



Common Wealth Sleep Center

4660 Kenmore Ave, Suite 900, Alexandria, VA 22302

Phone: 571-261-9877 | Fax: 571-248-0583

[CONTACT US](http://www.commonwealthsleepcenter.com) | www.commonwealthsleepcenter.com



SLEEP STUDY REGISTRATION FORM



PATIENT INFORMATION

Prefix/Suffix: _____ Patient Name: _____ Middle Name _____

Today's Date: ___/___/___ Sex: Male / Female / Transgender Date of Birth: ___/___/___

Age: _____ Social Security #: ____-____-____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: ____-____-____ Work Phone #: ____-____-____ Mobile Phone #: ____-____-____

Email Address: _____ Marital Status: Single Married Divorced Widow

Occupation: _____ Employer: _____



INSURANCE INFORMATION

Primary Insurance Name: _____ Insurance Co: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's DOB: ___/___/___

Secondary Insurance Information

Policy Name #: ____-____-____ Policy #: _____ Group #: _____



REFERRING PROVIDER INFORMATION

Referring Physician Name: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Phone Number #: ____-____-____ Fax #: ____-____-____

Family Physician (If different from Referring): _____

Family Physician's Name: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Phone Number #: ____-____-____ Fax #: ____-____-____





SCREENING QUESTIONS - SLEEP HISTORY

Patient Name: _____

Date of Birth: ____/____/____

Height: _____ (in inches) Weight: _____ (in LBS) Neck size: _____ (in cms) BMI _____

Have you ever had a sleep study? Yes No

If YES, please provide us the sleep study reports.

Are you currently using CPAP / BiPAP? Yes No

If YES, SKIP the section #1 & #2, **Go to section #3.**

What is your primary sleep problem?

How long have you had that problem?

What time do you usually go to bed and getup?	Weekdays	Go to bed	AM	PM
		Get up	AM	PM
	Weekends	Go to bed	AM	PM
		Get up	AM	PM

How many nights a week do you get:			
8+ hours of sleep?	7 hours of sleep?	6 hours of sleep?	5 or less hours of sleep?
_____ nights	_____ nights	_____ nights	_____ nights
How often do you nap?	/ week	For How Long?	/ min
Do you wake up feeling refreshed?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have excessive daytime sleepiness?	<input type="checkbox"/> Yes <input type="checkbox"/> No		



Section 1: Screening questions for SLEEP APNEA:

Do others complain about your snoring?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has anyone witnessed you during an apneic event? (Have you period when there is no snoring followed by a loud snort to a body jerk?) If so, how often?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you awaken from sleep short of breath or with a feeling of being choked?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have nighttime sweating?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have morning headaches?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have multiple nocturnal awakenings? What wakes up, when, how many times a night?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Weight gain or loss over the past 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 2: EPWORTH SLEEP 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 and indicate 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	Change of Dozing
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place (ie., school or movie)	
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 lunch	
In a car, while stopped for a few minutes in traffic	
Total (Range 0-24):	

Section 3: Screening questions for NARCOLEPSY

Includes the uncomfortable urge to sleep during the day, especially during emotional events
(feeling happy, sad, or mad)?

Do you feel your knees buckle, arms feel weak, or jaw drop with strong emotions? (Cataplexy)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you experience vivid dream-like episodes or scenes upon awakening or falling asleep that you can't tell whether they are real or not? (Hypnagogic Hallucinations)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you feel paralyzed when waking or falling asleep? (Sleep Paralysis)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you fall asleep at inappropriate times or experience sleep attacks?	<input type="checkbox"/> YES <input type="checkbox"/> NO



**Section 4: Screening questions for
RESTLESS LEG MOVEMENTS SYNDROME / PERIODIC LEG OF SLEEP**

Do you have leg cramps at bedtime?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you experience crawling and achy feelings in your legs during the day or night which makes you want to move them or	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you notice that these feelings in your legs are worse at night time?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do the symptoms occur with (or are worsened by) rest?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have relief with movement?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you wake yourself with body jerks (arms or legs)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you been told that your legs or arms move every 20 seconds or so during the night?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are your bedcovers in total disarray in the morning?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 5: Screening questions for PARASOMNIAS

(or things that go "bump" in the night including REM behavior disorder and include disorders of sleep walking or sleep talking)

Do you have nightmares?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you often move violently during your sleep while dreaming, and sometimes even hurt yourself or your partner by accident or fall out of bed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you been told you sleepwalk?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you been told you arouse from sleep totally confused or are inconsolable?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you awakened feeling panicked with your beating uncontrollably?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a history of seizures?	<input type="checkbox"/> YES <input type="checkbox"/> NO



Section 6: Screening questions for INSOMNIA

Check if you are currently diagnosed with:

Depression

Anxiety

Do you routinely require more than 30 minutes to fall asleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you wake up several times during the night and can't get back to sleep? What causes you to wake up? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you often wake up one or two before scheduled wake time and can't get back to sleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have thoughts racing through your mind while trying to fall asleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you read, watch TV, or use a laptop in bed?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you deliberately sleep less in order to do other things? If yes, please specify: _____ nights/week _____ hrs/night	<input type="checkbox"/> YES <input type="checkbox"/> NO
When you try to sleep, does worrying or problem solving often keep you awake?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you often lose sleep because your bed partner disturbs you at night?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 7: Screening questions for CIRCADIAN RHYTHM DISORDER

Do you have trouble waking up in the morning and would rather stay up later (ie. Sleep at 2-3AM and wake up at noon?) (Delayed Sleep Phase - more common in adolescents)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have to go to bed at 8PM only to find out that you wake up at 3AM? (Advanced Phase Syndrome - more common in elderly)	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does your job require you to work different shifts?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 8: Screening questions for BRUXISM

Do you have morning jaw pain?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you grind your teeth during sleep?	<input type="checkbox"/> YES <input type="checkbox"/> NO



Section 9: Other - WEIGHT LOSS AND WELLNESS

Are you concerned about your weight?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had significant weight loss? How much and over what period of time?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you had significant weight gain? How much and over what period of time? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 10: Other - NASAL OR BREATHING OBSTRUCTION

Do you have problems breathing through your nose especially at night?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the nasal blockage come and go?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is your nasal blockage constant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is one side always worse than the other?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Section 11: SOCIAL HISTORY

Caffeine consumption: How much per day? _____ cups/day
When do you typically consume your last serving of coffee? _____ AM /PM
Alcohol consumption: Type of drink: _____ How many times? _____ / wk
How many hours before bed? _____
Smoking habits: How many packs per day? _____ Over how many years? _____

Section 12: FAMILY HISTORY

Have any members of your family (blood kin) had:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart disease		
High blood pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have any immediate family members been diagnosed with or treated for a sleep disorder? If yes, please explain: _____ _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	



Section 13: ALLERGIES

No Known Allergies Other

Section 14: PERSONAL MEDICAL HISTORY

Arrythmia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Congestive Heart Failure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
COPD	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Coronary Artery Disease	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dementia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Attack	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hypertension	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Migraine	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Neuromuscular Impairment	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other medical history: _____ _____		

Section 15: SURGICAL HISTORY

Please choose any Head / Nose / Throat / Surgeries

Tonsillectomy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Adenoidectomy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sinuplasty	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Uvulopalatopharyngoplasty (UPPP)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Septoplasty	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any other Major surgical history: _____ _____		





SLEEP STUDY INSTRUCTIONS

What to bring:

- Photo ID (Driver's license)
- Insurance Card (s)
- Bed clothes. Bring something comfortable to sleep in, including a bathrobe and slippers. Keep in mind that both male and female technicians may monitor your sleep study.
- Toiletries. Bring whatever you need to spend night away from home (tooth brush, tooth paste, soap, etc.).
- All your medications.

Before your study:

- Do not take any naps the day of your sleep study if possible.
- Do not consume any alcohol or caffeine after 12pm (noon) the day of your sleep study.
- Take a shower prior to arriving for your sleep study and do not apply any hair care products (hair gel, hair spray, oils).
- Do not wear make-up or use heavy creams on your face the night of the study.

What to expect:

- The sleep study is a combination of several diagnostics tests all recorded simultaneously during sleep.
- Brain wave activity (EEG) will be recorded by attaching electrodes with adhesives and paste around the head.
- Additional sensors are placed on your chest, legs, finger and below your nose.
- All sensors are painless and will still allow you to sleep in any position you want.
- You will also be able to move around and get out of bed with the sensors (i.e. – to use the bathroom).
- The sleep technician will greet you once you arrive and will be able to answer any questions or concerns you have with the procedure.



FREQUENTLY ASKED QUESTIONS

»» What is a sleep study?

A sleep study contains 16 or more different measurements used for monitoring your sleep patterns. These measurements are primarily EEG (brain wave activity) and respiratory (breathing). The study will record for 6 or more hours while you sleep. Your sleep technician will greet you when you arrive and will explain the procedure as he/she is applying the necessary measurement sensors. The procedure for applying the sensors will usually take between 30 minutes to 50 minutes.

»» What are the sensors used for the sleep study?

The measurements are:

- EEGs - 6 sensors placed in your scalp area held in place with a water-soluble paste or adhesive. Your hair is not cut or shaved and the leads are painlessly placed and removed in the morning. These sensors are the main sensors used in determining if you are asleep or awake. If asleep, there are 4 different stages of sleep that are registered and recorded on the computer.
- Eye movements - 2 sensors, one near each eye but not touching your eyes in any way. Each sensor is applied with an adhesive. Eye movements are also used in determining the different stages of sleep.
- Muscle activity - 2 or 3 sensors applied on your chin or jaw line. These sensors are also applied with an adhesive and are used in determining the different stages of sleep.
- ECG - 2 sensors placed near the left and right shoulder/chest area. These sensors are applied with adhesives and measure your heart's activity during the study.
- Leg movements - 4 sensors, two sensors each placed on the left and right leg around your calf/shin area applied with adhesives. These sensors measure leg movement activity during your sleep.
- Breathing - 2 sensors placed under the nose and above your upper lip used to determine your breathing patterns during the study. One sensor is a soft plastic wire sensor w/ prongs just under each nostril and over your mouth. This sensor acts as a thermometer recording air you breathe in (cold air) and air you breathe out (warm air) and is recorded as a waveform.
- Oximeter - a sensor placed on your finger used to record the oxygen level in your blood. This sensor is placed with adhesive and a low illuminating red light is used to read the level of oxygen.
- Breathing effort - Two belts placed one around your chest and one around your stomach used to determine your breathing effort by stretching and contracting as you breathe in and out during your sleep study.



FREQUENTLY ASKED QUESTIONS (con'd)

»» Will you give me any medication to help me sleep?

No. This might change your sleep patterns and prevent us from identifying the source of your sleep problem. However, you may take whatever medication you usually take before bedtime. Be sure to inform the technician running your sleep study of what medications you are taking.

»» What happens if I need to go to the bathroom in the middle of the night?

All sensors are attached to a central box which you will be able to carry with you once detached from the main computer cable. This is a very simple process and can be done in a few seconds to allow you mobility to use the restroom whenever needed.

»» Will anyone else be in the sleep laboratory while I am there?

A technician will greet you once you arrive at the sleep lab and show you to your room. A member of our technical staff will be present and available to you during your entire night at the sleep lab as well as possibly other patients who will also be at the lab for sleep testing purposes.

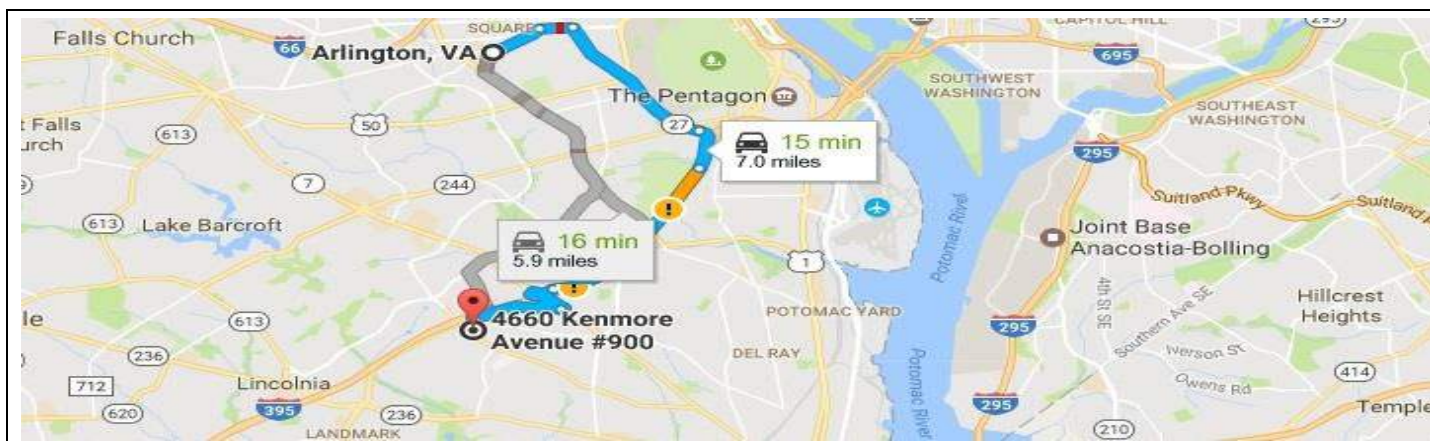
»» When can I leave?

Usually the sleep study will end between 05:00 AM and 07:00 AM. Removal of the sensors usually takes just a few minutes and once done, you may leave at any time thereafter. There will also be a short morning questionnaire. If you need to be up earlier, please notify the technician.



Google Maps & Directions for CSC, Alexandria Medical Center

4660 Kenmore Ave, Suite 900, Alexandria, VA 22302



FROM ARLINGTON, VEINNA or FAIRFAX

Go to Leesburg Pike/VA-7 E. Continue to follow VA-7 E. towards Old Town Alexandria
 1. Turn slight right onto N Beauregard St.
 left Seminary Rd
 0.5 mi Turn left onto Library Ln
 164 ft Turn left
 Destination will be on the left o

FROM Interstate 495

Go onto I-395 S
 Take exit 57B for Interstate 395 N toward Washington
 0.9 mi Merge onto I-395 N
 3.6 mi 16. Take exit 4 for Seminary Rd
 164 ft Turn left
 Destination will be on the left

If you have any questions please call at phone # 571-261-9877 or fax at 571-248-0583 or [click here to email us](#)

