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Dear Patient,

Your physician or healthcare provider is concerned that you may have a condition called Sleep Disordered Breathing (commonly referred to as "Sleep Apnea"). Many times either your Physician or your Insurance Carrier prefers the Home Sleep Test - HST (aka Out of Center Sleep Test – OOCST) evaluation as a "first step" to assess this potential problem. You have been scheduled for an appointment at Sleep Therapy & Research Center to instruct you on the use of the Home Sleep Test. You may watch a video of the HST on our website at www.OOCST.com.

To help ensure that we have accurate information about your sleep we request that you complete the attached questionnaire prior to your appointment. If possible someone who is familiar with your sleep should assist you in answering the questionnaire. That person is also welcome to accompany you to your appointment. Please remember to bring this completed questionnaire to your appointment

In many instances, after the Home Sleep Test is interpreted by one of our board certified physicians, you may need to have an In-Lab Sleep Study (Polysomnography) to either assess your sleep problems further or to assess the appropriate therapy (a Positive Airway Pressure (PAP) device or a Mandibular Advancement Device (MAD) needed to ensure proper treatment is achieved.

Sleep Therapy & Research NW
5290 Medical Drive
San Antonio, TX 78229
210-614-6000
Office Hours: 8:30 am - 5:00 pm

Thank you for choosing Sleep Therapy & Research Center for your sleep evaluation.

HEALTH INSURANCE INFORMATION	
INSURANCE COMPANY	
NAME OF POLICY HOLDER	
POLICY #	
GROUP #	

DATE ______________________

PATIENT INFORMATION			
Last name			
First name			
Address			
City / State / Zip	CITY	STATE	ZIP
Phone	( ) -	Alternate Phone	( ) -
Gender (check one)	☐ M / ☐ F / ☐ T		
Birth Date:	/ /	Referring Provider	Provider's Fax # ( ) -
EMAIL ADDRESS			

OFFICE USE ONLY		
HEIGHT	WEIGHT	NECK SIZE
in.	lbs.	in.
B/P	PULSE	O2 SAT%
/		%

Bed Time	Wake Up Time	Minutes to Fall Asleep	Number of Times You Wake Up During Sleep	Total Hours of Sleep
: am/pm	: am/pm	minutes	X per night	hours

PLEASE TURN FORM OVER AND FILL IN QUESTIONNAIRE COMPLETELY

NAME	

PLEASE LIST ALL MEDICATIONS INCLUDING OVER THE COUNTER MEDS AND SUPPLEMENTS			
1		11	
2		12	
3		13	
4		14	
5		15	
6		16	
7		17	
8		18	
9		19	
10		20	

MEDICATION ALLERGIES							
1		3		5		7	
2		4		6		8	

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or 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:

CHANCE OF DOZING

- 0 = no chance of dozing
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

SITUATION	YOUR 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	

SLEEP HISTORY QUESTIONNAIRE (check all that apply)

MEDICAL	SLEEP APNEA	INSOMNIA	RESTLESS LEG	NARCOLEPSY
☐ None	☐ None	☐ None	☐ None	☐ None
☐ Acid Reflux	☐ Previous Sleep Apnea	☐ Difficulty Initiating Sleep	☐ Urge to Move Legs	☐ Feel weak w/ laughing / angry
☐ Airborne allergies	☐ Wear CPAP / BiPAP	☐ Difficulty Maintaining Sleep	☐ Sensations in Legs	☐ Vivid Dreams
☐ Angina / Chest Pain	☐ Overweight / Obesity	☐ Unrefreshed Sleep	☐ Worse at rest / night	☐ Hallucinations
☐ Anxiety	☐ Gasping	☐ Early A.M. Awakening	☐ Better with exercise	☐ Feel Paralyzed when Wake Up
☐ Arthritis	☐ Snoring	☐ Difficulty Concentrating	☐ Leg movements in sleep	☐ Automatic behavior & unaware it (“spaced-out” – e.g. while driving)
☐ Asthma	☐ Daytime Sleepiness	☐ Impaired Thinking	☐ Leg Cramps	
☐ Cancer	☐ Falls Asleep Driving	☐ Moody	☐	☐ Head Injury / Concussion
☐ Chronic pain	☐ Witnessed Apnea	☐ Caffeine Use	**PARASOMNIAS**	**CIRCADIAN RHYTHM**
☐ COPD	☐ Morning Headache	☐ Alcohol Use	☐ None	☐ None
☐ Depression	☐ Night Sweats	☐ Illicit Drug Use	☐ Teeth Grinding / Clenching	☐ Shift Work
☐ Diabetes	☐ Urination at night > 2X	☐ Decongestants	☐ Sleepwalking	☐ Go to Sleep too late 2 – 4 am
☐ Heart Attack (MI / CAD)	☐ EPWORTH =	☐ Pain	☐ Nightmares	☐ Go to bed too early 6 – 8 pm
☐ High Blood Pressure	☐ Enlarged Tonsils / Adenoids	☐ Too much Thinking in bed	☐ Night Terrors	☐ Irregular sleep - Catnap throughout day and night
☐ High Cholesterol	☐ Nasal Fx / Deviated Septum	☐ Noises	☐ Act Out Dreams	
☐ Hypothyroidism	☐ Nasal Congestion	☐ Bedpartner	☐ Bed Wetting	☐ Jet Lag
☐ Fibromyalgia	☐ Dry Mouth	☐ Worry in bed	☐	☐ Free Running (Blind individuals)
☐ Smoking				
☐				