



Glenwood Springs, CO Welcome Packet

1517 Blake Ave, Suite 202, Glenwood Springs, CO 81601

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 1517 Blake Ave, Suite 202, Glenwood Springs Co 81601

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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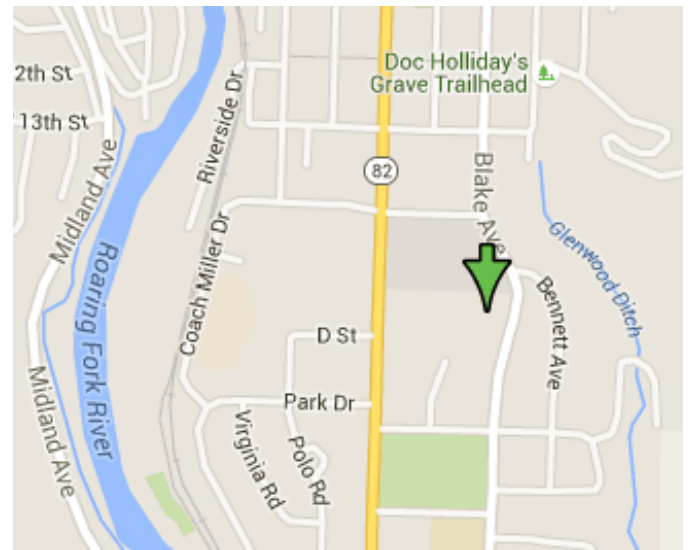
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The Glenwood Sleep Center is located at 1517 Blake Ave Suite 202, Glenwood Springs, CO 81601.

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

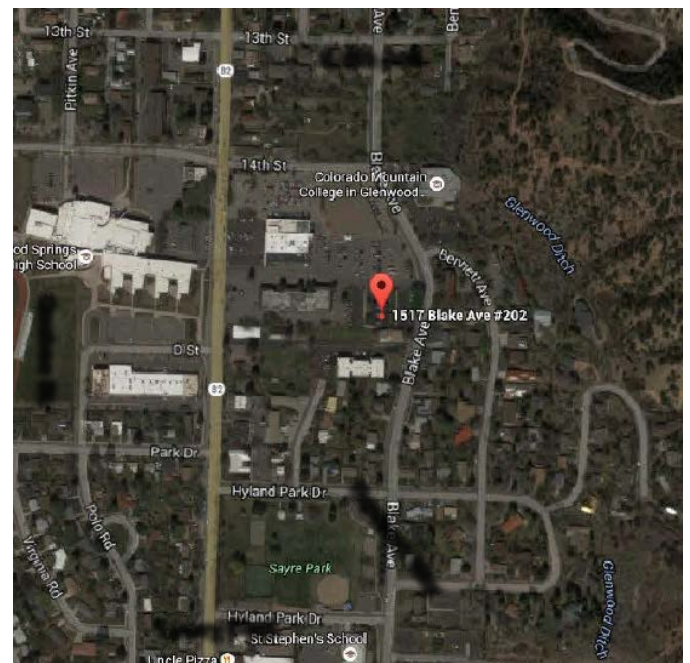
Directions from West Colorado:

- Merge onto East I-70
- Exit CO-82 (Grand Ave) East (Exit 116)
- Take Grand Ave to 14th St
- Turn left onto 14th St.
- Turn right onto Blake Ave.
- Destination will be on your right.
- Our Sleep Lab is located on the second floor and parking is available for this level on the east side of the building.



Directions from East Colorado:

- Merge onto West I-70 towards Glenwood Springs
- E CO-82 (Grand Ave) East (Exit 116)
- Take Grand Ave to 14th St
- Turn left onto 14th St.
- Turn right onto Blake Ave.
- Destination will be on your right.
- Our Sleep Lab is located on the second floor and parking is available for this level on the east side of the building.





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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):

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:

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
				Memory impairment
				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	