773- SDC-8(10-16-15) MR Form

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label

Name: _____

DOB: _____

M#:_____

Quest

PATIENT QUESTIONNAIRE

PLEASE USE THE PRE-PAID ENVELOPE PROVIDED TO RETURN THE
FOLLOWING COMPLETED QUESTIONNAIRE PRIOR TO YOUR APPOINTMENT.

_____ _____ _____
NAME DOB HOME PHONE

_____ _____
ADDRESS WORK PHONE

_____ _____ _____
CITY STATE ZIP

_____
REFERRING PHYSICIAN

My main sleep complaint is:

- ❑ **I have trouble sleeping at night.**
- ❑ **I am sleepy all day.**
- ❑ **I have unwanted sleep behaviors when I am asleep.**

Please explain: _____

_____

_____

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SEARLE GLOBAL SLEEP ASSESSMENT QUESTIONNAIRE

Developed by Buysse DJ, Young T, Roth T, Simon RD Jr., Dement WC, Kushida CA, and Walsh JK

Instructions: Answer the questions below by writing on the line provided or circling the most correct answer. Please select only one answer for each question.

Name: _____ Employment Status: ❑ Day shift ❑ Night Shift ❑ Rotation shift ❑ Retired ❑ Unemployed ❑ Part-time ❑ Homemaker ❑ Disabled

Age: _____ Height: _____ Weight: _____ Gender: ❑ Male ❑ Female

Family Physician: _____ Referring Physician: _____

❑ Smoker How many packs per week? _____ How many years? _____

❑ Non-Smoker

Over the past month, have you had any major traumatic or stressful event(s) that you feel affected your sleep? If so, please describe: _____

Over the past month

1. How would you rate the quality of your sleep?
   Very good Fairly good Fairly poor Very poor

2. a.) What time did you go to bed on workdays? _____
   b.) What time did you get out of bed on workdays? _____

3. a.) What time did you go to bed on non-workdays? _____
   b.) What time did you get out of bed on non-workdays? _____

4. How many nights did you have trouble falling asleep or staying asleep?
   Zero 1-5 6-15 More than 15

5. Approximately how many minutes did it usually take you to fall asleep once you decided to sleep?
   0-5 minutes 5-30 minutes 31-60 minutes Over 60 minutes

6. Approximately how many times did you typically awaken each night?
   0-1 2-3 4-5 More than *5*

7. How often did you fall asleep or fight to stay awake during the daytime?
   0 times/week 1-2 times/week 3-4 times/week More than 4 times/week

8. How much did you worry about sleep or problems sleeping?
   Not at all A little bit Quite a bit All the time

9. Approximately how many hours of sleep did you actually get each night, not counting time awake?
   Less than 6 hours Between 6 hours and 8 hours Between 8 hours and 10 hours

10. Approximately how much time did you typically spend awake in bed each night?
    More than 10 hours Less than 30 minutes 31 -60 min 1-2 hours More than 2 hours

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11. How often did you feel fatigued, but not sleepy during the daytime?
0 times/week 1-2 times/week 3-4 times/week More than 4 times/week

12. How often did you snore (based on your own knowledge or what others have told you)?
Never Rarely Sometimes Often Nightly

13. How loudly did you snore (based on your own knowledge or what others have told you)?
None Softly Somewhat loudly Loudly Very loudly

14. How often did you hold, pause, or stop breathing in your sleep (based on your own knowledge or what others have told you)?
0 times/night 1-2 times/night 3-4 times/night More than 4 times/night

15. How often did you have restless or "crawling" feelings in your legs at night that went away if you moved your legs?
0 times/night 1 -2 times/night 3-4 times/night More than 4 times/night

16. How often did you have repeated leg jerks or leg twitches at night (based on your own knowledge or what others have told you)?
0 times/week 1-2 times/week 3-4 times/week More than 4 times/week

17. How often did you scream, walk, or punch in your sleep (based on your own knowledge or what others have told you)?
0 times/week 1 -2 times/week 3-4 times/week More than 4 times/week

18. How many caffeinated beverages (coffee, cola, etc.) did you typically consume per day?
None 1-7 /day 8-14 /day More than 14/day

19. How many drinks containing alcohol did you typically consume per day?
None 1-7 /day 8-14 /day More than 14/day

20. How many prescription or non-prescription medications (except vitamins, aspirin, or dietary supplements) did you take for any purpose on a daily basis?
0-1 2-3 4-5 More than 5

21. How many times did you take a prescription or non-prescription medication for sleep?
Zero 1-6 nights 7-15 nights More than 15 nights

22. In general, how would you rate your health?
Excellent Very good Good

23. Have health problems affected your ability to perform daily activities?
Not at all A little bit Quite a bit

24. How sad or anxious have you felt?
Not at all A little bit Quite a bit

25. How much have you enjoyed your usual activities?
Completely Quite a bit A little bit

26. How often did a poor night's sleep interfere with your activities the next day?
Never Rarely Sometimes Often Nightly

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Epworth Sleepiness Scale©

In the past month or so, how likely are you to doze off or fall asleep in the following situations?

0 = never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing	
1. Sitting and reading	
2. Watching TV	
3. Sitting inactive in a public place (i.e. a theatre or meeting)	
4. As a passenger in a car for an hour without a break	
5. Lying down to rest in the afternoon, when circumstances permit	
6. Sitting and talking to someone	
7. Sitting quietly after a lunch without alcohol	
8. In a car stopped for a few minutes in traffic	
	Total /24

Medication	For what?	Dosage	How often?	How long?

Summary:

Briefly describe the nature of your sleep/wake complaint, as well as anything else that interferes with your sleep or daytime wakefulness. Also, add any pertinent information that your physician should know about your sleep:

_____

_____

_____

_____

_____

BOZEMAN HEALTH DEACONESS HOSPITAL

Patient Label

Consent

Name: _____

DOB: _____

M#:_____

Sleep Disorders Center Consent for Treatment

Consent for treatment: The Sleep Disorders Center uses a variety of leads and monitoring devices in order to record your sleep. These include, but are not limited to:

1. EEG Electrodes—small electrodes placed on the scalp in order to monitor brain waves (the number of these leads may vary depending on the type of study we are running).
2. EOG Electrodes—small electrodes taped outside of the eyes used to monitor eye movements.
3. EMG Electrodes—small electrodes used to monitor muscle tension in different areas of the body, usually, the chin and front of both legs.
4. Nasal/Oral Airflow Pressure Sensors—devices used to monitor airflow or pressure through the nose and mouth.
5. Thoracic and Abdominal Effort Belts—flexible belts worn around the chest and abdomen that measure the rise and fall of the chest and abdomen.
6. EKG Electrodes—small electrodes used to record the heart rhythm; typically, we use two electrodes which are placed on front of the chest.

Additional devices, which are sometimes used, will be explained as needed include CPAP/BIPAP. These are devices that are often used to treat sleep apnea. A small mask is worn over the nose and is connected to a small machine that delivers air pressure to maintain patency in the airway.

Please initial the following:

_____ I understand that I will be billed separately for the Sleep Center physician's professional component as described in the Sleep Disorders Center packet.

_____ I hereby consent to the use of audio/video monitoring/recording during my stay in the Sleep Disorders Center. I understand that these recordings are used to aide in the diagnosis and treatment of sleep disorders and that they are to be kept by the Sleep Disorders Center for a period of time (up to ten years). Recordings will be destroyed at the end of the archival period.

_____ I consent to the release of information pertinent to my care from my referring physician to the Sleep Disorders Center.

I certify that I have read the above information and as the patient, or one who is duly authorized to act in a representative capacity of the patient, that the information has been fully explained, that I understand its contents, that it may not be modified and that I may withdraw my consent for services at any time.

_____ _____

Patient/Guarantor Signature Date

Reason patient is unable to sign:

_____ _____ _____

Date Witness