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Mountain
Sleep Diagnostics
(AKA Sleep Colorado)

Colorado Springs Welcome Packet

1849 Austin Bluffs Parkway • Colorado Springs, CO 80918

Fax: (303) 957-5414 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 1849 Austin Bluffs Pkwy., Colorado Springs, CO 80918.

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 Staff
(719) 387-8685

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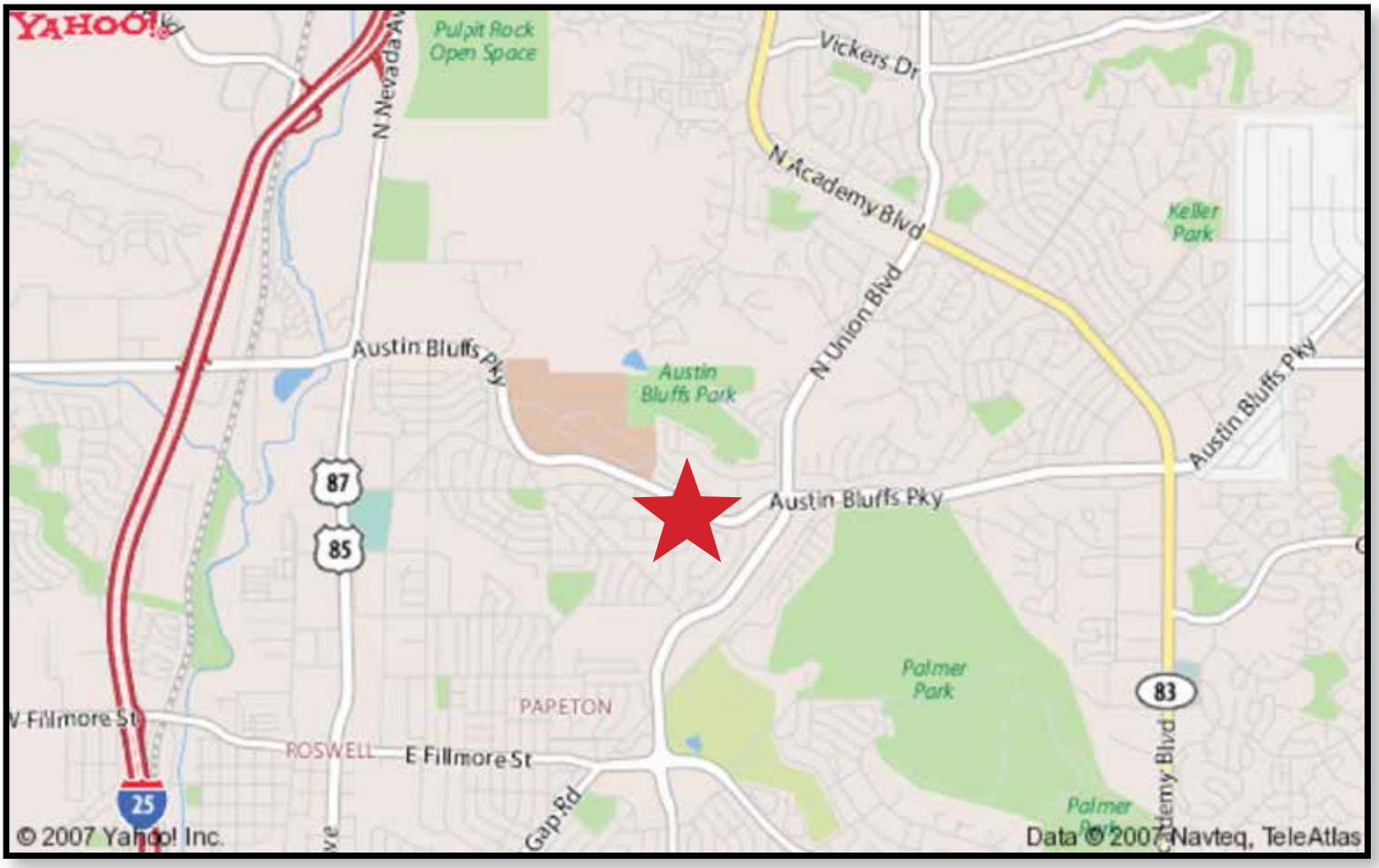
The Colorado Springs sleep center is located at 1849 Austin Bluffs Pkwy., Colorado Springs, CO 80918.

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



Directions:

From Intersection of Austin Bluffs and Union – Proceed West on Austin Bluffs Parkway. Make your first left into College Office Park. The sleep center is the building straight ahead.

From I-25 – Exit on Garden of the Gods Parkway (#146) and proceed East. Garden of the Gods Parkway will become Austin Bluffs Parkway. After passing the UCCS/Meadows signal light, make your next right into the University Office Park. The sleep center is straight ahead.

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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:

☐ 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

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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	

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