Milford Regional Physician Group
The Benchmark for Quality Care
194 West St.
Westview Plaza, Suite 10
Milford, MA 01757
Phone: 508-381-6590
FAX: 508-381-6593

SLEEP STUDY

Your doctor has requested a sleep study for you. The study may be a "Home Sleep Apnea Test" or an attended overnight Sleep Study (Polysomnography); with or without treatment.

All tests will be performed or set up at the Milford Regional Sleep Center at 194 West Street. Suite 10, Milford, MA, 01757. Home testing set ups take generally less than 1 hour, and overnight studies run from 8:30pm until 6-7:00am.

The sleep center will call you to book your study once the details of the order are verified and your medical insurance has provided prior authorization if required. This generally takes a few days.

Feel free to call us if you have any questions. Thanks!

VISIT US AT:
www.milfordregionalphysicians.org
(Practices/Milford Regional Sleep Center)

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SLEEP QUESTIONS

NAME:_____

DATE:_____HEIGHT:_____WEIGHT:_____
Has your weight changed in the past 5 years? YES NO Gained ___lbs Lost ___lbs
Do you snore or do people tell you that you snore? YES NO _____
If so, for how long? _____
Has anyone told you that you stop breathing while asleep? YES NO
When you wake up in the morning do you feel un- refreshed? YES NO
How long have you felt extra sleepy during the day? _____
Do you frequently awaken with a headache? YES NO
How many automobile accidents have you been involved in the past 5 years? _____
What time do you usually go to bed? _____ AM PM Wake up at: _____ AM PM
On a typical night at bedtime, do you leave on TV____ Music ___ Light____ Other_____
Comment:_____

Do you have: Difficulty falling asleep? YES NO Difficulty staying asleep? YES NO
Does anything frequently awaken you at night? HEARTBURN____ PAIN _____
GO TO BATHROOM ____BREATHING____ OTHER_____

Do you have an urge to move your legs or an uncomfortable feeling in your legs?

		YES	NO
If so:	Does this urge increase when you are inactive?	YES	NO
	Does this urge decrease or go away when you walk or stretch?	YES	NO
	Is this urge or discomfort worse in the evening/night?	YES	NO

Please 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 (0-3)
Sitting and reading	
Watching television	
Sitting inactive in a public place at a theater or meeting	
As a passenger in a car for 1 hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (when you have had no alcohol)	
In a car while stopped in traffic	
TOTAL	

NAME: _____ AGE: _____ BIRTHDATE: _____
SEX: MALE FEMALE
Do you have any problem caring for yourself at home? YES NO
Do you need someone to assist caring for you at night? YES NO
Do you use a wheelchair or a walker? YES NO
Do you need an electric hospital style bed or shower? YES NO
Do you have the following: Scalp/skin sensitivities_____ Wig or hairpiece_____

Operations and Surgery: Please indicate if you have had any of the following surgeries:
Cardiac/Bypass Surgery_____ Tracheostomy_____ Uvuloplasty (UPPP)_____
Nasal septal surgery or rhinoplasty ____ Tonsillectomy_____
Lung Surgery(indicate type) _____Other: _____

Medical Conditions: Check if you have or have had any of the following problems or conditions.

Heart Problems	Lung Problems	Sleep Problems	Other
__Angina / Chest Pain __Palpitations /Arrythmia __Heart attack/ MI __Heart Failure/CHF __High Blood pressure __Pacemaker: rate__ __Atrial Fibrillation	__Asthma __COPD __Use oxygen __Tuberculosis	__Snoring __Fall asleep slowly __Fall asleep quickly __Wake up frequently __Sleep walking __Sleep talking	__Depression __Anxiety __Thyroid problem __Seizures __Heartburn/GERD __Stroke __Arthritis __Cancer __Fibromyalgia __Diabetes

OTHER PROBLEMS:_____

Due to HIPAA guidelines we will not share any information (scheduling or medical) with anyone but you unless we have written permission. If you wish to give permission for us to speak to anyone other than yourself, please list them here and sign below.
Name_____relationship_____
Name_____relationship_____
I understand I will be undergoing a sleep test (polysomnography). I understand there may be video monitoring during the set up or monitoring. I authorize payment of benefits from the government and /or my insurance company, to Milford Regional Physician Group for services rendered. I also authorize the release of any medical or other information necessary to process claims.
I authorize Milford Regional Sleep Center to leave messages on my answering machine at the following phone numbers:
Home YES/NO_____ , Cell YES/NO_____
I understand that messages may contain protected health information, including diagnosis and treatments about me.

****Signed_____Date_____