**Brighton, CO Welcome Packet**

191 Telluride St., Suite 5 • Brighton, CO 80601

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**Clear Form**

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 191 Telluride St., Suite 5, Brighton, CO 80601.

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

The Brighton Sleep Center is located at 191 Telluride St., Suite 5, Brighton, CO 80601.

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

E. Bromley Ln. / E. 152nd Ave.

E. Bromley Ln. / E. 152nd Ave.

E. Southern St.

**85**

**76**

Hwy. 7 / E. Bridge St. / E. 160th Ave.

**Brighton**

S. 50th St.

# Directions from Highway 85:

S. Telluride St.

S. 27th Ave.

S. 8th Ave.

S. 4th Ave.

Exit on highway 7 (Bridge Street) and proceed east. Turn right heading south on Telluride St. Telluride is the next stoplight after 27th Ave. Take your first right off of Telluride Street into the Telluride Business Park. We are located in the 1st building (furthest east) in suite 5, Mountain Sleep Diagnostics.

# SLEEP HISTORY

Last Name:

First Name:

Date of Study:

Social security number:

race/Ethnicity:

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

# MEDICAL HISTORY

*Please check if you have had any of the following:*

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

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 |  |

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