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1.866.511.5678

Patient Information

Thank you for choosing Sleep**Trends** Diagnostic Centers for your sleep medicine needs. We want your stay with us to be as pleasant as possible. Therefore, here are some considerations to take into account in preparation for your stay with us.

- **48 hours notice is required for rescheduling / canceling.**
- Please arrive on time for your study. It is not necessary to arrive early.
- Please bring your identification, insurance card, and this completed paperwork.
- Please shower and wash your hair before arrival. Hair should be dry, and free of conditioners, hair spray, styling gels, etc.
- Please remove all make-up, and do not apply moisturizing lotion to face or legs.
- We will need one finger without an acrylic nail or dark polish.
- Please bring something comfortable to sleep in.
- Please understand that while you sleep we will be monitoring your biologic status through the use of diagnostic equipment that will be attached to you.
- Please advise us in advance of any **special needs or accommodations** you require.
- Please refrain from caffeinated and or alcoholic beverages on the night of your study.
- Please take normal medications unless your doctor has specifically advised against this.
- Overnight guests (other than necessary caregivers or legal guardians) are not allowed.
- Feel free to bring your favorite pillow and / or blanket. (not required)
- Feel free to bring a book or movie to read / watch prior to testing.
- Pagers and cell phones must be turned off during testing.
- Testing begins by approximately 10:30 p.m.
- Please make appropriate arrangements to leave in the morning (usually between 5 and 6 a.m.).
- After the study, your results will be available usually within 3 days.
- Schedule a **follow up** visit with the physician to discuss results and ask questions.
- If necessary, CPAP set-up will be completed in most cases within 1 week after titration.
- You should re-test annually to be certain that your prescribed pressure is accurate.

For questions, call 1.866.511.5678. Phone answered after hours.
Patients canceling without 48 hours notice will incur a \$100 fee.

Sleep **Trends** Diagnostic Centers

Sleep History Questionnaire

Name: _____ DOB: _____ Age: _____ Neck: _____ Date: _____

Male Female Height: _____ Weight: _____ Marital Status: M S D W

Occupation: _____ Emergency Name / #: _____

Primary Care Physician: _____ Referring Physician: _____

Medical History

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Nose Fracture |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nasal Surgery |
| <input type="checkbox"/> Hiatal Hernia / Reflux | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sinus Problems | |

Other: _____

Current Medications:

Medication allergies: _____

1. _____

Smoking: # of years: _____ Packs per day: _____

2. _____

Have you quit? Yes No When? _____

3. _____

Recent change in weight: _____

4. _____

On an average night:

How long does it take you to fall asleep? _____

How many hours do you spend in bed? _____

How many hours do you sleep at night? _____

Number of awakenings: _____

Length of awakenings: _____

Do you feel refreshed in the morning? Yes No

Do you awaken with a headache? Yes No

What is your usual Bedtime? _____

What time do you get up in the morning? _____

Do you or have you ever been told that you:

Grit or grind your teeth? Yes No

Have night sweats? Yes No

Experience leg cramps or tingling? Yes No

Repeatedly kick your legs while asleep? Yes No

Awaken with a sour or bitter taste in your mouth? Yes No

Hold your breath while you sleep? Yes No

Awaken choking, gasping, or short of breath? Yes No

Fall asleep unintentionally? Yes No

Snore? Since when? _____ Yes No

Do you experience any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Light Snoring | <input type="checkbox"/> Snoring interrupted by silence / gasping |
| <input type="checkbox"/> Moderate Snoring | <input type="checkbox"/> Trouble concentrating |
| <input type="checkbox"/> Loud Snoring | <input type="checkbox"/> Falling asleep at inappropriate times |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Short Temper |
| <input type="checkbox"/> Talking in Sleep | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Loss of Libido |
| <input type="checkbox"/> Restless Sleep | <input type="checkbox"/> Fatigue |

Do You ever:

- Read while in bed.
- Watch TV in bed. (or bed-partner does)
- Share your bed with anyone.
- Take naps. How long? _____
Are they refreshing? Yes No
- Awake to urinate during the night.
How often? _____

Are you experiencing excessive daytime sleepiness? Yes No How Long? _____

Are you bothered by feelings of restlessness, or need to move your legs, or pace when sitting for long periods of time?

Yes No During Awakenings? Yes No

Men: Do you ever have trouble achieving erections? YES NO Since when? _____

Do you feel anxious, depressed or irritable? YES NO If yes, Please Explain: _____

Please explain your sleep problem in detail:

Signs & Symptoms of Disordered Sleep

Name: _____ Date: _____

- Anxiety / Depression
- Falling Asleep at Inappropriate Times
- Fatigue or Malaise
- High Blood Pressure
- Insomnia of unknown etiology
- Insomnia with Apnea
- Irritability
- Loss of Energy
- Loss of Libido
- Loud or Disruptive Snoring
- Morbid Obesity
- Morning Headaches
- Narcolepsy – Daytime sleep attacks
- Nocturnal Awakenings / Arousals during sleep
- Obesity
- Periodic Limb Movements during sleep
- Restless Legs just prior to, or while falling asleep
- Shift Work Disorder
- Somnolence or Drowsiness
- Witnessed Breathing Pauses during sleep

Epworth Sleepiness Scale

Name: _____ Male Female Date: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

- 0 = would never doze
- 1 = slight chance of dozing
- 2 = moderate chance of dozing
- 3 = high chance of dozing

* It is important that you circle a number (0 to 3) on each question.

<u>Situation</u>	<u>Chance of Dozing</u>			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactively in a public place (e.g., a theater or meeting)	0	1	2	3
As a passenger in a car for about an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking	0	1	2	3
Sitting quietly after lunch (without alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3
TOTAL	_____			

Sleep *Trends* Diagnostic Centers

Beck/Cage Questionnaire

Name _____

Date _____

On this questionnaire are groups of statements. Please read each group carefully, then pick the one statement in each group which best describes the way you have been feeling the past week, including today. Circle the number beside the statement you have chosen. If two statements apply equally well, circle both. Be sure to read all the statements in each group before making your choice.

- | | |
|---|---|
| <p>1. 0 I do not feel sad
 1 I feel sad
 2 I feel sad all the time and I can not snap out of it
 3 I am so sad and unhappy I can not stand it</p> <p>2. 0 I am not particularly discouraged about the future
 1 I feel discouraged about the future
 2 I feel I have nothing to look forward to
 3 I feel the future is hopeless and things cannot improve</p> <p>3. 0 I do not feel like a failure
 1 I feel that I have failed more than the average person
 2 As I look back on my life, I see a lot of failures
 3 I feel I am a complete failure as a person</p> <p>4. 0 I get as much satisfaction out of things as I used to
 1 I don't enjoy things the way I used to
 2 I don't get satisfaction out of anything anymore
 3 I am dissatisfied and bored with everything</p> <p>5. 0 I don't feel particular guilty
 1 I feel guilty a good part of the time
 2 I feel quite guilty most of the time
 3 I feel guilty most of the time</p> <p>6. 0 I do not feel I am being punished
 1 I feel I may be punished
 2 I expect to be punished
 3 I feel I am being punished</p> <p>7. 0 I don't feel disappointed in myself
 1 I feel disappointed in myself
 2 I am disgusted with myself
 3 I hate myself</p> <p>8. 0 I don't feel I am worse than anybody else
 1 I am critical of myself and my weaknesses or mistakes
 2 I blame myself all the time for my faults
 3 I blame myself for everything bad that happens</p> <p>9. 0 I do not think about killing myself
 1 I have thought of killing myself, but would not do so
 2 I would like to kill myself
 3 I would kill myself if I had the chance</p> <p>10. 0 I do not cry any more than usual
 1 I cry more now than I used to
 2 I cry all the time now
 3 I used to be able to cry, but now I can not cry anymore</p> <p>11. 0 I am no more irritated now than I ever am
 1 I get annoyed or irritated more easily than I used to
 2 I feel irritated all the time now
 3 I do not get irritated at all by things that used to irritate</p> | <p>12. 0 I have not lost interest in other people
 1 I am less interested in other people than I used to be
 2 I have lost most of my interest in other people
 3 I have lost all my interest in other people</p> <p>13. 0 I make decisions as well as I ever could
 1 I put off making decisions more than I used to
 2 I have greater difficulty making decisions than before
 3 I can not make decisions at all anymore</p> <p>14. 0 I do not feel I look worse than I used to
 1 I am worried that I am looking old and unattractive
 2 I feel there are negative changes in my appearance
 3 I feel I look ugly</p> <p>15. 0 I can work as well as before
 1 It takes extra effort to get started at doing things
 2 I have to push myself very hard to do something
 3 I can not do any work at all</p> <p>16. 0 I can sleep as well as usual
 1 I do not sleep as well as I used to
 2 I wake up 1 or 2 hours earlier than I used to
 3 I wake up hours earlier and can not go back to sleep</p> <p>17. 0 I do not get more tired than usual
 1 I get tired more easily than I used to
 2 I get tired from doing almost anything
 3 I am too tired to do anything</p> <p>18. 0 My appetite is no worse than usual
 1 My appetite is not as good as it used to be
 2 My appetite is much worse than it used to be
 3 I have no appetite at all anymore</p> <p>19. 0 I have not lost much weight, if any lately
 1 I have lost more than 5 pounds I am trying to
 2 I have lost more than 10 pounds lose weight by
 3 I have lost more than 15 pounds eating less Y N</p> <p>20. 0 I am no more worried about my health than usual
 1 I am worried about my physical problems
 2 I am very worried and often think about my health
 3 I am so worried I think all the time about my health</p> <p>21. 0 I have not noticed any change in my interest in sex
 1 I am less interested in sex than I used to be
 2 I am much less interest in sex now
 3 I have lost all interest in sex</p> <p>Do you drink alcoholic drinks. <input type="checkbox"/> YES <input type="checkbox"/> NO
 If yes, please answer the following:</p> <p>Y N I feel I need to cut down on drinking alcoholic drinks
 Y N People have criticized me and told me to drink less
 Y N I sometimes feel bad or guilty about my drinking
 Y N I sometimes have a drink the first thing in the morning to start my day</p> |
|---|---|

TOTAL _____