Texas Neurology Center

Appointment Information

Your physician has requested that you have a sleep study performed. This test is noninvasive and completely painless. While having sensors placed on you is a bit uncomfortable, we pride ourselves in providing a warm and professional setting where you can relax and get a good night's sleep. Every effort has been made to provide you with a comfortable, non-clinical environment. We use the "Sleep Number Bed" by Select Comfort as well as temperature-sensitive contoured pillows.

Please fill out a sleep questionnaire before your appointment. We realize that all of these forms can be a little long, but please keep in mind that accurate results are directly dependent upon the information you provide. If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance. *Late cancellations, late rescheduling, and no-shows are billed at $75 per occurrence.*

Follow these instructions prior to your test date.

- ☐ Please bathe and shampoo and dry your hair prior to your test.
- ☐ Avoid using skin creams, oils, or hairspray.
- ☐ Avoid caffeine usage—which includes coffee, most carbonated beverages, and chocolate—for at least 12 hours prior to the study.
- ☐ Avoid alcohol usage for at least 12 hours prior to the study.
- ☐ Bring loose-fitting pajamas to sleep in.
- ☐ Feel free to bring your own pillow and teddy-bear with you for the night.
- ☐ Your study will end by 6:30 AM.
- ☐ Take all medications as you would normally take them, *unless* otherwise instructed.
- ☐ Bring all your medications with you to your study.
- ☐ Try not to take naps during the day if you can help it.

Once the study ends, you may have some coffee, tea, or juice. If you have any questions, please call us at 512-744-0015 during business hours or at 512-431-5291 after 3:30 p.m. Visit our website **www.texasneurologycenter.com** for more information on sleep studies and detailed information on sleep disorders.

Coming from the north: Go south on MoPac to the Northland / 2222 exit. Take the off ramp to the stoplight. Turn right at the light onto Northland. Pass the Shell gas station on your right. Turn right onto Balcones Drive. Texas Neurology Center is in a red brick building on your left across from the McDonald's. The sleep lab entrance in on the north side of the building.

Coming from the south: Go North on MoPac to the Northland / 2222 exit. Take the off ramp to the stoplight. Turn left (under MoPac) and get into the right lane. Pass the Shell gas station on your right. Turn right onto Balcones Drive. Texas Neurology Center is in a red brick building on your left across from the McDonald's. The sleep lab entrance is on the north side of the building.

www.TexasNeurologyCenter.com
5750 Balcones, Suite 110 **s** Austin, TX 78731 **s** 512-744-0015 **s** fax 512-744-1654

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PATIENT NAME _____ DATE _____

Please fill out this questionnaire before you come to your appointment. Complete and accurate responses are to your benefit. Please take your time, and feel free to add additional comments.

BEDTIME

Do you have any difficulty falling asleep? _____

If so, how long has this been a problem? _____

How long do you estimate it takes you to fall asleep? _____

What prevents you from falling asleep? _____

How long has this been a problem? _____

Do you require special noise, light, or position to fall asleep? _____

If so, give details: _____

Have you ever experienced vivid dream-like episodes when attempting to fall asleep? _____

When falling asleep or awakening, do you ever feel paralyzed? _____

When resting awake in bed, do you ever experience an uncontrollable urge to move your legs?

_____

DAYTIME SLEEPINESS

Do you find yourself falling asleep during the day when you don't want to? _____

If so, how long has this been a problem? _____

How likely are you to doze off or fall asleep in the following situations? Use the following scale to rate the likeliness of falling asleep. (Epworth Sleepiness Scale)

Would never doze	**0**
Slight chance of dozing	**1**
Moderate chance of dozing	**2**
High chance of dozing	**3**

	0	**1**	**2**	**3**
1. Sitting and reading	☐	☐	☐	☐
2. Watching television	☐	☐	☐	☐
3. Sitting inactive in a public place (movie theatre)	☐	☐	☐	☐
4. As a car passenger for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon	☐	☐	☐	☐
6. Sitting and talking to someone	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
8. In a car while stopping for a few minutes in traffic	☐	☐	☐	☐

Total _____

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Patient Name _____

REGULARITY AND DURATION OF SLEEP

What time do you usually go to bed? _____

Do you feel that you usually get enough sleep? _____

Do you work odd hours? If so, list them. _____

How often do you travel across time zones? _____

Do you walk/talk in your sleep (include frequency)? _____

Do you ever awaken from sleep screaming, confused, or violent? _____

AWAKENINGS

Are you having difficulty sleeping through the night? _____

What awakens you? _____

How long has this been a problem? _____

How often do you wake up? _____

How long do you remain awake? _____

What keeps you from falling back to sleep? _____

At what time do you usually awaken in the morning? _____

What is your mood like in the morning? _____

SNORING

Have you or anyone else noticed that you snore loudly? _____

Have you or anyone else noticed that you stop breathing in your sleep? _____

GENERAL

Do you smoke (or have you ever)? _____

If so, how much and how often? _____

Are you exposed to second-hand smoke? _____

If so, how much and how often? _____

Do you consume alcohol? _____

If so, how much and how often? _____

Do you consume caffeinated beverages? _____

If so, how much and how often? _____

What is your height and weight? Ht _____ Wt _____

Have you ever lost consciousness (or felt weak) when suddenly surprised, angered, or frightened? _____

Has anyone in your family been diagnosed with narcolepsy? _____

If so, what is their relation to you? _____

Patient Name _____

MEDICAL HISTORY

Please mark any of the following that you have a **diagnosed history** of:

- ☐ Respiratory disease (type?)
- ☐ Allergies
- ☐ Asthma
- ☐ Congestive heart failure
- ☐ Emphysema
- ☐ Sinus congestion/infections
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anxiety disorder
- ☐ Head injury
- ☐ Cancer (location?) _____
- ☐ Liver disease (type?) _____
- ☐ Kidney disease (type?) _____
- ☐ Other _____
- ☐ Claustrophobia
- ☐ Neurological disease
- ☐ Thyroid problems
- ☐ Muscle/joint pains
- ☐ Illegal drug use
- ☐ Indigestion
- ☐ Chronic pain
- ☐ Obstructive Sleep Apnea
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ GERD
- ☐ Night terrors
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Teeth grinding
- ☐ Leg movement disorder
- ☐ Depression
- ☐ Heart attack/disease
- ☐ Stroke

Please mark and date any of the following **surgeries** that have been performed:

- ☐ Tonsillectomy DATE:
- ☐ Palate Surgery DATE:
- ☐ Thyroidectomy DATE:
- ☐ Adenoidectomy DATE:
- ☐ Heart Surgery DATE:
- ☐ Sinus Surgery DATE:
- ☐ Nasal Surgery DATE:

Please list all medications you have taken in the last two weeks. Include non-prescription medications, supplements, herbs, and extracts. Also note if you have recently discontinued any of these medications.

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name _____

BED PARTNER QUESTIONNAIRE

Please have your bed partner, or a person who has observed your sleep, complete this page.

How often have you observed this person's sleep? _____

Does sleepiness appear to affect this person's daily activities? _____

If so, how? _____

Has this person fallen asleep in dangerous situations? _____

Are you forced to sleep in a separate bedroom? _____

Check all of the following you have observed in this patient at nighttime. Circle the frequency as it applies.

Behavior While Sleeping	Frequency of Behavior		
☐ Light snoring	Nightly	Weekly	Infrequently
☐ Choking	Nightly	Weekly	Infrequently
☐ Becoming rigid	Nightly	Weekly	Infrequently
☐ Loud snoring	Nightly	Weekly	Infrequently
☐ Pauses in breathing	Nightly	Weekly	Infrequently
☐ Anxiety at night	Nightly	Weekly	Infrequently
☐ Occasional snorts	Nightly	Weekly	Infrequently
☐ Twitching	Nightly	Weekly	Infrequently
☐ Head rocking	Nightly	Weekly	Infrequently
☐ Acting out dreams	Nightly	Weekly	Infrequently
☐ Kicking	Nightly	Weekly	Infrequently
☐ Nocturnal eating	Nightly	Weekly	Infrequently
☐ Aggressive/violent behavior	Nightly	Weekly	Infrequently
☐ Sleep walking	Nightly	Weekly	Infrequently
☐ Teeth grinding	Nightly	Weekly	Infrequently
☐ Bed wetting	Nightly	Weekly	Infrequently
☐ Sleep talking	Nightly	Weekly	Infrequently
☐ Other activity (describe below)			

Please describe this person's sleep or report any other sleep-related behavior:

_____

_____

_____

_____

_____

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Sleep Diary

Name_____

Over the period of a week, answer the following questions in the morning. Please indicate if you feel this is a normal week for you.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
What time did you go to bed last night?							
How long did it take you to fall asleep?							
How many times did you wake up last night?							
What time did you wake up this morning?							
How many naps did you take yesterday?							
How long were the naps?							
How much of the following did you consume yesterday?							
• Soda (caffeinated)							
• Coffee							
• Chocolate							
• Alcohol							

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Additional Reminders **J**

Please follow all instructions listed in the sleep study packet prior to your scheduled sleep study.

When coming to the facility for your sleep study, you will use the side door on the right side of the building (when facing the front of the building). Please park on the right side of the parking lot under the trees. Your car will not be towed or ticketed in these spots.

There is a sign on the door that says “Sleep Lab Entrance”. You will see a white doorbell that needs to be rung in order to let the technician know that you have arrived. She will let you in and the set-up will take approximately 45 minutes to one hour.

The rooms are equipped with a TV that has cable and a DVD player, fans for white noise, Wi-Fi internet connection, and a lamp for reading. The room has a microphone so if you need any help, the technician will be able to hear you. Please do not get out of bed without the assistance of the technician so as to avoid pulling on your skin or the machinery. Your study will be completed between 6:30a and 7:30a. If you have a specific wake-up time, please let the technician know so she can accommodate you.

Thank you and we look forward to seeing you.