TEXAS NEUROLOGY, P.A. SLEEP DISORDERS CENTER
PATIENT PREPARATION SHEET FOR SLEEP STUDY

Appointment Date: ___________________________ Arrival Time: _______________

On the night of your sleep study:

1. Please bring night attire to change into as well as any toiletries, pillow, medication(s), and any other items you may require.

2. In order to insure proper electrode and sensor application please arrive freshly showered with your hair washed and completely dry. No body lotion, make-up, hair spray or gels. You may wear under-arm deodorant. Men are required to shave prior to the study. However, beards are acceptable.

3. The morning following your sleep study, please allow additional time from your normal routine to have all the testing equipment removed by the technician as well as time for you to shower.

4. Please feel free to bring reading material. A lounge is available for your use prior to and following your sleep study.

5. If you are suffering from severe sinus or cold symptoms prior to your appointment, please contact the Sleep Disorders Center prior to your scheduled arrival time at 214-443-5154. You may need to be rescheduled.

6. Do not take naps on the day of your scheduled sleep study.

7. Electrodes will be placed on your scalp. Please notify us immediately if there is anything that would interfere with the necessary process (hair weaves, toupee, extensions, etc…)

8. If you have any additional questions prior to your study, please feel free to contact the Sleep Disorders Center at 214-443-5154.
WELCOME TO OUR SLEEP CLINIC! The following questions will help us understand more about you. These questions will also help the physician when he looks at your sleep study. Please ask your bed partner to help you answer these questions. Please answer the questions as accurately as possible as they relate to the last 12 months. Do not leave any question unanswered. You may add comments to any of your answers in the margin beside the question. ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

Answer the questions using our number scale, if your answer is “no”, please circle “no”.

1=rarely or never  2=sometimes  3=often  4=frequently  5=always

1. Your main complaint(s) is: ( ) Snoring ( ) My breathing stops ( ) I’m sleepy
   ( ) I talk or walk in my sleep ( ) I can’t fall asleep
   ( ) Other: ___________________________

2. How long have you had this problem? ___________________ years ________________ months

3. How has this problem affected your life? ________________________________
4. Do you feel that you get enough sleep at night? No 1 2 3 4 5
5. Do you feel that you get too much sleep at night? No 1 2 3 4 5
6. On average how many hours do you sleep in a 24 hour period? ____________________ hrs
7. What time do you go to bed at night? __________________________________________
8. What time do you wake up in the morning? ______________________________________
9. Do you vary this pattern on weekends? No 1 2 3 4 5
10. No matter how much sleep you get, do you wake up feeling tired? No 1 2 3 4 5
11. Do you have a problem with your work performance because you are sleepy or tired? No 1 2 3 4 5
12. Have you fallen asleep at work? No 1 2 3 4 5
13. Have you fallen asleep while driving? No 1 2 3 4 5
14. Do you sleep with a bed partner? No 1 2 3 4 5
15. Do you snore? No 1 2 3 4 5
16. Does your snoring disturb others? No 1 2 3 4 5
17. Do you hold your breath or gasp for air in your sleep? No 1 2 3 4 5
18. Do you have trouble breathing at night? No 1 2 3 4 5
19. Is your sleep is disturbed by tossing and turning at night? No 1 2 3 4 5
20. Do you sweat excessively during the night? No 1 2 3 4 5
21. I wake up in the morning with a headache. No 1 2 3 4 5
22. I have asthma attacks during sleep. No 1 2 3 4 5
23. My legs seem to kick constantly during sleep. No 1 2 3 4 5
24. There are times when I must fall asleep and I cannot stop it. No 1 2 3 4 5
25. I have felt muscle weakness when I have strong emotional feelings. No 1 2 3 4 5
26. I have vivid dreams right after I fall asleep. No 1 2 3 4 5
27. I am unable to move when I wake up. No 1 2 3 4 5
28. A nap does not make me feel refreshed. No 1 2 3 4 5
29. Do you purposely nap on weekends? No 1 2 3 4 5
30. How often do you nap and how long do you nap? ____________________________
31. What time do you nap? ____________________ am ________________ pm
32. I have a problem falling asleep at night. No 1 2 3 4 5
33. How long does it take you to fall asleep? ________________ minutes
34. I require special conditions to fall asleep at night. (i.e.; music, tv) No 1 2 3 4 5
35. As I try to fall asleep I have anxious thoughts race through my head. No 1 2 3 4 5
36. I awaken with anxiousness, dread, or worry. No 1 2 3 4 5
37. On average, how many times do you wake up during the night?________________________
38. How long do you spend awake during the night? ________________________________
39. On average, how many times do you wake during the night? _______________________
40. How long do you spend awake during the night? ________________________________
41. Is your sleep disturbed by a medical problem? ________________________________
   If yes, please list. ___________________________________________________________
42. I awaken because of aches, pains, and headaches. No 1 2 3 4 5
43. As a child, did you have a problem falling asleep or waking in the morning? No 1 2 3 4 5
44. Do you have trouble going back to sleep if you wake during the night?  No 1 2 3 4 5
45. I am bothered by outside noises during the night such as planes, trains, or barking dogs. No 1 2 3 4 5
46. I tend to fall asleep when trying not to, or in a place other than my bedroom. No 1 2 3 4 5
47. As bedtime approaches I become anxious. No 1 2 3 4 5
48. When I am awake at night I will lie there until I fall back asleep. No 1 2 3 4 5
49. Because of my poor sleep at night I feel fatigued or “washed out” during the day. No 1 2 3 4 5
50. I have a crawling, creeping, feeling in the back of my legs which keeps me from falling asleep. No 1 2 3 4 5
51. Do you now or did you as a child do some sort of body rocking or head movements during sleep? No 1 2 3 4 5
52. Do you now or did you as a child awaken in a room other than the one you went to sleep in? No 1 2 3 4 5
53. Are you now or have you ever been a sleepwalker? No 1 2 3 4 5
54. According to your bed partner, have you ever seemed to be acting out a dream while asleep? No 1 2 3 4 5
55. Do you now or have you ever suffered from nightmares? No 1 2 3 4 5
56. According to your bed partner, have you ever woke screaming in fear and acting agitated? No 1 2 3 4 5
57. Do you now or have you ever had seizures in your sleep? No 1 2 3 4 5
58. I wake in a state of panic or distress? No 1 2 3 4 5
59. I talk in my sleep. No 1 2 3 4 5
60. I grind my teeth when sleeping. No 1 2 3 4 5
61. I feel “groggy” or “sleep drunk” when I wake in the morning.

62. Do you work a swing shift? _______yes_______no If yes, what hrs? ____________

63. If yes, does your shift rotate in a clockwise direction? _______yes_______no

64. Do you go to bed at the same time every night? _______yes_______no

65. Do you fall asleep earlier than you want to, No 1 2 3 4 5 sleep normally, then wake in the early morning hours?

66. Do you feel sleepy late at night, then receive less sleep due to a necessary early wake time? No 1 2 3 4 5

67. Do you sleep in several small periods of time during a 24 hour period? No 1 2 3 4 5

68. Do you have significant stress in your life at the present time? No 1 2 3 4 5

69. Do you presently feel sad or depressed? No 1 2 3 4 5

70. Have you ever been seen by a psychologist or psychiatrist? No 1 2 3 4 5

71. Do you take medications to stay awake/fall asleep? _______yes_______no

72. Do you sleep in a water bed? _______yes_______no

73. Do you eat one to two hours before sleep? _______yes_______no

74. Do you smoke before sleep? _______yes_______no

75. Do you exercise before sleep? _______yes_______no

76. Do you sleep alone? _______yes_______no

77. Do you watch TV nightly in bed? _______yes_______no

78. Have you ever had a sleep study before? _______yes_______no

79. Do you have any relatives with a sleep disorder? _______yes_______no

80. Do you use recreational drugs? _______yes_______no
81. Do you experience any pain that keeps you from sleeping? ________yes_______no

If yes, list the location: ____________________________________________________________

Pain type: ___________________ dull ___________________ aching__________________ sharp

What causes the pain? ________________________________________________________________

What relieves the pain? ______________________________________________________________

PLEASE LIST YOUR INTAKE OF THE FOLLOWING

Coffee______________________ per day  Liquor______________________ per day
Tea__________________________ per day  Soda__________________________ per day
Beer__________________________ per day  Cigarettes____________________ per day
Cigars_______________________ per day  Pipes___________________________ per day
Snuff_______________________ per day

Have you had any of the above today? ________yes_________no  Circle which one(s) above.

Please list your medications, both prescription and over the counter. You may use the back of
this form if needed.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Are you allergic to any medications? ___________________yes_________________ no

If yes, please list the medication (s)________________________________________________

Any other known allergies?__________yes__________no

If yes, please list______________________________________________________________
Please circle any problem(s) or illness(es) you have or have had.

Heart disease  High blood pressure  Heart attack  Low blood pressure  Diabetes
Asthma  Fainting  Dizziness  Headaches  Black outs  Epilepsy
Hemophilia  Ringing of the ears  Back trouble  Hernia  Prostate trouble
Mental problems  Allergies  Gout  Seizures  Bronchitis  Ulcers
Cancer  Kidney problems  Bladder problems  Eye problems  Hearing problems
Pneumonia  Meningitis  Arthritis  Heartburn  Impotence  Depression
  Venereal disease  Tuberculosis  Muscle cramps

Do you have any other past or present medical or psychiatric problems or have you had any recent surgeries? __________yes__________no
Please list: __________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

Have any of your family members had or currently have a sleep disorder? _______yes_______no
Please list: __________________________________________________________
________________________________________________________
________________________________________________________
________________________________________________________

____________________________________  ______________________________________
Patient Signature  Reviewed By – Physician Signature
THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling “just tired”? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
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<tbody>
<tr>
<td>Sitting and reading</td>
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<tr>
<td>Watching television</td>
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<tr>
<td>Sitting inactive in a public place (movie theater or meeting)</td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
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<tr>
<td>Sitting and talking quietly to someone</td>
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<tr>
<td>Sitting quietly after lunch without alcohol</td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
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TOTAL __________________

I understand that I should not drive when sleepy or drowsy.

Patient Signature
I understand I will be undergoing a sleep study. Electrodes and sensors will be attached to my body. The tape used may cause discomfort during removal and the tape or cream used may cause redness at the attachment site. During the study, I will be free to roll over in bed, but will have to ask for assistance to get out of bed to use the restroom. I will be observed by the technician on camera throughout the study. There are no significant risks to me during the study, and I understand the reason for the test and the procedure has been explained to me.

__________________________________________  _________________________
Signature (patient or guardian)                      Date

__________________________________________  _________________________
Signature (witness)                                 Date
I, ________________________________,

Patient/Guardian

hereby authorize the taking of photograph(s) and/or audio-videotape(s)

of ________________________________.

Name of Patient

By the Texas Neurology, PA staff, with the understanding that such photograph(s) and/or videotape(s) may be used for clinical or educational purposes or in the event of legal action. Texas Neurology, PA and trustees of Texas Neurology, PA and its duly appointed representatives are hereby released without recourse from any liability arising from the taking and use of such photograph(s) and/or videotape(s).

The undersigned also hereby transfers and assigns to Texas Neurology, PA the right to copy the materials in whole or in part. Any use of the tape for medical education will not identify me by name.

( ) Check here if you do NOT authorize use for educational purposes

_________________________________________  _______________________
Signature (patient or guardian)                  Date

_________________________________________
Relationship (if guardian)

_________________________________________  _______________________
Signature (witness)                             Date
Texas Neurology, P.A. Sleep Disorders Center
7001 Preston Road, Suite 404 Dallas, TX 75205
(214) 443-5154

Directions to Sleep Center from the North

Central Expressway
Travel South on Highway 75 to Northwest Hwy
Exit Right onto Northwest Hwy and Turn Left on Preston Road
(South West corner of intersection at Lovers Lane)
Go past Lovers Ln on Preston and Turn Right on Hyer Street
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

North Dallas Tollway
Travel South on Tollway to Northwest Highway
Exit Left onto Northwest Hwy and Turn Right on Preston Road
(South West corner of intersection at Lovers Lane)
Go past Lovers Ln on Preston and Turn Right on Hyer Street
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Stemmons Freeway (I-35)
Travel South on Interstate 35 to Mockingbird Lane
Exit Left onto Mockingbird Ln and Turn Left onto Preston Road
(South West corner of intersection at Lovers Lane)
Turn Left on Hyer Street before Lovers Lane
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Directions to Sleep Center from the East

Mesquite
Travel 30West to 75North (Central Expwy)
Exit Left onto Mockingbird Ln and Turn Right onto Preston Road
(South West corner of intersection at Lovers Lane)
Turn Left on Hyer Street before Lovers Lane
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Garland
Take Garland Road to Northwest Hwy West
Turn Left on Preston Road
(South West corner of intersection at Lovers Lane)
Go past Lovers Ln on Preston and Turn Right on Hyer Street
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Directions to Sleep Center from the South

Highway 175
Travel 175 West to 75 North (Central Expwy)
Exit Left onto Mockingbird Ln and Turn Right onto Preston Road
(South West corner of intersection at Lovers Lane)
Turn Left on Hyer Street before Lovers Lane
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Interstate 20
Travel 20 East to 75 North (Central Expwy)
Exit Left onto Mockingbird Ln and Turn Right onto Preston Road
(South West corner of intersection at Lovers Lane)
Turn Left on Hyer Street before Lovers Lane
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Interstate 45 (Ennis)
Travel 45 North to 75 North (Central Expwy)
Exit Left onto Mockingbird Ln and Turn Right onto Preston Road
(South West corner of intersection at Lovers Lane)
Turn Left on Hyer Street before Lovers Lane
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Directions to Sleep Center from the West

Interstate 30
Travel 30 East to 75 North (Central Expwy)
Exit Left onto Mockingbird Ln and Turn Right onto Preston Road
(South West corner of intersection at Lovers Lane)
Turn Left on Hyer Street before Lovers Lane
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.

Highway 114 (from DFW Airport using the North exit)
Travel East on Highway 114 to the Intersection of 183
Take 183 East almost to Interstate 35 merge
Exit Left onto Mockingbird Ln and Turn Left onto Preston Road
(South West corner of intersection at Lovers Lane)
Turn Left on Hyer Street before Lovers Lane
Turn Right into underground garage parking with your code.
We are on the 4th floor, suite 404.
**TEXAS NEUROLOGY, P.A. SLEEP DISORDERS CENTER**

**SLEEP LOG**

**Name:**

**INSTRUCTIONS:** Complete these logs as instructed using the directions provided below. Complete the logs in the morning and the evening. Do not complete the logs during the night. Write additional comments on the back. Bring these logs with you for your appointment or mail them to your physician.

1. Leave the times you are awake **BLANK**.
2. **SHADE** crosshatch, or color the times when you sleep.
3. **ARROW DOWN** whenever you lie down to sleep.
4. **ARROW UPWARD** when you awaken (include naps.)
5. "M" for meals, "S" for snacks, and a "D" for drinks with alcohol.
6. Include notes below each week or on the back.

**EXAMPLE:**

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<th>Date</th>
<th>6am</th>
<th>8am</th>
<th>10am</th>
<th>Noon</th>
<th>2pm</th>
<th>4pm</th>
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**FIRST WEEK**

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**SECOND WEEK**

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