Dear Patient,

It is our pleasure to welcome you to the PMA Sleep Wellness Center. Your new patient appointment will take approximately 30 - 45 minutes. The doctor will take a medical history and perform a brief physician examination to determine the best course of treatment for you. If a study is necessary it will be scheduled at this time.

A Sleep study is a series of tests that help evaluate what happens to your body during sleep. A trained sleep lab technician as per guidelines of the American Academy of Sleep Medicine performs this study. You will be given a private room much like a hotel room where these tests will take place.

Enclosed you will find the following forms (The Epworth Sleepiness Scale and a Patient Questionnaire). Please complete and bring them with you to your appointment along with your insurance cards, any co pays that may be due and a referral, if necessary.

Please do not hesitate to contact our Phoenixville office at 610-933-8484, Limerick Office at 610-495-2300, Pottstown Office at 610-323-3100 or The PMA Sleep Wellness Center at 610-933-0200 if you need further information.

We appreciate your selecting The PMA Sleep Wellness Center for your medical care and will strive to provide service excellence.

Yours truly,

Raymond J. Kovalski, MD
Medical Director

THE PMA SLEEP WELLNESS CENTER
826 Main Street Suite 100
Phoenixville, PA 19460
610-933-0200
Fax: 610-935-8759

THE EPWORTH SLEEPINESS SCALE

Name: _____

oday's date ____ Age (years): _____

Sex: Male or Female (Circle One)

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 theses things recently, try to work out how they would have affected you. 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 to someone	
Sitting, quietly after lunch without alcohol	
Ina car, while stopped for a few minutes in traffic	

09/07/07

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PATIENT QUESTIONNAIRE
QUESTIONS ABOUT YOUR SLEEP AND AWAKE BEHAVIOR

1. Please state in your own words the reason you (or your doctor) contacted the Sleep Studies Program.

_____

About Falling Asleep

2. What time do you usually try to fall asleep? _____ __ AM __ PM

3. Does this time vary?

4. How long does it usually take you to fall asleep? _____hrs. _____ min.

5. How many days each week does it take you more than 30 minutes to fall asleep? ____

   More than 60 minutes to fall asleep? _____ Never _____

6. When falling asleep or trying to fall asleep, how often do you:
   CHECK ONE BOX FOR EACH STATEMENT

	Never	Sometimes	Often
A. have thoughts racing through your mind?	____	____	____
B. feel sad or depressed?	____	____	____
C. have anxiety (worry about things)?	____	____	____
D. feel muscular tension?	____	____	____
E. Feel afraid of not being able to sleep?	____	____	____
F. feel unable to move?	____	____	____
G. have creeping, crawling, aching or twitching feelings in your leg (feel like you have to move them)?	____	____	____
H. have vivid, dream-like scenes even though you know you are not totally asleep?	____	____	____
I. have any kind of pain or discomfort?	____	____	____
J. feel afraid of the dark or anything else?	____	____	____
K. suddenly become aware or alert?	____	____	____

About Sleeping

7. On average, how many hours of sleep do you get each night? ____hrs. ____min.

8. How does your nightly amount of sleep vary?
   From: _____ hours and _____ minutes To: _____ hours and _____ minutes

9. How many times do you usually awaken each night? _____
   Do you have trouble getting back to sleep? _____ Yes _____ No

10. On a typical night, what is your longest period of wakefulness? _____hrs. _____ min.

11. How long are you awake all together during the night? _____hrs. _____min.

12. If you awaken during the night, is it usually during the (CHECK ONE)
    a. First half of the sleep period? ___
    b. Second half of the sleep period? ___

13. How often do you:
    CHECK ONE BOX FOR EACH STATEMENT

	Never	Sometimes	Often
A. feel afraid you won't return to sleep after awakening?	_____	_____	_____
B. sleep with someone else in your bed?	_____	_____	_____
C. sleep with someone else in your room?	_____	_____	_____
D. have restless, disturbed sleep?	_____	_____	_____
E. get up at night to attend your children or something else?	_____	_____	_____
F. snore loudly?	_____	_____	_____
G. feel your heart pounding during the night?	_____	_____	_____
H. sweat a lot during the night?	_____	_____	_____
I. walk in your sleep?	_____	_____	_____
J. fall out of bed while sleep?	_____	_____	_____
K. wake up screaming, violent or confused?	_____	_____	_____
L. have unusual movements while asleep?	_____	_____	_____
M. wet the bed?	_____	_____	_____
N. have dreams?	_____	_____	_____
O. grind your teeth?	_____	_____	_____

14. My sleep is frequently disturbed by: (**CHECK ALL THAT IS TRUE**)

____	heat	____	choking
____	cold	____	indigestion, "gas", or heartburn
____	light	____	hunger
____	noise	____	thirst
____	noise or movement of your bed partner	____	need to urinate
____	asthma	____	chest pain
____	cough	____	frightening dreams
____	shortness of breath	____	creeping, crawling, or aching in your legs

15. What time do you usually have your final awaking? _____ AM/PM

16. What time do you usually get out of bed after your final awakening? _____ AM/PM

17. How much does your final awakening vary? From: _____ AM/PM
To: _____ AM/PM

18. How often do you:
CHECK ONE BOX FOR EACH STATEMENT

	Never	Sometimes	Often
A. depend on an alarm clock to wake up?	_____	_____	_____
B. "sleep in" in the morning (more than one hour) past your usual wake-up time?	_____	_____	_____
C. have a very hard time waking up?	_____	_____	_____
D. feel unable to move when waking up?	_____	_____	_____
E. have dream-like images when waking up even though you know you are not asleep?	_____	_____	_____
F. wake up confused or disoriented?	_____	_____	_____
G. wake up with a headache?	_____	_____	_____
H. wake up nauseous (sick to your stomach)?	_____	_____	_____
I. wake up with dry mouth?	_____	_____	_____
J. wake up 1 or 2 hrs before you have to get up?	_____	_____	_____

About Daytime Functioning

19. How many naps do you take in a usual week? _____ Naps

20. How long do you usually sleep during a typical nap? _____ Hrs. _____ Min.

21. Are the naps refreshing? _____ Yes _____ No

22. How often do you:
CHECK ONE BOX FOR EACH STATEMENT

	Never	Sometimes	Often
A. feel sleepy during the day?	_____	_____	_____
B. fall asleep unintentionally?	_____	_____	_____
C. have thoughts racing through your mind?	_____	_____	_____
D. feel sad or depressed?	_____	_____	_____
E. have anxiety (worry about things)?	_____	_____	_____
F. feel muscular tension?	_____	_____	_____
G. feel weakness in your muscles when laughing, surprised, angry, excited, etc?	_____	_____	_____

23. Do you currently use a Home Health Care Company to obtain medical supplies? □ Yes □ No

Company Name: _____

Address: _____

_____

Name of Contact Person: _____

Do you currently use CPAP? □ Yes □ No

24. Height _____ Weight _____

Patient Name: _____