MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

SLEEP STUDY INSTRUCTIONS

Dear: _____

Date of study and time: _____ P.M.

Thank you for choosing Mission Sleep Disorders Institute. Following are some guidelines to help assist you in preparation for your sleep study.

Attached you will find registration information, a questionnaire and a daily sleep log for you to complete prior to your appointment. Please bring in the completed questionnaire the night of your sleep study.

Please bring your pajamas or appropriate attire, robe, slippers and any toiletries you may need during the study. We will provide pillows, although you are welcome to bring pillows of your own. Please shower and wash your hair prior to coming in for your sleep study as this will help remove skin oils. Please do not apply any hair spray or creams. In order to monitor your brain waves, heartbeat, respirations, and body movements while you sleep our technologists will apply sensors to your skin surface.

If you are taking any prescribed medications, please continue to take them, unless you are advised otherwise. Please do not bring any valuables with you to your sleep study.

You will be released in the morning before 6:30 am, unless you are scheduled for daytime nap testing. There is a **$6.00 charge for overnight parking.**

If it becomes necessary to cancel or reschedule your appointment, please notify us as soon as possible so we may reassign your appointment to another patient. If you cancel a scheduled study without giving 24 hours notice, you will be charged a $200.00 cancellation fee so that we may cover expenses.

Mission Sleep Disorders will call your insurance company to verify if your sleep study test needs to be authorized. For your coverage benefits, please call your insurance company and refer to CPT codes 95810, 95811. If you are staying for nap tests the next day an additional code is 95805.

MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

INFORMATION REGARDING YOUR SLEEP STUDY

Information Regarding Your Sleep Study

At Mission Sleep Disorders Institute we are committed to providing you with as comfortable of a visit with us as possible. From the latest technologies to relaxed and home-like surroundings, we strive to make your stay pleasant.

Our Registered Polysomnographic Technologists, (RPSGT), are trained in the procedures of sleep recordings and are able to answer any questions you may have regarding your sleep study. They are thoroughly qualified at applying sensors and operating the monitoring equipment used during your sleep study. They are not, however, able to answer specific questions about your sleep complaint or resulting diagnosis. Please make the necessary arrangements to receive your results from your referring physician.

During your sleep study it may become necessary for Continuous Positive Airway Pressure (CPAP) to be utilized at some point during the night. If so, all relevant information will be given to your referring physician. This will consist of the pressure setting used and your mask size. CPAP is the most successful and commonly used method in treating sleep disorders such as sleep apnea. Your RPSGT will explain in full the details of CPAP, if and when it is indicated.

As you sleep, CPAP will calmly deliver air into your airway through an expressly designed mask, as mentioned above, that fits over your nose. Enough pressure will be created to keep your airway open and provide instantaneous relief from sleep apnea and snoring. CPAP does not breathe for you; rather it allows you to breathe at a rate that is normal.

Nearly all our patients find that they become used to wearing the mask just after a short time, and have little or no complications while sleeping. Your RPSGT is specifically educated in the use of CPAP and is able to answer most questions that you may have. If a diagnosis of sleep apnea is made, your referring physician or sleep specialist may make a recommendation for CPAP therapy for treatment of sleep apnea.

We look forward to seeing you and hope that you find the experience a positive one.

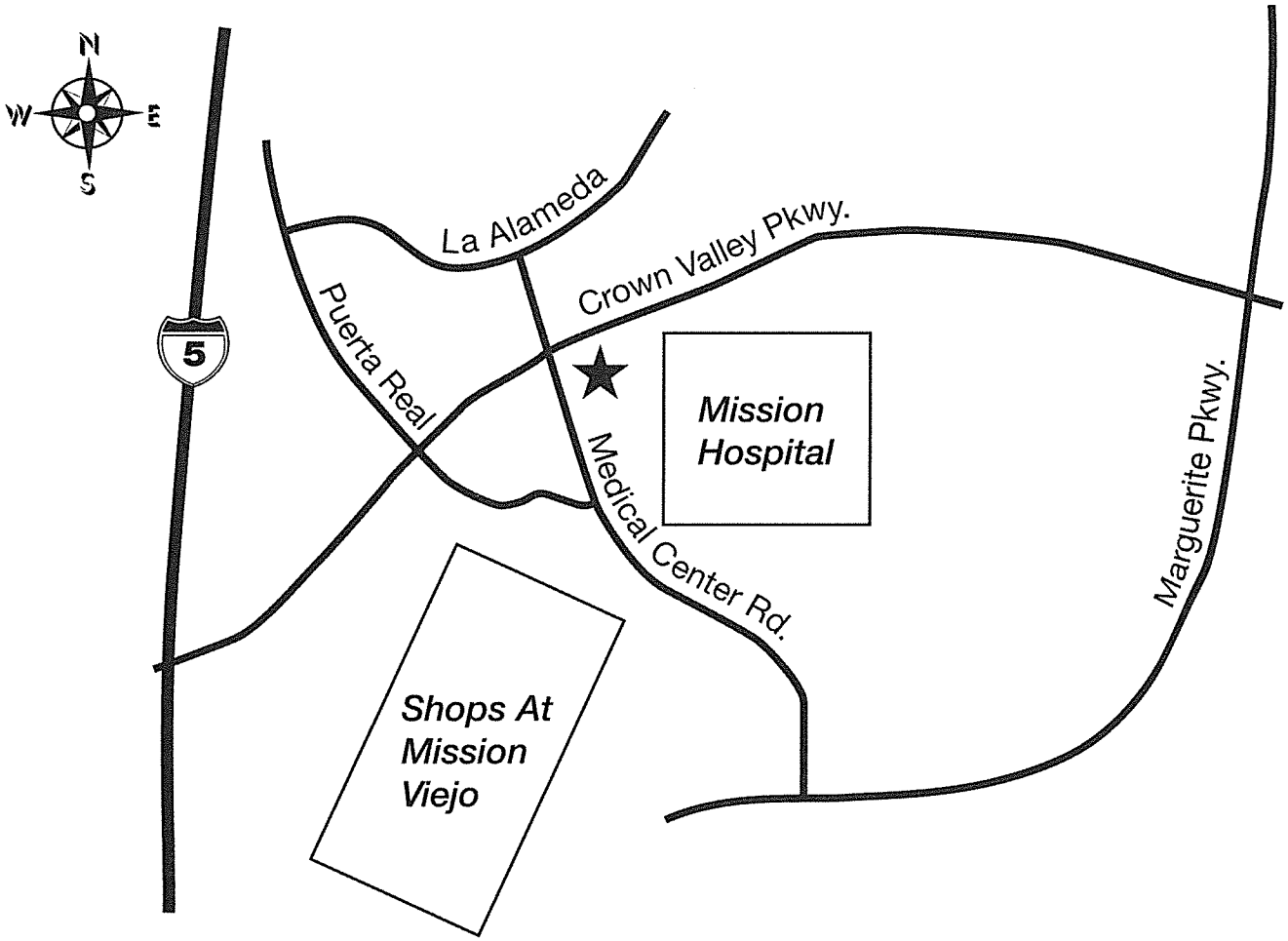
St.JosephHealth

Mission Heritage Medical Group

Mission Sleep Disorders Institute

(949) 364-1236

Located on the corner of Crown Valley Parkway and Medical Center Road at 26800 Crown Valley Parkway, in the Mission Medical Plaza. Our office is on the second floor in Suite 215. Parking will be located in the parking structure adjacent from the medical building. Enter main lobby and take the elevator to the second floor. When you exit the elevator turn to your right. Proceed two doors down on the right to Suite 215.



Front Entrance Doors are OPEN nightly from 7-9 pm.

If Entrance Doors do not open -

please contact night technicians at (949) 364-1236 ext. 2

or use the intercom to the right of the front doors.

MRN: _____

Date: _____

Hoag Medical Group • Mission Heritage Medical Group
St. Joseph Heritage Medical Group • St. Jude Heritage Medical Group
• St. Mary High Desert Medical Group
In alliance with St. Joseph Heritage Healthcare

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ (Last) _____ (First) _____ (Middle)

Date of Birth: _____ Sex: _____ Driver's Lic #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

Last 4 digits of Social Security #: _____ Ethnicity: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

I'd like to receive appointment and clinical reminders via text. ☐ Yes ☐ No Cell # _____

Preferred Telephone # for Routine Communication: _____ ☐ Home ☐ Work ☐ Cell

Secondary Phone: _____ ☐ Home ☐ Work ☐ Cell

E-mail: _____ Primary Spoken Language: _____

Primary Care Provider: _____ How were you referred?: _____

Employer: _____ Employer Phone #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

If patient is a child, please provide an emergency contact other than a parent/guardian.

Contact Name: _____ Relation to Patient: _____

Address (Street or P.O.B.) _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone:(____) _____ Cell Phone:(____) _____

PRIMARY RESPONSIBLE PARTY

☐ I am responsible party ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Name: _____ (Last) _____ (First) _____ (Middle)

Date of Birth: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Driver's Lic #: _____

Employer: _____ Employer Phone #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

SECONDARY RESPONSIBLE PARTY

Name: _____ ☐ Spouse ☐ Parent ☐ Guardian ☐ Other _____

Employer: _____ Employer Phone #: _____

Work Address: _____ City: _____ State: _____ Zip: _____

MRN:_____

INSURANCE INFORMATION

Primary Insurance Company Name _____

Subscriber's Name _____Date of Birth___/___/_____

Relation to patient_____

Subscriber's address if other than patient _____

Secondary Insurance Company Name _____

Subscriber's Name _____Date of Birth___/___/_____

Relation to patient_____

Subscriber's address if other than patient:_____

ELIGIBILITY GUARANTEE

I hereby certify that I am eligible with the health insurance company under the subscriber indicated on my registration sheet. I also certify that I have chosen a St. Joseph Heritage Healthcare affiliated medical group to provide healthcare services. I understand that if the above is not true or I am not eligible under the terms of my medical and hospital subscriber agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill.

Signature_____ Date ___/___/____

COMMUNICATION CONSENT

By providing the St. Joseph Heritage Healthcare or its service providers with a telephone number for a cellular or other wireless device and/or an e-mail, I agree that St. Joseph Heritage Healthcare or its service providers may use the provided telephone number or e-mail to service my account(s) (including contacting me about obtaining potential financial assistance for my account(s)), to send the patient appointment and follow-up health care reminders by text or e-mail, to send me information, to schedule patient appointments, and to collect any amounts I may owe to my healthcare provider(s). I understand and agree that St. Joseph Heritage Healthcare and its agents, representatives, or other service providers as well their respective agents and contractors, including any billing or account management companies and/or debt collectors may contact me at the provided telephone number(s) which could result in charges to me. I expressly consent that methods of contact may include using pre-recorded and artificial voice messages, text, email, (if an email address has been provided) and/or the use of an automatic dialing device, as applicable. This consent applies to all services and billing associated with my account number(s) and is not a condition of purchasing property, goods, or services. I am not required to sign this consent as a condition of receiving healthcare services .

☐ Initials / Approve ☐ Initials / Decline

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize and request the insurance company(s), or agent thereof, to pay directly to St. Joseph Heritage Healthcare for services provided to me by a St. Joseph Heritage Healthcare affiliated medical group. I am aware that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. This signature will also serve as an authorization to release medical information necessary to satisfy payment.

_____ ___/___/____

Signature of Patient (If minor, signature of responsible party) Date

_____ ___/___/____

Print Patient Name Patient Date of Birth

Date: _____ Date of birth: _____

Name: _____ Alias/ Nicknames: _____

Height: _____ Weight: _____

Main Reason for visit: _____

MEDICAL HISTORY: (note year diagnosed with details)

- ☐ Asthma _____
- ☐ Bladder /Kidney disorders _____
- ☐ Blood Disorders _____
- ☐ Breast / GYN disorders _____
- ☐ Cancer (_____) _____
- ☐ Chronic eye/ear/nose disorders _____
- ☐ Depression/anxiety _____
- ☐ Diabetes _____
- ☐ Gastrointestinal disorders _____
- ☐ Heart disorders _____
- ☐ High blood pressure _____
- ☐ High Cholesterol _____
- ☐ Lung/COPD/Emphysema _____
- ☐ Neurologic/ Stroke/ Seizure _____
- ☐ Prostate Problems _____
- ☐ Skin disorders _____
- ☐ Thyroid disorders _____
- ☐ Others _____

SURGERIES (major) (Note Year)

- ☐ Abdominal _____
- ☐ Appendix _____
- ☐ Breast _____
- ☐ Gall bladder _____
- ☐ Heart _____
- ☐ Orthopedic _____
- ☐ Prostate _____
- ☐ Uterus / Ovary _____
- ☐ Other _____

Other Concerns:

Weight: Is your weight a concern? ☐ Yes ☐ No

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Exercise: Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise? _____

How long (minutes) _____ How often? _____

Other Concerns *Continued*:

Safety: Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you fall frequently? ☐ Yes ☐ No

Have you completed a living will or durable power of attorney for health care? ☐ Yes ☐ No

SOCIAL HISTORY:

Single Married Widowed Divorced Separated

Children: None 1 2 3 4 5

Occupation: _____

Years of education/highest degree: _____

Tobacco Use:

Cigarettes: ☐ Never ☐ Quit year _____

☐ Current smoker: packs/day ____ # of years _____

Other Tobacco: ☐ pipe ☐ cigar ☐ snuff ☐ chew

Are you interested in quitting? ☐ Yes ☐ No

Drink caffeine: ☐ Yes ☐ No Cups per day _____

Alcohol Use: ☐ Yes ☐ No # drinks/week _____

Is your alcohol a concern for you or others?

☐ Yes ☐ No

Drug Use:

Have you used any recreational drugs? ☐ Yes ☐ No

Have you ever used needles to inject drugs?

☐ Yes ☐ No

PAST TESTS:			**Year last done**
Bone Density Scan	Y	N	_____
Colonoscopy	Y	N	_____
Mammogram	Y	N	_____
PAP test (female)	Y	N	_____
PSA (prostate)	Y	N	_____
Treadmill (heart)	Y	N	_____

Briefly describe your symptoms:

_____

_____

_____

MRN _____

Patient Name: _____

Date of Birth _____

SC-1722 (1/14)

St.JosephHealth

Mission Internal Medical Group

Sleep Disorders Institute

PATIENT HISTORY FORM

ALLERGIES OR REACTIONS TO MEDICINES / FOOD / OTHER AGENTS:

MEDICATION	REACTION OR SIDE EFFECT	DATE

FAMILY HISTORY:

Check all that apply	Mental Health Disorders	Alcohol Abuse	CANCER				Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Cause of death or major illness	**ADULT IMMUNIZATIONS: Please note if you have had any of the following immunizations (Note Year)** **(Year)**
			Breast	Colon	Prostate	Lung						
Father												Gardasil Y N _____
Mother												Hepatitis B: Y N _____
Maternal Grandfather												Influenza (yearly): Y N _____
Maternal Grandmother												Pertussis: Y N _____
Paternal Grandfather												Pneumonia: Y N _____
Paternal Grandmother												Shingles: Y N _____
Brothers												Tetanus: Y N _____
Sisters												

Comments:

MRN _____

Patient Name: _____

Date of Birth _____

St. Joseph Health
Mission Internal Medical Group

Sleep Disorders Institute

PATIENT HISTORY FORM

MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

QUESTIONNAIRE FOR SPOUSE OR SLEEP PARTNER

Patient Name: _____ Date: _____

Please **Circle** any of the following patterns that you have observed the patient doing while asleep:

Loud snoring	Twitching of legs or feet while sleeping
Light snoring	Kicking of legs while sleeping
Pauses in breathing	Sitting up in bed while asleep
Grinding teeth	Getting out of bed while asleep
Biting tongue	Head rocking or banging
Wetting the bed	Becoming very rigid and/or shaking
Sleep talking	Sleep walking

How long have you been aware of the sleep patterns you have circled above?

_____

_____

Do you recall hearing any short pauses in the snoring or loud snoring sounds?

☐ **YES** ☐ **NO**

MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

SLEEP PATTERN QUESTIONNAIRE

Please mark any of the following statements that are accurate to you:

PARASOMNIAS

- ☐ I have been observed sleepwalking, as a child or an adult.
- ☐ I have been heard sleep talking, as a child or an adult.
- ☐ I have been observed grinding my teeth, as a child or an adult.
- ☐ I have been observed pounding my head at night, as a child or adult.
- ☐ I am often awakened by my dreams.
- ☐ I have very lucid dreams.
- ☐ I believe I dream excessively.
- ☐ I have wet the bed as an adult.

DISTURBED SLEEP

- ☐ I am an extremely restless sleeper.
- ☐ When I wake up in the morning my covers are all muddled up.
- ☐ My spouse/sleep partner has told me I kick or jab them at night.
- ☐ My spouse/sleep partner has told me I snore very loud.
- ☐ My spouse/sleep partner leaves bedroom due to my snoring.
- ☐ My spouse/sleep partner has noticed I stop breathing at night.
- ☐ My spouse/sleep partner has noticed my legs jerk or twitch.
- ☐ Sometimes I wake up with a choking sensation.
- ☐ I have woke up feeling paralyzed and unable to move.
- ☐ Sometimes I hallucinate or have dream-like visions.
- ☐ Sometimes I wake up abruptly with uneasy feelings of anxiety, fear, sadness or tension.
- ☐ Sometimes I wake up with tightness in my chest and arms.
- ☐ Sometimes I wake up with a headache.
- ☐ During the night I have to go to the bathroom a lot.
- ☐ During my sleep I sweat.
- ☐ One or more times I have awakened during the night having vomited.
- ☐ I believed that the quality of my sleep is very unsatisfactory.

INSOMNIA

- ☐ I have a great difficulty at night falling asleep.
- ☐ I wake up in the night and have difficulty falling back asleep.
- ☐ I wake up very early in the morning way before I need to.
- ☐ I am sometimes unable to fall asleep at all.
- ☐ I tend to worry the next day when I have not had a good nights sleep.
- ☐ I am usually not sleepy when I go to bed at night.
- ☐ I often have thoughts racing through my mind while trying to sleep.

MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

SLEEP PATTERN QUESTIONNAIRE

Patient Name: _____

The main complaint regarding my sleep pattern right now is: **Check**

- ☐ I have difficulty falling asleep
- ☐ I have difficulty staying asleep
- ☐ I am sleepy all day

Regular sleep patterns:

On work days I usually go to bed at: _____

On work days the earliest bed time in the last two weeks is: _____

On work days the latest bed time in the last two weeks is: _____

On days off I usually go to bed at: _____

On work days I usually wake up at: _____

On days off I usually wake up at: _____

I usually start feeling sleepy in the evening at: _____

I usually fall asleep in _____ hour(s) _____minute(s)

I usually wake up _____ on my own _____ by an alarm

I usually exercise _____ YES _____ NO What time: _____

I usually nap during the week _____ YES _____ NO

Waking up during regular sleep:

I usually wake up _____ times during the night.

It usually takes me _____hrs _____ mins to fall back asleep

Please **check** any of the following statements that relate to you.

- ☐ Shift or night work
- ☐ Travel time zones often
- ☐ Sleep with spouse/bed partner
- ☐ I like sleeping a lot
- ☐ Sleep is waste of time
- ☐ Use eye mask or ear plugs

I usually sleep: Check

☐ On my back ☐ On my stomach ☐ On my side ☐ In no real particular position

I remember my dreams:

- ☐ Rarely
- ☐ Approximately once a week
- ☐ A couple times a week
- ☐ Almost every night

My dream recollection is usually:

- ☐ A hazy feeling of having dreamed
- ☐ A vague account of a thought/image
- ☐ A very vivid recollection

Thirty minutes after I wake up in the morning I am: Check

☐ Alert ☐ Drowsy ☐ Very drowsy

MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

SLEEP PATTERN QUESTIONNAIRE

INSOMNIA (CONT.)

- ☐ I experience anxiety or nervousness while trying to fall asleep.
- ☐ I worry whether or not I will be able to fall asleep.
- ☐ I often feel hungry or thirsty when I try to fall asleep.
- ☐ I often wake up from pain which keeps me from falling back to sleep.
- ☐ I experience a creeping, crawling sensation in my legs in bed.
- ☐ I will sometimes use a sleeping pill to help me sleep.
- ☐ I feel that I do sleep well once I finally fall asleep.
- ☐ I am easily awakened during sleep and consider myself a light sleeper.
- ☐ I can usually sleep better in a hotel room or room unfamiliar to me.
- ☐ I am disturbed by heat or cold during my sleep.

DAYTIME SLEEPINESS

- ☐ If I slept one more hour each night, I would feel much better.
- ☐ I usually feel better the day after a good nights sleep.
- ☐ I am usually not sleepy when it's time to sleep, so I stay up later.
- ☐ I believe I sleep excessively.
- ☐ I believe I do not get enough sleep.
- ☐ I usually feel sleepy and tired all day.
- ☐ The morning is usually when I function best.
- ☐ The evening is usually when I function best.
- ☐ I have woken up later than scheduled after going to bed on time.
- ☐ When I have plans the next day I will usually go to sleep earlier.
- ☐ I have fallen asleep while driving, conversation or eating.
- ☐ I have had accident(s) or almost had an accident(s) due to sleepiness.
- ☐ My work performance is poor due to sleepiness.
- ☐ I have lost track of a topic or have been confused due to sleepiness.
- ☐ I usually will fall asleep during just a half-hour TV show.
- ☐ I have arrived somewhere unaware of how I got there.
- ☐ I have suddenly had a sensation of weakness in my legs while awake. (May occur in emotional states).

MEDICAL

- ☐ I sometimes experience chest pain at night.
- ☐ I will have a sour or bitter taste in my mouth at night or in morning.
- ☐ I will sometimes experience heartburn when I wake up.
- ☐ I will sometimes experience back pain when I wake up.
- ☐ I will sometimes experience the sensation of pins and needles in my legs when I wake up.
- ☐ I have bitten my tongue during sleep.

MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

SLEEP PATTERN QUESTIONNAIRE

MEDICAL (CONT.)

- ☐ Sometimes cough mucus or sputum during night or in the morning.
- ☐ Due to shortness of breath, I am unable to sleep in a flat position.
- ☐ My spouse/sleep partner has told me I shake my head during sleep.
- ☐ My spouse/sleep partner has told me I have had convulsions or seizures during sleep.
- ☐ I have experienced convulsions or seizures during the daytime.
- ☐ I have been diagnosed with high blood pressure.
- ☐ In the last year I have gained more than 10 pounds.
- ☐ In the last year I have lost more than 10 pounds.

SLEEP HISTORY

- ☐ I sleepwalked as a child.
- ☐ I talked in my sleep as a child.
- ☐ I experienced nightmares as a child.
- ☐ I screamed in my sleep as a child.
- ☐ I suffered convulsion during sleep as a child.
- ☐ I would grind my teeth as a child.
- ☐ I would rock or bounce my head as a child in order to sleep.
- ☐ I occasionally wet my bed after the age of six.
- ☐ My current sleep pattern disorder began when I was a child.
- ☐ I have fallen asleep at school as a child or youth.
- ☐ I was considered to be hyperactive or hyperkinetic as a child or youth.
- ☐ I would snore while sleeping as a child or youth.
- ☐ I would stay up late during the evening when I was a child or youth.

FAMILY HISTORY

- ☐ There are relatives that suffer from insomnia.
- ☐ There are relatives that snore loudly during sleep.
- ☐ There are relatives that have fallen asleep during the day.
- ☐ There are relatives that have suffered sudden weakness or paralysis, most in an emotional state.
- ☐ There are relative that were hyperactive or hyperkinetic as children.
- ☐ There are relatives that died from "SIDS" sudden infant death syndrome.
- ☐ I share the same sleep pattern disorder with other relatives in my family.

WOMEN

- ☐ My sleep pattern varies during my menstrual cycle.
- ☐ I currently am using birth control pills.
- ☐ My sleep pattern disorder began or worsened with onset of menopause.

MRN _____

Patient Name: _____

Date of Birth _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

MEDICATION REVIEW

Please list below the medications you are currently taking, or have taken a prescription for. Please list the time of day you take your medication and the dose each time. Please list any side effects that you may experience, especially if it relates to sleepiness and sleeplessness.

MEDICATION NAME	TIME TAKEN	DOSE	REASON FOR TAKING MEDICATION	SIDE EFFECTS

Do you take any of the following:

Calcium: ☐ Yes ☐ No ☐ Past

Vitamin D: ☐ Yes ☐ No ☐ Past

Estrogen (Premarin): ☐ Yes ☐ No ☐ Past

Progesterone (Provera): ☐ Yes ☐ No ☐ Past

Other: _____

_____

_____

Please list any known allergies to any medications that you are aware of:

MEDICATION NAME:

_____ _____

_____ _____

_____ _____

Accredited Member of the American Academy of Sleep Medicine

MRN _____

Patient Name: _____

Date: _____

St.JosephHealth

Mission Heritage Medical Group

Sleep Disorders Institute

EPWORTH SLEEPINESS SCALE (ESS)

Always tired?
Having trouble staying awake?

Find out now if your daytime sleepiness is excessive.

It's easy. **The Epworth sleepiness Scale (ESS)** has 8 routine daytime situations that you rate on a scale of 0 to 3, based on your likelihood of dozing off or falling asleep in each situation. Write the number that corresponds with your answer for each situation in the "My score" box. Then add up your score, and share the results with your doctor.

Situation	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing	My score
Sitting and reading	0	1	2	3	
Watching television	0	1	2	3	
Sitting inactive in a public place — for example, a theatre or meeting	0	1	2	3	
Lying down to rest in the afternoon when circumstances permit	0	1	2	3	
Sitting and talking to someone	0	1	2	3	
Sitting quietly after lunch without alcohol	0	1	2	3	
In a car, while stopped for a few minutes in traffic	0	1	2	3	
As a passenger in a car for an hour without a break	0	1	2	3	
				Total score:	

The ESS is a simple survey that you can take to measure your general level of sleepiness. A total score of 10 or more on the ESS suggests the need for further evaluation. It is important for your doctor to identify if you have an underlying sleep disorder.

Accredited Member of the American Academy of Sleep Medicine

St. JosephHealth
Mission Heritage Medical Group
Sleep Disorders Institute

MRN _____

Patient Name: _____

Date of Birth _____

DAILY, WEEK-LONG SLEEP PATTERN LOG

Start date:_____

In order to get a more accurate understanding of your sleep pattern disturbances, we would like you to keep a one-week log of the activities listed below. If you are unable to log an exact amount or time, please estimate to the best of your ability when logging your response.

Activity	Sunday Date:_____	Monday Date:_____	Tuesday Date:_____	Wednesday Date:_____	Thursday Date:_____	Friday Date:_____	Saturday Date:_____
Morning wake up time:							
Coffee, tea, caffeinated sodas: Number of cups drank and at what time.							
Medications taken: At what time and what dose.							
Naps taken: Start time and for how long.							
Alcoholic beverages: Number of drinks and at what time.							
Time went to bed:							
Waking up during the night: Number of times and minutes of time spent awake.							
Estimated length of time to fall asleep:							

Please feel free to use the back of this sheet to note any occurrences that are not normal.

SC-1715 (10/19)