



Northern Arizona Healthcare

NAHMG – Sleep / Flagstaff
1895 N Jasper Dr, Ste 3
Flagstaff, AZ 86001
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NAHMG – Sleep / Cottonwood
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Cottonwood, AZ 86326
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Sleep Study Information

Your sleep study appointment is scheduled for:

Your follow up appointment is scheduled for:

We are looking forward to having you as our guest in our sleep center.

Please read and complete the attached/included Sleep History Questionnaire.

Flagstaff Address: 1895 N Jasper Drive Suite 3 - Flagstaff AZ, 86001

928-226-6430 Day time phone number

928-226-6406 Night time number for sleep study technicians

Before your appointment

Please let us know if you have any special needs, particularly special medications, pulmonary treatments, supplemental oxygen, difficulty walking or getting in / out of bed, or using the restroom.

***** If you are not self-sufficient and/or require a caretaker or family member for assistance please inform the lab ASAP so proper arrangements can be made.*****

Polysomnogram (PSG) – Overnight Sleep Study

A PSG is a recording during sleep that uses EEG (brain activity), breathing and other physiologic measures to evaluate sleep disorders. Patients usually come to the laboratory in the evening and stay overnight for continuous monitoring. The study is usually completed around 5:00am to 6:00 am.

The technologist records various information for interpretation by our sleep medicine physician. Sleep studies are utilized to help evaluate patients who experience excessive sleepiness during the day, snoring, high blood pressure as well as other heart and medical conditions. There are many sleep disorders and the most common is sleep apnea, which is repeated interruptions in breathing while asleep.

How to prepare for your sleep study

- Please complete the included/attached Sleep History Questionnaire and bring with you to your appointment.
- Please have your hair and skin clean and free of all hairsprays, lotions, and oils.
 - **One fingernail needs to be free from acrylics and/or nail polish.**
- Try to follow your normal routine – no excessive exercise, stress, eating, etc.
- Avoid caffeine and alcohol after 12 pm on the day of your study.
- Take your regular medication as directed by your physician and **bring all medications that you may need during your stay at the lab.**

What to Bring

- Comfortable, loose-fitting clothing for sleep.
- Your normal nighttime medications.
- Also, feel free to bring a book, magazine, laptop / tablet, or other items that will help you feel comfortable while staying away from home.

- Each room has a private bathroom with shower for your convenience in the morning.
- Pack your favorite pillow and/or blanket if you feel this will help you sleep better in the sleep lab.

What to expect when you arrive at the lab

- First, the sleep technologist will show you to your bedroom. You will be able to finish any questionnaires and change into your nightclothes.
- The sleep technologist will explain your procedure in great detail and answer all your questions before they begin.
- The sleep technologist will then apply electrodes to your scalp to record brain waves and elastic belts to monitor your breathing. Other electrodes are used to monitor eye movements, heart rhythms, and leg movements. You will be sleeping alone in the recording room but monitored by the technologist via closed circuit video.

Following your sleep study

- You will be finished between 5am – 6am in which time you will complete morning questionnaires.
- A sleep center staff physician will review your sleep study and make recommendations for treatment based upon the results of your study.
- **If you have not made a follow-up appointment with our Sleep provider team, please call us at 928-226-6430 to schedule.**

Frequently Asked Questions

Will I have my own room?

Yes, you will have a private bedroom with a television and premium cable channels.

What if I need to use the restroom?

No problem. The wires are all arranged for easy access to the restroom. You will simply call out to your technologist who will promptly respond and disconnect you from the wall connections for you to be able to use the restroom at any point during the night.

If you need assistance getting in/out of bed or while using the restroom, please notify us prior to your study and ASAP as special staffing and scheduling arrangements will need to be made.

What if I need to wake early for work or personal reasons?

If you need to wake early for any reason, please notify your technologist before your test begins. We need to record at least 6 hours for a complete sleep study.

What should I bring?

We want your stay with us to be as comfortable as a night in your own bedroom. Bring comfortable, loose-fitting clothing to sleep in and your normal nighttime medications. You are also welcome to bring a book, magazine, laptop / tablet, pillow, blanket or other items that will help you feel comfortable while staying away from home.

In addition, please remember to bring your completed Sleep History Questionnaire.

Do I take my medications?

Take all of your regular medications on the day of your study unless otherwise specified by your physician. Please remember to bring any medications that you usually take before bedtime or when you wake up in the

morning. We are an outpatient facility and do not have access to medications.

Can I bring a drink or snack?

Please eat dinner before you arrive for your sleep study. However, you may bring your own snacks to keep in the bedroom with you.

How does a sleep study work?

Once it is time to begin the study, you will be hooked up to approximately 20 small wires, which are held in place with tape and other adhesives. This takes approximately 30 minutes. All of these sensors help us measure your brain activity, heart rate/rhythm, breathing patterns, snoring, oxygen levels, and leg movements. This is a non-invasive procedure, and no needles are used in this process. The sensors are attached using all hypoallergenic medical tape and water-soluble paste.

Will I be able to sleep with all those wires on me?

Most patients say that once all the wires are on, they forget about them and have very little trouble sleeping. The wires are very small and organized. You have full range of motion in your bed and are able to sleep in all positions.

Do I have to sleep on my back?

You are able to sleep in any position that is comfortable for you. It is helpful for the physician to make an accurate diagnosis to see how your body responds to sleeping in several positions (on your side and on your back) so you may be asked to try to change positions at some point during the night.

Do I have to go to bed that early?

We want to simulate your normal bedtime routine as much as possible. Upon your arrival to the sleep lab, there is time for you to complete the check-in process, relax, and get set up for the sleep study. Most sleep studies begin with lights off between 9:00 and 11:00pm.

Can my spouse/friend/family come?

Your friends and family members are asked to remain home as this is a sensitive test that can have skewed results if interrupted during the night.

However, we do allow a patient to have someone stay with them if it is deemed medically necessary by the Sleep Clinic Staff.



SLEEP MEDICINE HISTORY FORM

Name: Today's date:

DOB: Sex: Male Female Primary Care Provider:

Weight: Height: Collar size (inches):

What TIME do you GO TO BED?

How long does it take for you to fall asleep?

What occurs during that time?

Do you frequently wake up in the middle of the night? Yes No

If yes, how many times?

What is the reason for waking up?

How long does it take to return to sleep?

What TIME do you WAKE UP in the morning?

Do you feel REFRESHED UPON WAKING UP? Yes No

Do you take any:

Scheduled / planned naps? Yes No

If yes, how long?

Unscheduled / unplanned naps? Yes No

When driving? Yes No

When inactive? Yes No

In conversations? Yes No

If YES, do you feel refreshed after naps? Yes No

Any change in sleep schedule on your DAYS OFF? Yes No

Have you had any change in weight in the past 3 years? Yes No

Gained? / How much?

Lost? / How much?

What sleep position do you prefer? Side Back Stomach

How many hours do you sleep on average in 24 hours?

SLEEP APNEA SYMTPOMS:

Has anyone told you that you SNORE? Yes No

If yes, how loud? Mild Mod Loud Very Loud

Has anyone seen you STOP BREATHING? Yes No

Do you have pauses in breathing when you sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wake up from sleep with:	
Choking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gagging?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Racing heart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has anyone told you that you are make gasping noises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wake up with a DRY MOUTH?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wake up with a HEADACHE?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drool on the PILLOW?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you SWEAT a lot when sleeping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you feel TIRED during the day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please describe?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

RESTLESS LEGS SYMTPOMS:

Do you have UNCOMFORTABLE SENSATIONS in your legs before bedtime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please describe them?	_____
Do you have any of the following during sleep?	
SLEEPWALKING	<input type="checkbox"/> Yes <input type="checkbox"/> No
SLEEP TALKING	<input type="checkbox"/> Yes <input type="checkbox"/> No
NIGHTMARES	<input type="checkbox"/> Yes <input type="checkbox"/> No
ACTING OUT DREAMS	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have ever been told that you yell, scream, flail your arms, fall out of bed or kick your partner while asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, please explain	_____

SLEEP HYGIENE:

Do you do any of these activities in your bedroom:	
Watch TV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Read?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink coffee / caffeinated beverages?	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Moderately
SMOKING	<input type="checkbox"/> Never <input type="checkbox"/> Former <input type="checkbox"/> Current
Do you drink ALCOHOL?	<input type="checkbox"/> Never <input type="checkbox"/> Occasionally <input type="checkbox"/> Moderately
Do you use illicit drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No / Type: _____
Is your bedroom usually quiet, dark and a comfortable temp?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sleep ALONE or SHARE your bed with a partner?	<input type="checkbox"/> Sleep alone <input type="checkbox"/> Share with partner
Any PETS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do the pets sleep in your bed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sleep better at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sleep better outside of your home (hotels, etc...)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

MISCELLANEOUS:

When FALLING ASLEEP or WAKING UP:

	Do you SEE or HEAR things?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please describe:	_____
	Do you ever FEEL PARALYZED?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you ever feel SUDDEN MUSCLE WEAKNESS?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HISTORY:

Does anyone in your family have sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, in what relation to you?	_____

DRUG ALLERGIES:

Do you have any known drug allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please list medication and reaction below:		
Drug name: _____	Reaction: _____	
Drug name: _____	Reaction: _____	
Drug name: _____	Reaction: _____	
Drug name: _____	Reaction: _____	

CURRENT MEDICATIONS:
Please list all of your current medications

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever had a SLEEP STUDY before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use oxygen or any devices at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, which do you use?	
<input type="checkbox"/> Oxygen <input type="checkbox"/> CPAP <input type="checkbox"/> BIPAP <input type="checkbox"/> ASV <input type="checkbox"/> MAD oral appliance <input type="checkbox"/> Bite guard		

SURGERIES:
Please list all of your surgeries:

_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY:
Please check any of the following that apply:

<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/> Nasal allergies / congestion	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Diabetes

- | | | |
|--|--|--|
| <input type="checkbox"/> Cardiac arrhythmias | <input type="checkbox"/> Stroke / TIA | <input type="checkbox"/> Heartburn / reflux |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> Lung problems / COPD / Asthma |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Menopause | <input type="checkbox"/> Anemia / iron deficiency |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Broken nose |
| <input type="checkbox"/> Depression / anxiety / bipolar | <input type="checkbox"/> End stage kidney disease / dialysis | <input type="checkbox"/> Head injury |
| <input type="checkbox"/> Difficulty controlling blood pressure | <input type="checkbox"/> Difficulty controlling blood sugar | <input type="checkbox"/> Chronic pain / reason |

REVIEW OF SYMPTOMS:

Please check any symptoms that you frequently experience:

ENT:

- | | | |
|---|---|--|
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Hoarseness lasting more than 2 weeks | <input type="checkbox"/> Nasal discharge |
| <input type="checkbox"/> Nasal congestion | | |

Heart:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Passing out | <input type="checkbox"/> Chest pain, tightness, or pressure | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swellings of feet / ankles | |

Resp:

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Frequent cough for more than 2 weeks | <input type="checkbox"/> Wheezing |
|--|---|-----------------------------------|

GI:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Difficulty swallowing / food "sticking" | <input type="checkbox"/> Frequent heartburn / indigestion |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Vomiting | | |

MSK:

- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Joint stiffness |
| <input type="checkbox"/> Limb pain | <input type="checkbox"/> Limb swelling | <input type="checkbox"/> Muscle pain |
| <input type="checkbox"/> Back pain | | |

Neuro:

- | | | |
|---|--|--|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness / tingling |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Ringing in ear(s) | |

Behav:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Change in personality | <input type="checkbox"/> Sleep disturbance |
| <input type="checkbox"/> Depression | | |

Hema:

- | | | |
|---|--|--|
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Easy bruising |
|---|--|--|

GU:

- | | | |
|-----------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Nocturia | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Sexual dysfunction / loss of libido |
|-----------------------------------|---------------------------------------|--|



EPWORTH SLEEPINESS SCALE FORM

NAME _____ DOB _____ DATE _____

The test is a list of eight situations in which you rate your tendency to become sleepy

Instructions: Be as truthful as possible.

Write down the number corresponding to your choice in the right-hand column. Total your score below.

No chance of dozing =0

Slight chance of dozing =1

Moderate chance of dozing =2

High chance of dozing =3

SITUATION

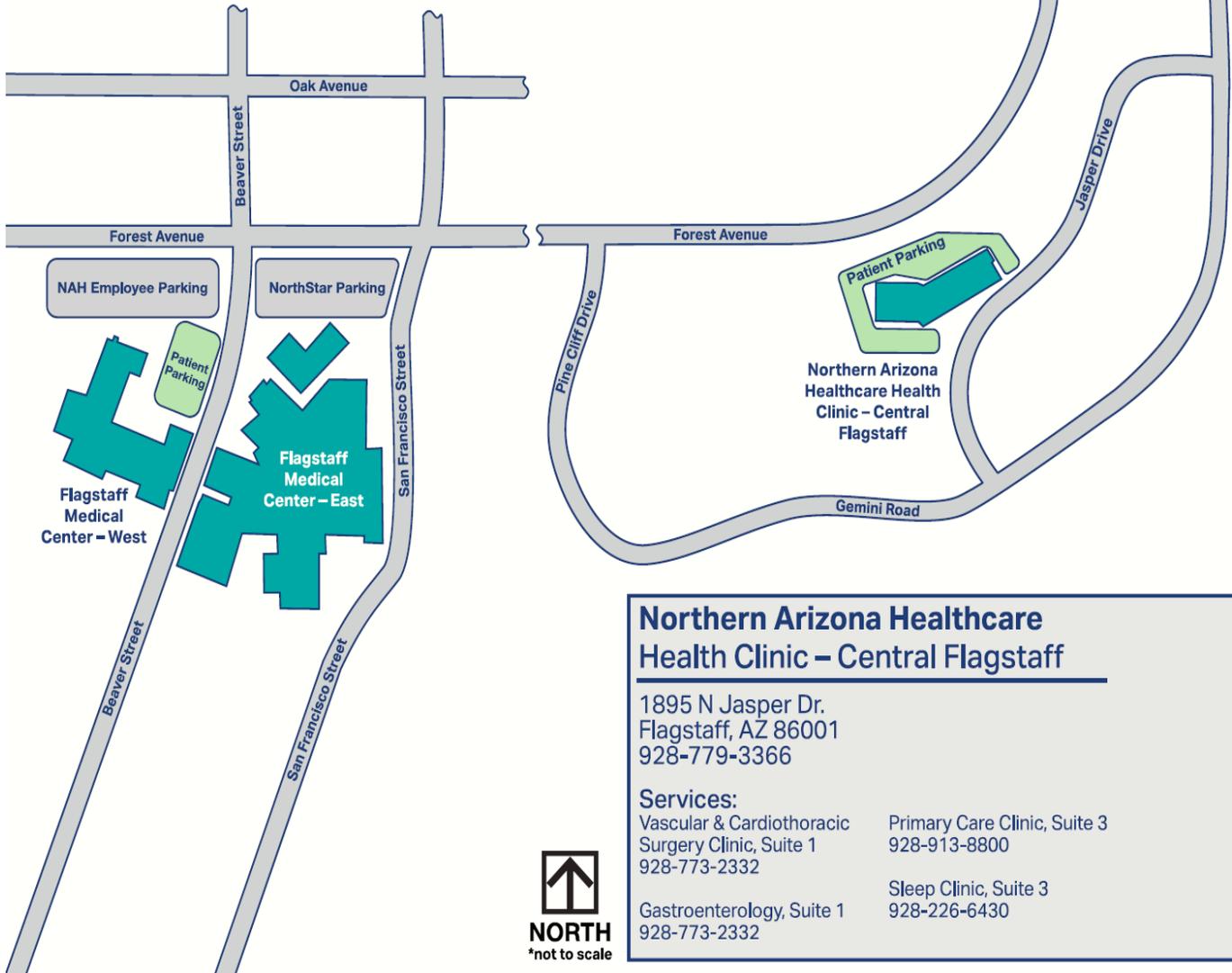
CHANCE OF DOZING

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 = _____



Northern Arizona Healthcare



**Northern Arizona Healthcare
Health Clinic – Central Flagstaff**

1895 N Jasper Dr.
Flagstaff, AZ 86001
928-779-3366

Services:

Vascular & Cardiothoracic Surgery Clinic, Suite 1 928-773-2332	Primary Care Clinic, Suite 3 928-913-8800
Gastroenterology, Suite 1 928-773-2332	Sleep Clinic, Suite 3 928-226-6430



NORTH
*not to scale