Integrated
Sleep Services

Tel: 703-313-9111 Fax: 703-313-4945
7115 Leesburg Pike Suite 201 Falls Church, VA 22043 9010 Lorton Station Blvd #220, Lorton, VA 22079

SLEEP STUDY QUESTIONNAIRE & INSTRUCTIONS

Appointment Location:_____ Appointment Date:_____ Appointment Time:_____

INSTRUCTIONS:

Please note that we have three sleep lab locations, one at each of our offices. Please refer to the directions below in how to enter our suite after hours. All of the offices are locked after hours, and you will need to refer to these instructions to gain entry.

9010 Lorton Station Blvd Suite 220, Lorton, VA 22079

- Arrive promptly at your scheduled appointment time, 9:00 or 9:30 PM. Do not arrive earlier than scheduled. Park in the back of the building, the silver call box is located to the right of the back entrance. Please scroll to find and select the name Integrated Sleep Lab and hit the call button. This will call our suite and the tech on duty will buzz you into the building. Our office is on the second floor. If you do not use the call box, the sleep technologist on duty will not know you have arrived and the door to the suite will be locked. Please use the call box as instructed.

7115 Leesburg Pike Suite 201, Falls Church, VA 22043

- Arrive promptly at your scheduled appointment time, 9:00 or 9:30 PM. Do not arrive earlier than scheduled. Use the silver call box located to the right of the building entrance. Press # for directory, and locate “Sleep Lab”, then you will be prompted to dial 02 to call our suite and the tech on duty will buzz you into the building. Our office is on the second floor. If you do not use the call box, the sleep technologist on duty will not know you have arrived and the door to the suite will be locked. Please use the call box as instructed.

6355 Walker Lane, Suite 313, Alexandria VA, 22310

- Arrive promptly at 8:45 PM, despite your scheduled appointment time. Elevators in this building lock at approximately 9:00 PM, therefore if you arrive later – you may need to use the staircase to access the suite. Enter through the emergency room entrance. Let the security guard at the front desk know that you are here for suite 313 if asked. Our office is on the third floor.

- ✓ Please complete the sleep questionnaire prior to your appointment time and bring it with you to give to your technologist.
- ✓ 48 hour notice is required for cancellations, otherwise a $200.00 will be charged for missed appointments. Your insurance will not cover this charge.
- ✓ Please arrive to your designated sleep lab at your scheduled time on the night of your study. There may not be someone to let you into the building if you arrive very early for your appointment.
- ✓ Please arrive with clean, dry hair, and be certain your scalp is fully accessible (no wigs), and avoid hair products, makeup, and excessive cream or body lotions on the night of your study.
- ✓ Please take all of your regular medications, unless otherwise instructed by your physician. Please bring all medication that you may need during your stay.
- ✓ Please do not drink alcoholic beverages on the day of your study.
- ✓ Please do not consume caffeine after 12:00 PM on the day of your study.
- ✓ Please try to get a full night sleep prior to the night of your study, and please avoid taking any naps.
- ✓ Please bring comfortable night clothes for your sleep study. Loose fitting cotton pajamas are preferred.
- ✓ Please feel free to bring any personal belongings to your study that may help you sleep more comfortably, for example a favorite pillow, book, tablet, etc.
- ✓ Bathrooms and shower stalls are available for your convenience. A special conductive paste will be used in your hair to monitor EEG activity. For this reason, you may want to wash your hair prior to leaving the sleep lab.
- ✓ Your technologist will end the sleep study between 5:00 AM – 5:30 AM.

SLEEP QUESTIONAIRE:

Name: _____ Date: _____

Date of Birth: _____ Referring Physician: _____

Phone Number:_____ Address: _____

*** This is required if you have not been seen in our office by one of our physicians prior to this sleep study appointment.**

Primary Insurance: _____

Insurance Address:_____

Policy #_____ Group #_____

Policy Holder Name: (Last)_____ (First)_____ (Middle)_____

Date of Birth_____ Sex_____ Relationship to Policy Holder:_____

MEDICAL HISTORY:

Please indicate your Height: _____ ft _____ in Current Weight: _____ lbs Weight 1 Year Ago: _____ lbs

Has your weight changed significantly within the last 5 years? □ YES □ NO

If yes, how so? _____

Have you ever had your tonsils removed? □ YES □ NO

Have you ever had your adenoids removed? □ YES □ NO

Have you had any other surgeries? □ YES □ NO

If yes, please list surgery and date (mm/yy): _____

REASON FOR THIS VISIT:

Why are you seeking treatment at this time?

□ Snoring □ Excessive daytime sleepiness □ Leg movement during sleep

□ Difficulty falling asleep □ Difficulty staying asleep □ Poor sleep-wake schedule

□ Disruptive behaviors during sleep □ Awaken too early

□ Other: _____

When did your sleep problems start? _____

- Have you ever had a sleep evaluation or overnight sleep study (polysomnography)?

(If available, please supply a copy of your previous sleep study report)

□ YES □ NO

- Were you ever diagnosed with apnea?

Thank you for choosing Integrated Sleep Services

□ YES □ NO

- If yes, what treatment did you receive? _____
- Are you still utilizing the treatment?
  □ YES □ NO
- If not, why not?

_____

_____

EPWORTH SLEEPINESS QUESTIONNAIRE:

How likely are you to doze off or fall asleep in the 8 situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't 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	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (eg, a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

SUSPECTED SLEEP APNEA QUESTIONAIRE:

Are you snoring loudly?	□ YES	□ NO
Experiencing excessive daytime sleepiness?	□ YES	□ NO
Have witnessed Apneas?	□ YES	□ NO
Have high blood pressure?	□ YES	□ NO
Have a BMI greater than 35?	□ YES	□ NO
Are of an age greater than 50?	□ YES	□ NO
Neck Cirumference greater than 40?	□ YES	□ NO

ALLERGIES:

Are you allergic to any medications? □ YES □ NO

Thank you for choosing Integrated Sleep Services

If yes, please list all the medications: _____

Do you have any other allergies? □ YES □ NO

If yes, please list all allergies: _____

MEDICATIONS:

Please list all prescription and over-the-counter medications that you currently use

Medication	Dose	Directions

Thank you for choosing Integrated Sleep Services