

# 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 on 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](http://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 is 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.

# Texas Neurology Center

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	<b>0</b>
Slight chance of dozing	<b>1</b>
Moderate chance of dozing	<b>2</b>
High chance of dozing	<b>3</b>

- |   | <b>0</b>                 | <b>1</b>                 | <b>2</b>                 | <b>3</b>                 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Sitting and reading                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Watching television                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sitting inactive in a public place (movie theatre)   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. As a car passenger for an hour without a break       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Lying down to rest in the afternoon                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Sitting and talking to someone                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Sitting quietly after lunch without alcohol          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In a car while stopping for a few minutes in traffic | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Total \_\_\_\_\_

**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? \_\_\_\_\_

## MEDICAL HISTORY

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

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

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Tonsillectomy <small>DATE:</small>  | <input type="checkbox"/> Adenoidectomy <small>DATE:</small> | <input type="checkbox"/> Sinus Surgery <small>DATE:</small> |
| <input type="checkbox"/> Palate Surgery <small>DATE:</small> | <input type="checkbox"/> Heart Surgery <small>DATE:</small> | <input type="checkbox"/> Nasal Surgery <small>DATE:</small> |
| <input type="checkbox"/> Thyroidectomy <small>DATE:</small>  |   |   |

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.

---

---

---

---

---

---

---

---

---

---

**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

<input type="checkbox"/> Light snoring	Nightly	Weekly	Infrequently
<input type="checkbox"/> Choking	Nightly	Weekly	Infrequently
<input type="checkbox"/> Becoming rigid	Nightly	Weekly	Infrequently
<input type="checkbox"/> Loud snoring	Nightly	Weekly	Infrequently
<input type="checkbox"/> Pauses in breathing	Nightly	Weekly	Infrequently
<input type="checkbox"/> Anxiety at night	Nightly	Weekly	Infrequently
<input type="checkbox"/> Occasional snorts	Nightly	Weekly	Infrequently
<input type="checkbox"/> Twitching	Nightly	Weekly	Infrequently
<input type="checkbox"/> Head rocking	Nightly	Weekly	Infrequently
<input type="checkbox"/> Acting out dreams	Nightly	Weekly	Infrequently
<input type="checkbox"/> Kicking	Nightly	Weekly	Infrequently
<input type="checkbox"/> Nocturnal eating	Nightly	Weekly	Infrequently
<input type="checkbox"/> Aggressive/violent behavior	Nightly	Weekly	Infrequently
<input type="checkbox"/> Sleep walking	Nightly	Weekly	Infrequently
<input type="checkbox"/> Teeth grinding	Nightly	Weekly	Infrequently
<input type="checkbox"/> Bed wetting	Nightly	Weekly	Infrequently
<input type="checkbox"/> Sleep talking	Nightly	Weekly	Infrequently
<input type="checkbox"/> Other activity (describe below)			

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

---



---



---



---



---

# Texas Neurology Center

## 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							