEL YOU GET TOO LITTLE SLEEP AT NIGHT?	YES	NO

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Please Check All That Apply:

SLEEP HABITS

- I FREQUENTLY TRAVEL ACROSS 2 OR MORE TIME ZONES
- I USUALLY WATCH TV OR READ IN BED PRIOR TO SLEEP
- I DRINK ALCOHOL PRIOR TO BEDTIME
- I SMOKE PRIOR TO BEDTIME OR WHEN I AWAKEN DURING THE NIGHT
- I EAT A SNACK AT BEDTIME
- I HAVE TROUBLE FALLING ASLEEP
- THOUGHTS RACE THROUGH MY MIND WHEN I TRY TO FALL ASLEEP
- I HAVE EXPERIENCED WEAKNESS OR PARALYSIS WHEN GOING TO SLEEP
- I HAVE AN ACIDIC STOMACH WHEN I SLEEP
- I EXPERIENCE CREEPING, CRAWLING OR TINGLING SENSATION IN MY LEGS WHEN I TRY TO FALL ASLEEP
- I AWAKEN FREQUENTLY DURING THE NIGHT
- I AM UNABLE TO EASILY RETURN TO SLEEP IF I AWAKEN
- I AM HUNGRY WHEN I AWAKEN DURING THE NIGHT
- I WILL EAT SOMETHING IF I AWAKEN DURING THE NIGHT
- I TYPICALLY AWAKE TO URINATE DURING THE NIGHT
- I HAVE NIGHTMARES OR DISTURBING DREAMS
- I SWEAT A GREAT DEAL DURING SLEEP
- I EXPERIENCE IRREGULAR OR SUDDEN, FAST HEARTBEAT
- I CANNOT SLEEP ON MY BACK
- I AWAKEN EARLY, AND STILL TIRED, BUT UNABLE TO RETURN TO SLEEP
- I AWAKEN FROM SLEEP WITH A HEADACHE
- I HAVE EXPERIENCED WEAKNESS OR PARALYSIS ON AWAKENING
- I EXPERIENCE SEEING THINGS OR HEARING VOICES THAT ARE NOT REAL
 - WHEN GOING TO SLEEP
 - DURING THE NIGHT
 - ON AWAKENING FROM SLEEP

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BREATHING

- I HAVE BEEN TOLD THAT I SNORE
- I HAVE BEEN TOLD THAT I SNORE ONLY WHEN SLEEPING ON MY BACK
- I HAVE BEEN AWAKENED BY MY OWN SNORING
- I AWAKEN AT NIGHT CHOKING, SMOTHERING OR GASPING FOR AIR
- I HAVE BEEN TOLD THAT I STOP BREATHING WHILE ASLEEP

RESTLESSNESS

- I AM A RESTLESS SLEEPER
- I KICK OR JERK MY LEGS AND/OR ARMS DURING SLEEP
- I EXPERIENCE RESTLESSNESS, TINGLING OR CRAWLING SENSATION IN MY ARMS/LEGS
- I EXPERIENCE AN INABILITY TO KEEP MY LEGS STILL PRIOR TO SLEEP
- I TALK IN MY SLEEP
- I HAVE SLEPT WALKED AS AN ADULT
- I GRIND MY TEETH IN MY SLEEP
- I HAVE CHRONIC PAIN THAT PREVENTS ME FROM BEING COMFORTABLE TO SLEEP

DAYTIME SLEEPINESS

- I HAVE A TENDENCY TO FALL ASLEEP DURING THE DAY
- I HAVE EXPERIENCED LAPSES OF TIME OR BLACKOUTS
- I HAVE FALLEN ASLEEP WHILE DRIVING
- I HAVE HAD AUTO ACCIDENTS AS A RESULT OF FALLING ASLEEP
- I FALL ASLEEP WATCHING TV
- I FALL ASLEEP DURING CONVERSATIONS
- I FALL ASLEEP DURING SEDENTARY SITUATIONS
- I PERFORM POORLY IN WORK/SCHOOL DUE TO SLEEPINESS
- I HAVE EXPERIENCED SUDDEN MUSCLE WEAKNESS IN RESPONSE TO EMOTION SUCH AS LAUGHTER, ANGER, ETC.
- I HAVE EXPERIENCED INABILITY TO MOVE WHEN FALLING ASLEEP OR AWAKENING
- I FEEL VERY FATIGUED DURING THE DAY
- I FEEL DEPRESSED DURING THE DAY

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SOCIAL HABITS

DO YOU SMOKE? YES NO

IF YES:	<u>TYPE</u>	<u>AMOUNT</u>	<u>HOW MANY YEARS</u>
<input type="checkbox"/>	CIGARETTES	_____ packs	_____ yrs
<input type="checkbox"/>	CIGARS	_____ cigars	_____ yrs
<input type="checkbox"/>	TOBACCO	_____ pipes	_____ yrs

DO YOU DRINK ALCOHOL? YES NO

IF YES:	<u>TYPE</u>	<u>FREQUENCY</u>	<u>AMOUNT PER WEEK</u>
<input type="checkbox"/>	BEER	<input type="checkbox"/> DAILY <input type="checkbox"/> WEEKENDS	_____ cans/week
<input type="checkbox"/>	WINE	<input type="checkbox"/> DAILY <input type="checkbox"/> WEEKENDS	_____ glasses/week
<input type="checkbox"/>	LIQUOR	<input type="checkbox"/> DAILY <input type="checkbox"/> WEEKENDS	_____ shots/week

DO YOU USE COCAINE OR CRACK? YES NO

DO YOU USE "UPPERS OR DOWNERS"? YES NO

DO YOU SMOKE MARIJUANA? YES NO

DO YOU USE OTHER NON-PRESCRIBED DRUGS? YES NO

IF YES, PLEASE LIST _____

SOCIAL HISTORY

____ SLEEP ALONE

____ SHARE A BED WITH SOMEONE

____ SHARE A BEDROOM WITH SEPARATE BEDS

____ SHARE A BED WITH A PET

____ PROVIDE ASSISTANCE TO SOMEONE DURING THE NIGHT (e.g. child, invalid etc)

IS YOUR SLEEP OFTEN DISTURBED BY:

____ HEAT
____ COLD
____ NOISE
____ BED PARTNER
____ LIGHT
____ NOT BEING IN YOUR USUAL BED
____ OTHER _____

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WHAT IS YOUR HEIGHT? _____ YOUR WEIGHT? _____

WHAT WAS YOUR WEIGHT ONE YEAR AGO? _____ FIVE YEARS AGO? _____

FOR EACH BEVERAGE LISTED, WRITE IN THE AVERAGE NUMBER YOU DRINK PER DAY

REGULAR COFFEE _____ CUPS A DAY
DECAFFEINATED COFFEE _____ CUPS A DAY
TEA _____ CUPS A DAY
SOFT DRINKS WITH CAFFEINE _____ CANS A DAY

CURRENT MEDICATIONS

MEDICATION DOSE FREQUENCY REASON

ALLERGIES: _____

ADVERSE MEDICATION REACTIONS: _____

PAST SLEEP EVALUATION AND TREATMENT

___ I HAVE HAD A PREVIOUS SLEEP DISORDER EVALUATION

___ I HAVE HAD A PREVIOUS OVERNIGHT SLEEP STUDY

___ I HAVE HAD A DAYTIME NAP STUDY

___ I HAVE BEEN PRESCRIBED A CPAP OR BIPAP MACHINE FOR HOME USE

___ I HAVE HAD SURGICAL TREATMENT FOR A SLEEP DISORDER

___ I HAVE PREVIOUSLY BEEN PRESCRIBED MEDICATION FOR A SLEEP DISORDER

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HEALTH HISTORY

PROBLEM	✓ IF POSITIVE	COMMENTS	DATE OF ONSET	WHERE TREATED
INSOMNIA				
MENTAL HEALTH				
EAR, EYES, NOSE, MOUTH AND THROAT				
HEART				
CIRCULATION				
ASTHMA				
COPD (emphysema, bronchitis)				
DIABETES				
BLOOD PRESSURE				
THYROID, GLANDS				
ARTHRITIS				
HEADACHES				
STROKE				
HIGH CHOLESTEROL				
SKIN PROBLEMS				
ALCOHOLISM				
DRUG DEPENDENCY				
EPILEPSY				
GASTRIC REFLUX				
CANCER				
FIBROMYALGIA				
PROSTATE				
KIDNEY				
URINARY				
BACK/JOINT				
SEXUAL				
CHEST PAIN				

PLEASE LIST ALL OTHER PAST MEDICAL PROBLEMS AND OR SURGERIES

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FAMILY HISTORY

HAS AN IMMEDIATE BLOOD RELATIVE HAD ANY OF THE FOLLOWING?

<u>YES</u>	<u>NO</u>	<u>PROBLEM</u>	<u>RELATIONSHIP</u>
<input type="checkbox"/>	<input type="checkbox"/>	CANCER	_____
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	_____
<input type="checkbox"/>	<input type="checkbox"/>	HYPERTENSION	_____
<input type="checkbox"/>	<input type="checkbox"/>	HEART DISEASE	_____
<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE	_____
<input type="checkbox"/>	<input type="checkbox"/>	STROKE	_____
<input type="checkbox"/>	<input type="checkbox"/>	ANXIETY/DEPRESSION	_____
<input type="checkbox"/>	<input type="checkbox"/>	SLEEP APNEA	_____
<input type="checkbox"/>	<input type="checkbox"/>	NARCOLEPSY	_____
<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____	_____

EMPLOYMENT STATUS

EMPLOYED UNEMPLOYED RETIRED STUDENT

___ MY JOB REQUIRES DRIVING A VEHICLE

___ I AM WORKING WITH DANGEROUS EQUIPMENT OR SUBSTANCES

___ I AM A SHIFT WORKER ON ROTATING SHIFTS

___ I AM A PERMANENT OR LONG TERM THIRD SHIFT (MIDNIGHT) WORKER

___ IF A STUDENT, WHAT GRADE OR LEVEL ARE YOU IN _____

IF EMPLOYED, WHAT ARE YOUR TYPICAL WORKING HOURS? _____

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EPWORTH SLEEP SCALE

The questions below are designed to assist us with evaluating your sleepiness during routine activities. Please answer these questions to the best of your ability. Even if you have not performed some or all of these activities, how do you think you would feel if you had?

The question is asking you, how high is your chance of falling asleep during that situation.

Choose from the following scale, the most appropriate number for each situation:

0 = would NEVER fall asleep

1 = SLIGHT chance of falling asleep

2 = MODERATE chance of falling asleep

3 = HIGH chance of falling asleep

<i>Situations</i>	<i>Chance of Falling Asleep</i>
1) Sitting and Reading	_____
2) Watching TV	_____
3) Sitting, inactive in a public place (i.e. a theater or meeting)	_____
4) As a passenger in a car for an hour without a break	_____
5) Lying down to rest in the afternoon	_____
6) Sitting and talking with someone	_____
7) Sitting quietly after a lunch without alcohol	_____
8) In a car, while stopped for a few minutes in traffic	_____

TOTAL SCORE : _____