Sleep Laboratory at Virginia Hospital Center

Please print and complete this questionnaire.

How did you first hear about our center?

☐ Signage	☐ Sleep society	☐ Newspaper	☐ Relative/Friend
☐ Physician	☐ Radio	☐ Seminar	☐ Journal
☐ Other			

Who is the physician ordering the Sleep Study? _____

Physician's address:

_____

Physician's phone number: _____

Demographic Information

Patient's Name:

_____
Last First Middle

Date of Birth: _____/ _____/_____

Home Address: _____
Street City State Zip Code

Home Phone: (____)_____ **Work Phone:** (____) _____

Social Security #: _____/ _____/_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Life Partner

Place of Employment: _____

Occupation: _____

Sex: _____ **Age:** _____ **Height:** _____ **Weight:**_____ **lbs.**

In case of an emergency, please contact:

_____
Name/Relationship/Phone #

Insurance Information

Policy Holder/Guarantor Information (if different from the patient):

Name: _____ Social Security #: _____/_____/_____

Relationship to patient: _____ Date of Birth: _____

Place of Employment:

_____

Primary Insurance: _____

Phone Number: _____

Policy/Member #: _____

Group Number : _____

Claims Address:

_____

Name of Policy Holder: _____ Relationship: _____

Secondary Insurance: _____ Phone Number: _____

Policy/Member #: _____ Group #: _____

Claims Address:

_____

Name of Policy Holder: _____ Relationship: _____

Questionnaire

The purpose of this questionnaire is to help our physicians understand the nature of your complaints and possible sleep disorder. This information will be held in the strictest confidence. In order to assist us in serving you better, please answer each question completely and as accurately as possible.

Describe the main reason your study was ordered:

_____

_____

_____

_____

Please answer the following:

	Patient Response	**Partner Response, If applicable**
How long do you feel you've had a problem with your sleep?		
How many nights a week does your sleep problem affect you?		
On the average, how many hours do you sleep each night?		
How many times do you wake up each night?		
On the average, how long are you awake during the night?		
How long does it normally take you to fall asleep?		
Do you experience the inability to keep your legs still?	☐ YES ☐ NO	☐ YES ☐ NO
Do you have any unusual sleep patterns? Please describe:	☐ YES ☐ NO	☐ YES ☐ NO
Are you currently working shift work? If yes, please describe:	☐ YES ☐ NO	

Approximately how many ounces of the following beverages/foods do you consume daily?

Coffee: _____ Soft drinks w/caffeine: _____ Chocolate: _____

Alcoholic drinks: _____ Decaf. coffee: _____ Tea: _____

Check any of the following that you feel apply to you:

□ Nightmares	□ Palpitations	□ Feelings of panic
□ Unable to relax	□ Bowel disturbance	□ Fainting
□ Headaches	□ Dizziness	□ Tense feelings
□ Poor memory	□ Depression	□ Difficulty with decisions
□ Shyness	□ Insomnia	□ Poor home conditions
□ Suicidal thoughts	□ Anxiety	□ Stomach problems

Answer the following questions utilizing the scale below. Please circle the number that best relates to your symptoms.

Evaluation Scale:

1 - No problem, never occurs
2 - Mild problem, rarely occurs
3 - Moderate problem, happens occasionally
4 - Moderately severe problem, occurs frequently
5 - Severe problem, occurs frequently

Is your sleep disturbed by any of the following?

1. Sleeping in an unfamiliar bed	1 2 3 4 5
2. Asthma	1 2 3 4 5
3. Coughing	1 2 3 4 5
4. Difficulty breathing in a flat position	1 2 3 4 5
5. Awakening due to regurgitation (throat burning, gagging)	1 2 3 4 5
6. Urgent need to urinate	1 2 3 4 5
7. Nasal congestion or stuffiness	1 2 3 4 5

How much difficulty have you had with the following?

1. Daytime sleepiness; dozing off or struggling to stay awake?	1 2 3 4 5
2. Fatigue, exhaustion or lethargy during the day	1 2 3 4 5
3. Do you snore while you sleep?	1 2 3 4 5
4. Actually falling asleep during the day	1 2 3 4 5
Sleep partner's response	1 2 3 4 5
5. Work/studies compromised because of fatigue or sleepiness	1 2 3 4 5
Sleep partner's response	1 2 3 4 5
6. Falling asleep while operating a motor vehicle	1 2 3 4 5
Sleep partner's response	1 2 3 4 5
7. Accidents as a result of falling asleep while driving	1 2 3 4 5
Sleep partner's response	1 2 3 4 5
8. Feeling sleepy/fatigued after and emotional change (anger/stress)	1 2 3 4 5
9. Feeling of weakness after a surprise or emotional change	1 2 3 4 5
10. Daytime hallucinations or dreaming	1 2 3 4 5
11. Not being able to move when first waking up, despite the feeling of being awake	1 2 3 4 5
12. Do you hold your breath, stop breathing, or make "gagging" sounds when sleeping?	1 2 3 4 5
Sleep partner's response	1 2 3 4 5
13. Do you wake up gasping for air or feel unable to breath when sleeping?	1 2 3 4 5

Do you have any other breathing problems during sleep?

_____
_____
_____

Have you ever seen a psychiatrist or mental health counselor? ☐ **YES** ☐ **NO**
If yes, please explain:

_____
_____
_____
_____

Is there any additional information pertaining to your sleep evaluation that you feel is important to explain? Is there anything you feel was not covered by this questionnaire? If so, please explain:

_____
_____
_____
_____
_____

Are you on home oxygen? ☐ **YES** ☐ **NO**

How many hours a day? _____ hours
How many liters per minute during the day? _____ liters/minute
How many liters per minute during the night? _____ liters/minute

Medical History
Please list any chronic present or past medical illness diagnosed by a physician (i.e. diabetes, hypertension, incontinence, etc.)

1.
2.
3.
4.
5.

Please list the medications you take on a daily basis. (Prescription and Over the counter)

Medication	Daily Dosage

How likely are you to doze off to 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 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 (e.g. a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total score	_____

Sleep Laboratory at Virginia Hospital Center

Lawrence M. Stein, MD, FACP, FCCP, FAASM
Medical Director

Ponnarit Loeu, RPSGT
Technical Director

Welcome to the Sleep Laboratory at Virginia Hospital Center where an overnight stay could pinpoint what is causing your sleep disruptions. Our board-certified physicians can simultaneously record brainwaves, muscle activity, heart rhythms, belly and chest wall effort, air flow to the nose and mouth, snoring patterns, blood oxygen levels and nerve impulses to the eye. These factors can help identify the onset of REM (rapid eye movement) dream states and possible impediments to sound sleep.

If you have been scheduled for sleep testing at Virginia Hospital Center, please read the following instructions:

Location: The Sleep Laboratory is located on the first floor of 1625 N. George Mason Drive, adjacent to Cardio Pulmonary.

Parking: Please park in the "Blue" Garage; take the garage elevators to the ground floor; proceed through the Registration area of the Emergency Department and ask for the bed control clerk.

Registration: Please arrive at Virginia Hospital Center by 8:30 P.M. Security will direct you to Patient Registration once you arrive in the Emergency Department. After registering please proceed to the Coffee Stand in the Main Lobby, a sleep lab technician will escort you to the Sleep Center at 9:00 pm.

Cancellations: If you are unable to keep your appointment, please call our patient care coordinator at 703.236.7171 within 48 hours, Monday through Friday, 9:00 am to 4:30 pm.

Tardiness: If you will be arriving late, please call the sleep lab technician at 703.558.6789 after 9:00 pm.

Please retain a copy of your referral/doctor's order and give to the technician prior to your sleep study.

VIRGINIA HOSPITAL CENTER

Lawrence M. Stein, MD, FACP, FCCP, FAASM
Medical Director

Ponnarit Loeu, RPSGT
Technical Director

Welcome to the Sleep Laboratory at Virginia Hospital Center. As part of your clinical evaluation in sleep disorders you have been scheduled for sleep testing at our center. This letter introduces you to our medical director, Dr. Lawrence M. Stein.

Lawrence M. Stein, MD is a graduate of the State University of New York Downstate Medical Center, Brooklyn, New York (MD, 1985). He did his internal medicine training at Columbia Presbyterian Hospital (in NYC) during 1985-1988. Dr. Stein trained in pulmonary and critical care medicine at the Albert Einstein College of Medicine during 1988-1991. He is board certified in Internal Medicine with added qualifications in Pulmonary Disease by the Subspecialty Board. He is also board certified in Critical Care Medicine and Sleep Medicine. A staff member at Virginia Hospital Center, Dr. Stein has his own private practice in Pulmonary and Internal Medicine in Arlington, Virginia.

Your doctor may have referred you for medical consultation or for testing only. A formal medical consultation and examination may be scheduled at your request or at your physician's request. For most patients this has been done before testing. For more information please call 703.236.7171.

Sleep Laboratory at Virginia Hospital Center
Fact Sheet & Sleep Testing Information

SLEEP TESTING

PSG: Date _____ **MSLT: Date** _____
Time _____**AM/PM** **Time** _____**AM/PM**

SPLIT NIGHT: Date _____ **CPAP: Date** _____
Time _____**AM/PM** **Time** _____**AM/PM**

Before your visit, please take the time **at home** to complete the forms that accompany this letter and bring them with you to the center.

1. Sleep history questionnaire
2. Insurance information sheet
3. Insurance card
4. Referral form from your primary physician, if applicable

Directions to Virginia Hospital Center:

From the Capital Beltway (495)
Take Route 66 East to the Washington Boulevard exit. At the traffic light turn left onto Lee Highway. Go approximately 21 blocks to North George Mason Drive. Turn right onto North George Mason Drive and go approximately 5 blocks. Virginia Hospital Center will be on the left.

From Washington, DC
Take Route 66 West to the Glebe Road exit. At the traffic light, turn right onto Glebe Road. Go to the second traffic light and turn left onto 16th Street. Go approximately 7-8 blocks to North George Mason Drive. Turn right onto North George Mason Drive. Virginia Hospital Center will be on the right.

From Route 50
Take Route 50 to the North George Mason Drive exit. Follow North George Mason Drive approximately 10-15 blocks. Virginia Hospital Center will be on the right.

Instructions for your sleep study

1. Please wash your hair prior to coming to the sleep center. Do not use hair sprays, cream rinses or conditioners. Please do not apply any type of oil-based product to your face or body. Do not apply any makeup or after-shave to your face or body. Please remove any nail polish or artificial nails from at least two fingers.

2. Take your regular medications unless otherwise instructed by your referring Physician. Please record the time all medications were taken the day of the study and submit to the sleep lab technician when you arrive for the study. **Bring all medications that you may need during your stay m the lab.**

3. Please try to get a normal night's sleep the night before your study. Try to maintain your normal sleep patterns, i.e., do not take naps during the day of your study and do not try to stay awake the night before your study.

4. **Do not consume any type of caffeinated or alcoholic beverages the day of your sleep study and limit your total fluid intake after 5:00 PM the evening of your study.**

5. You are required to sleep in nightclothes (e.g., pajamas, gowns, shorts and T-shirts); sleeping in undergarments only is not allowed. Your nightclothes should be loose and, preferably, two-piece. Cotton clothing is preferred. Do not wear anything of a silky nature (silk, satin, nylon, etc.). Please feel free to bring with you any personal belongings that may help you sleep more comfortably (e.g., pillow, blanket, etc.).

6. Please feel free to bring books or magazines with you as aids to help you fall asleep.

7. Bathroom and shower facilities are available for your convenience. However, please bring all the supplies you will need the morning after your sleep study (shampoo, soap, hairdryer, hairspray, shaving cream, razor, toothpaste, toothbrush, personal feminine hygiene items, etc.).

8. If you have been scheduled for an MSLT (Multiple Sleep Latency Test), (daytime sleep study), you may want to prepare your own meals to bring with you. A refrigerator and microwave are available for your use.

9. **All studies will be terminated between 5:00 and 5:30 AM. Departure from the lab will be no later than 6:00 AM.**