NSSC NEUROLOGY, SEIZURE & SLEEP CLINIC

Patient Pre-Study Instructions

Please read the following information below to assist us in making your overnight study more comfortable, as well as maximizing the quality of our data collection.

Before your arrival:

- Make sure your hair is clean and free of any hair products such as hairspray, gels, etc. Weaves must be removed and tight braids should be taken down.
- Do not use any body lotions or facial creams before the study.
- If possible please remove any nail polish or acrylic nails from your index finger on both hands.
- Bring/Wear comfortable clothing for the study.
- You may bring a light snack with you, but please try to have your evening meal before your arrival.
- You may bring a DVD movie to watch while waiting you will have about one hour of free time.
- Do not forget to bring all necessary medications with you.
- If you already own a CPAP unit and headgear, please bring the headgear with you.
- Please bring any patient paperwork and proof of insurance to your study.

Things to Know:

- If you have any special needs (i.e. trouble with mobility, incontinence, etc.), please let us know in advance so that we can properly care for you.
- We end most studies at 5:00 A.M., so please prearrange any necessary transportation needs to be ready by 6:00 A.M.
- We cannot guarantee your insurance company will cover the cost of your study. Please contact your insurance company before the study and give them the applicable procedure codes to determine any cost you may be responsible for. Thank You.

If for any reason you need to cancel your appointment, please advise us 1 business day before your scheduled appointment. Failure to do so will result in a $100.00 cancellation fee.

If you need to reach a sleep technician and it is AFTER 7:30PM please call (214)574-4999 or call the office during normal business hours. Thank you for choosing us and we look forward to your stay.

Southwestern Neuroscience Institute
Neurology Seizure and Sleep Clinic
M: 214.496.0500 F: 214.496.0922

SNI Sleep Center
1215 Kinwest Parkway Ste 120
Las Colinas/Irving, TX 75039

SNI Sleep Center

SLEEP QUESTIONNAIRE

Name:_____ Date: _____

Age:_____Sex: Male / Female Weight:_____Height:_____Neck Circumference: _____

MEDICAL HISTORY: (Circle all that apply)

High blood pressure	Lung Disease	Cancer	Diabetes
Headaches	Thyroid Disease	Liver Disease	Seizures
Stroke	Depression	Neuropathy	Kidney Disease
Parkinson's	Fibromyalgia	Arthritis	Mood Disorders

Other: _____

Have you ever been diagnosed with Sleep Apnea? **Yes No** If, so have you ever been treated with a CPAP machine? **Yes and I still use my CPAP, Yes but I no longer use my CPAP or No**

Have you tried alternative Sleep Apnea treatments? **Yes No**. If so what treatment options have you tried?

Date of last sleep study: _____

PAST SURGICAL HISTORY (Circle all that apply)

Heart Surgery Tonsillectomy UPPP LAUP Somnoplasty

Other: _____

MEDICATIONS:_____

SLEEP HISTORY

What time do you go to bed?	_____
What time do you wake up?	_____
How long does it take up to fall asleep?	_____
What are your average hours of sleep per night?	_____
Does your sleep schedule vary?	_____
Do you work shift work? If so what shift?	_____
Do you take any medications to help you fall asleep? If so what medication?	_____
Do you take any medications to help you stay awake? If so what medications?	_____
How many naps do you take in a week? And how long do they last?	_____
Are your naps refreshing?	Yes No
Have you fallen asleep while driving, causing an accident?	Yes No
Have your sleep problems caused poor job/school performance?	Yes No
How many caffeinated beverages do you drink in a day? How many within two hours of bed time?	_____
Do you smoke Cigarettes, Cigars or Pipes? If so how much?	_____
Do you use recreational drugs? If so what and how often?	_____
Do you exercise? If so when	_____

SNI Sleep Center

SLEEP QUESTIONNAIRE

SYMPTOMS AT SLEEP ONSET (Circle all that occur always or often)

Muscular tension
Creeping, crawling aching, twitching legs
Vivid dreamlike scenes
General Fear
Fear of not sleeping
Uncontrollable urge to move legs
Racing thoughts
Suddenly becoming alert/aware
Sadness/Depression
Unable to move
General discomfort
Anxiety (worry)
Fear of dark

SYMPTOMS DURING SLEEP (Circle all that occur always or often)

Fear of not returning to sleep if awakened
Sleeps with a bed partner
Gets up to attend to someone or something
Feeling your heart pounding
Walks in your sleep
Wake up screaming or violent
Has unusual movements in sleep
Has dreams
Having trouble going back to sleep
Has restless disturbed sleep
Snores loudly
Night sweats
Falls out of bed while asleep
Wakes up confused
Wets the bed
Grinds your teeth

MY SLEEP IS FEQUENTLY DISTURBED BY: (Circle all that apply)

Heat
Hunger
Choking
Cold
Asthma
Thirst
Light
Noise
coughing
Shortness of breath
Need to urinate
Feeling of or movement of legs
Movement of partner
Heartburn or gas
Creeping, crawling, aching feeling of the legs

SYMPTOMS UPON AWAKENING (Circle all that occur always or often)

Depend on an alarm clock
Have dreamlike images
Wake up nauseated
Wake one to two hours before required time
Sleep in more than usual time
Wake up confused or disoriented
Wake up with a dry mouth
Have a hard time waking up
Wake up with a headache
Wake up unable to move

SYMPTOMS OF DAYTIME FUNCTIONS (Circle all that occur always or often)

Feel sleepy during the day
Have racing thoughts
Feel weak when laughing Surprised, angry or excited
Fall asleep unintentionally
Feel sad or depressed
Have anxiety
Feel muscular tension

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BED PARTNER QUESTIONNAIRE

(To be completed by the patient's bed partner regarding the patients' sleep)

Patient Name: _____ Date: _____

Bed Partner Name: _____

I OBSERVE THE PATIENT'S SLEEP (circle the best answer)

Never	Once or Twice	Often	Every Night

THE PATIENT EXPERIENCES THE FOLLOWING BEHAVIORS DURING SLEEP: (circle all that apply)

Light snoring	Occasional loud snoring	Twitching/kicking Legs	Twitching/jerking arms
Bedwetting	Frequent loud snoring	Eating at night	Head rocking/banging
Choking	Awakening in pain	Becoming very rigid	Sitting up but not awake
Shaking	Pausing in breathing	Talking in Sleep	Sleepwalking
Grinding Teeth	Texting in Sleep	Biting Tongue	

DESCRIBE THE BEHAVIOR CHECKED IN MORE DETAIL (include time of night, frequency during the night and how many nights a week it occurs)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HAS THE PATIENT EVER FALLEN ASLEEP DURING NORMAL DAYTIME ACTIVITES OR IN DANGEROUS SITUATIONS? **YES NO**

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ESS: _____
STOP-BANG: _____

Patient Name: _____ Date: _____

Age: Sex: _____ Weight: _____ Height: _____ Neck Circumference: _____

EPWORTH SLEEPINES SCALE

Directions:

1. Please read the list of situations and answer how likely you would be to doze off or fall asleep, and not just tired, at these times.
2. The situations refer to the last three weeks.
3. Even if you have not done or been in these situations recently, please try to guess how they may have affected you.
4. Please use the following scale graded 0,1,2 and 3 for each situation and give the total.

0 = would never dose ***1 = slight chance of dozing***
2 = moderate chance of dozing ***3 = high chance of dozing***

Sitting and reading	_____
Watching Television	_____
Sitting quietly in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a care, while stopped for a few minutes in traffic	_____
TOTAL	_____

THE STOP –Bang Questionnaire

(OSA screening tool)

1.	Do you **S**nore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
2.	Do you often feel **T**ired, fatigued, or sleepy during the day?	Yes	No
3.	Has anyone **O**bserved you to stop breathing during your sleep?	Yes	No
4.	Do you have or are you being treated for high blood **P**ressure?	Yes	No
5.	**B**ody Mass Index (BMI) more than 35? (BMI = (your weight in pounds * 703) / (your height In inches * your height in inches))	Yes	No
6.	**A**ge over 50 yr. old?	Yes	No
7.	**N**eck circumference greater than 40 cm?	Yes	No
8.	**G**ender male?	Yes	No

Scoring: Yes to 3 or more of the 8 questions indicate that you are High Risk for OSA. Answering less yes to less than three indicates that you are low risk for OSA

The Southwestern Neuroscience Institute

Neurology Seizure and Sleep Clinic

Patient information Form

Please complete the following questions in the spaces provided. Attach additional information if necessary

1. Patient's Full Name ____

   Street Address, City, State, Zip:

   _____

   Primary Phone_____Secondary Phone _____

   Social Security Number_____DOB _____

   Gender_____

2. Employers Name_____Occupation _____

3. Primary Insurance Carrier ____

   Name of Policy Holder_____Policy Holder DOB_____

   Identification Number_____Group Number _____

4. Insurance Address _____

   Secondary Insurance Carrier _____

   Name of Policy Holder_____Policy Holder DOB_____

   Identification Number_____Group Number _____

   Insurance Address _____

5. Who referred you to this office?_____Phone _____

   Name of your Primary Care Physician_____Phone _____

6. In case of an emergency, please list relatives or friends that are not living with you.

Name	*Relation*	*Address*	*Phone*

7. I understand that *Southwestern Neuroscience Institute Neurology Seizure and Sleep Clinic* will file my insurance. I hereby authorize this office to furnish medical information to insurance agencies if necessary to file my claim. I also understand that if my insurance claim is not paid in 90 days, I am fully responsible for payment of any and all charges.

   Signature _____ Date _____

The Southwestern Neuroscience Institute

Neurology Seizure and Sleep Clinic

Release of Medical Records

I hereby authorize Southwestern Neuroscience Institute Neurology Seizure and Sleep Clinic to send or obtain any medical information needed for my care.

I understand that the specific information to be released may include all physician records as well as treatment of drug or alcohol abuse, mental illness, or communicable disease; this does include Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information had been made prior.

_____ _____

Printed Name Date

_____ _____

DOB Signature

You have the right to limit medical information we disclose to someone involved in your care. If you wish to do so, please write down any persons or facilities that you do not want to receive information and the information you want limited. Please note that Henry G Raroque Jr., MD does not have to agree to your request.

Restrictions:

_____

_____

_____

Please list persons we may speak to regarding your care, on your behalf. (ie. Spouse, child, friend):

_____

_____

_____