ALASKA SLEEP CLINIC
an ALYESKA INTERNATIONAL, INC. company

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Prior Sleep Study History

Patient Name: _____ Date of Birth: _____

Please describe why you need a sleep study at this time:

_____

_____

_____

_____

Have you ever had a sleep study in the past? ____Yes ____No

If you answered **NO**, ignore this page. If **YES**, please provide a copy of your sleep study records. Please bring your current Positive Airway Pressure Machine (CPAP, APAP, BiLevel, ASV) machine and mask if applicable, and answer the following questions:

When was your previous sleep study? _____

Where was your previous sleep study conducted? _____

What were the study results? _____

Are you currently using Positive Airway Pressure Machine (CPAP, APAP, BiLevel, ASV) machine? ____Yes ____No

If yes, what is your treatment setting? _____

Please indicate the make, model and age of your machine:

Make: _____

Model: _____

Age: _____

Do you expect to be replacing your machine? ____Yes ____No

Please indicate the name, size and age of the mask that you are using:

Name: _____ Size: _____ Age: _____