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 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.
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)

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

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:

- 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

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

- Tonsillectomy **DATE:**
- Adenoidectomy **DATE:**
- Sinus Surgery **DATE:**
- Palate Surgery **DATE:**
- Heart Surgery **DATE:**
- Nasal Surgery **DATE:**
- Thyroidectomy **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.

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
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___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
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.

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

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

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

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.

<table>
<thead>
<tr>
<th></th>
<th>DAY 1</th>
<th>DAY 2</th>
<th>DAY 3</th>
<th>DAY 4</th>
<th>DAY 5</th>
<th>DAY 6</th>
<th>DAY 7</th>
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</thead>
<tbody>
<tr>
<td><strong>What time did you go to bed last night?</strong></td>
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<td><strong>How long did it take you to fall asleep?</strong></td>
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<td><strong>How many times did you wake up last night?</strong></td>
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<tr>
<td><strong>What time did you wake up this morning?</strong></td>
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<td><strong>How many naps did you take yesterday?</strong></td>
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<td><strong>How long were the naps?</strong></td>
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<tr>
<td><strong>How much of the following did you consume yesterday?</strong></td>
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<td>• Soda (caffeinated)</td>
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<tr>
<td>• Coffee</td>
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<td></td>
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</tr>
<tr>
<td>• Chocolate</td>
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<tr>
<td>• Alcohol</td>
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</tbody>
</table>
Additional Reminders

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.