



# Littleton, CO Welcome Packet

8151 Southpark Lane, Suite 200 • Littleton, CO 80120

Fax: (303) 957-5414 OR 720-542-8699 Phone: (303) 396-5923 Email: office@mountainsleepdiagnostics.com

***For any after-hours questions, please call (303) 956-5145***

Dear Mountain Sleep Patient,

You have been scheduled for a sleep study at 8151 Southpark Lane, Suite 200, Littleton, CO 80120.

Please fill out the attached form and bring it with you and also bring your insurance card and a photo ID.

You will sleep in a private room that is set up very similar to a hotel room. You should be done with the study and free to go home between 5:30 and 6:00 AM.

You will need to do the following for the most accurate results of your sleep study:

- Avoid caffeine and naps after 2:00 PM for the day of your study.
- Wear comfortable clothing to sleep in.
- Do not wear hair gel, hairspray, make-up, lotion, or nail polish.
- Take all prescribed medications as you normally do.
- The center has pillows and blankets, but you are welcome to bring your own.

Please call us if any scheduling conflicts should arise. We do require 48-hours notice if you should need to cancel. If less than that is given, you could be subject to a \$100 cancellation fee.

**FOR ANY AFTER-HOURS QUESTIONS AND/OR EMERGENCIES PLEASE CALL (303) 956-5145**

Thank you,

Mountain Sleep Diagnostics  
(303) 396-5923



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The Littleton Sleep Center is located at 8151 Southpark Lane, Suite 200, Littleton, CO 80120.

***The phone number is 303-956-5145 after 8pm if you are delayed or cannot find the Sleep Center***

## Directions:

From Broadway and County Line, go west on County Line to Southpark Lane (Just past Southpark Terrace).

Turn right onto Southpark Lane, and take the first left past Quest Diagnostics onto West Canal Court.

Take a right at the stop sign and take the second right into the parking lot to find Suite #200, located next to the physical therapy office.





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## SLEEP HISTORY

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Study: \_\_\_\_\_ Race/Ethnicity: \_\_\_\_\_

Social security number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Residence Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Neck Size: \_\_\_\_\_ in. Gender:  Female  Male

Spouse or emergency contact(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician(s): \_\_\_\_\_

## CHIEF COMPLAINT

Check any of the following that apply:

- Loud snoring
- Breathing or snoring stops for brief periods in my sleep
- Awaken gasping for breath
- Do not feel restored when I awaken

Become sleepy during the day (*please circle any/all that apply*)

- sitting  talking  riding  eating  driving  standing
- Difficulty falling asleep  Difficulty remaining asleep  Awaken too early

My MAIN sleep problem has bothered me:

- Less than 12 months  Greater than 1 year

## SLEEP TREATMENT (*please check answer*)

I have had a nocturnal pulse oximetry test:  Yes  No If yes, when? \_\_\_\_\_

I have had a sleep study:  Yes  No If yes, when and where?  
\_\_\_\_\_

I was previously diagnosed with Sleep apnea:  Yes  No If yes, when and where?  
\_\_\_\_\_

I still have my tonsils and adenoids:  Yes  No When removed? \_\_\_\_\_

I have been told I have a deviated septum:  Yes  No ENT surgery is an option:  Yes  No



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## MEDICAL HISTORY

Please check if you have had any of the following:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Morbid Obesity  | <input type="checkbox"/> Hypoventilation               |  |
| <input type="checkbox"/> Chronic Lung Disease   | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Depression                    |  |
| <input type="checkbox"/> Insomnia   | <input type="checkbox"/> Disturbed Sleep | <input type="checkbox"/> Erectile Dysfunction          |  |
| <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> Restless Legs   | <input type="checkbox"/> Excessive Sleepiness          |  |
| <input type="checkbox"/> Snoring  | <input type="checkbox"/> Low Oxygen      | <input type="checkbox"/> Morning Headaches             |  |
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Fibromyalgia                  |  |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Frequent night time urination |  |
| <input type="checkbox"/> Pain which disrupts sleep. The typical location(s) for this pain is/are: |  |  |  |
| <input type="checkbox"/> Headaches  | <input type="checkbox"/> Neck            | <input type="checkbox"/> Back                          | <input type="checkbox"/> Chest             |
| <input type="checkbox"/> Leg  | <input type="checkbox"/> Abdominal       | <input type="checkbox"/> Pelvic                        | <input type="checkbox"/> Joint (arthritis) |

Other medical problems which may affect sleep (please list):

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## MEDICATION

Do you take anything to help you sleep?  Yes  No

If yes, what? \_\_\_\_\_ How often? \_\_\_\_\_

List current medications and dosages, including both prescriptions and over-the-counter medications:

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## SOCIAL HISTORY

Do you smoke?  Yes  No Did you previously smoke?  Yes  No

If yes, how many years of smoking? \_\_\_\_\_ How much per day? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_ drinks per  day  week  month

How much caffeinated coffee, tea or cola do you drink daily? \_\_\_\_\_

What activity level do you expend at work?  Heavy  Moderate  Light  Sedentary

## ENVIRONMENT (Check one)

Is your bedroom  Loud or  Quiet;  Light or  dark

Is your mattress  Soft  Hard  Just Right

Do you go to sleep with the television on?  Yes  No

Is your sleep disturbed because of your bed partner or others in your household (children or pets)?

Yes  No



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Indicate ON AVERAGE how often you experience the following symptoms especially when sleeping or trying to sleep:

*Number of times per week*

None	1-3	4-6	Daily	Symptom
				My mind races with many thoughts when I try to fall asleep
				I often worry whether or not I will be able to fall asleep
				Fatigue
				Anxiety
				<b>Memory impairment</b>
				Inability to concentrate
				Irritability
				Depression
				Awaken with a dry mouth
				Morning headaches
				Pain which delays or prevents my sleep
				Pain which awakens me from sleep
				Vivid or lifelike visions (people in room, etc) as you fall asleep or wake up
				Inability to move as you are trying to go to sleep or wake up
				Sudden weakness or feel your body go limp
				Irresistible urge to move legs or arms
				Creeping or crawling sensation in your legs before falling asleep
				Legs or arms jerking during sleep
				Sleep talking
				Sleep walking
				Nightmares
				Fall out of bed
				Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
				Bed wetting
				Frequent urination disrupting sleep
				Teeth grinding
				Wheezing or cough disrupting sleep
				Sinus trouble or nasal congestion interfering with sleep
				Shortness of breath disrupting sleep



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## EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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 with someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total	