The Center for Sleep Medicine
579 Franklin Turnpike
Ridgewood, NJ 07450
201-251-3487
201-251-3490 fax
www.valleyhealth.com/sleep

The Valley Hospital
Valley Health System

Instructions For the Day of Your Testing

When you come to our Center, please abide by the following:

- Arrive already showered. Private shower facilities are available for you in the morning, as well as hair dryers upon request.
- Your hair must be dry (no oils, gels or sprays).
- Men must be clean shaven. If you have a full beard, do not shave.
- Please take your regular medications as you normally would. The exception is any medication you take for sleep. Sleeping medications are to be taken once you are here at the Center and ready for bed.
- Please limit your caffeine and/or smoking the day of the test.

Please bring the following items with you:

- Driver's license
- An up-to-date Insurance card
- An insurance referral, if your insurance requires one
- The enclosed Epworth Sleepiness Scale, Patient Questionniare, and Pre-Sleep Questionnaire
- A robe (optional)
- Slippers
- Sleeping apparel (no silk or satin)
- Personal toiletries (soap, shampoo, and toothpaste are available in your room.)
- You may bring your own pillow if you wish.
- If you are diabetic, please bring your Accu-check machine.

For your convenience, the Center offers snacks and beverages, and a light breakfast.

Patients are welcome to schedule a guided tour of our facility and/or view a video explaining the tests we perform at the Center.

After your test:
Please follow up with your doctor two to four weeks after your test for your results.

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EPWORTH SLEEPINESS SCALE

Name:

Date _____/_____/_____ Age: Sex

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 **single *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 such as a theater or 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 Score (add all responses): _____

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Patient Questionnaire

Name:

Date _____/_____/_____

Are you planning on having surgery in the next year? ☐ Yes ☐ No

If yes, explain: _____

Do you have nasal obstruction or sinus problems? ☐ Yes ☐ No

Has your weight increased over the past year? ☐ Yes ☐ No If yes, _____lbs

Has anyone ever told you that you stop breathing when you are asleep? ☐ Yes ☐ No

Have you ever been in an accident or suffered an injury because you have fallen asleep? Yes No

If yes, explain _____

What time do you go to bed? _____ What time do you wake up? _____

How long do you normally sleep? _____

Do you take naps? ☐ Yes ☐ No If so, how often/long do you nap? _____

Do you now or have you ever used cigarettes or other products? ☐ Yes ☐ No

Quantity used per day: _____

Quit? ☐ Yes ☐ No If yes, when _____

Do you now or have you ever used alcoholic beverages? ☐ Yes ☐ No

If so, indicate weekly quantity consumed _____

Quit? ☐ Yes ☐ No If yes, when _____

Do you now or have you ever used caffeinated beverages? ☐ Yes ☐ No

If so, indicate weekly quantity consumed _____

Quit? ☐ Yes ☐ No If yes, when _____

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PRE-SLEEP QUESTIONNAIRE – TO BE COMPLETED EVENING OF YOUR STUDY

Name: Height: Weight:

Date _____/_____/_____

1. What time did you go to sleep last night? _____ □ am □ pm
2. What time did you wake up today? _____ □ am □ pm
3. Approximately how many hours of sleep did you have last night? _____
4. In the past week, how many times has your bedtime varied by more than one hour? _____
5. Has anything out of the ordinary happened to you recently? □ Yes □ No

   If yes, what? _____

6. Did you take any naps today? □ Yes □ No

   If yes, how long? _____ What time? _____

7. Have you had any alcoholic beverages today? □ Yes □ No
8. What time did you last eat? _____ Was this a meal or a snack? _____
9. Have you had any caffeinated beverages or chocolate after 12:00 Noon? □ Yes □ No

   If yes, what, how much, when? _____

10. Do you take prescription medication? □ Yes □ No Please list: _____

_____

Please complete the following right before bedtime:

Do you have any physical complaints at the present time? □ Yes □ No

If yes, what? _____

1. Are you feeling anxious about sleeping in the lab:

   □ Not at all □ Slightly □Moderately □ Very

2. Choose the statement that best describes the way you feel right now:

□ Active, vital, alert, wide awake
□ High level but not at peak, able to concentrate
□ Relaxed, awake, responsive
□ A little foggy, not at peak, let down
□ Fogginess, losing interest in remaining awake, slow