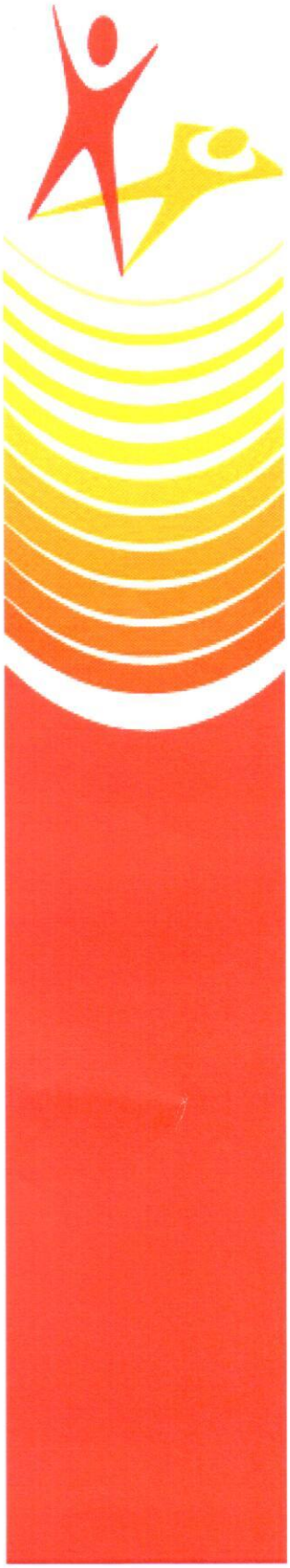

Sleep & Daytime Fatigue Center
12322 East Freeway Ste B3

Houston, Texas 77015
Ph (281) 598-6218 Fax (281) 481-0093

Dear_____,

Your sleep study has been scheduled on _____ _____. Please report to the Sleep Center located at 12322 East Freeway #B3 (Located next to Monarch Dental) where you will be already registered.

The test your physician has ordered will be done on an outpatient basis but does require an overnight stay.

When you arrive, you will be shown to your private room. The technologist who greets you will thoroughly explain the testing procedures to you. Shortly after you arrive test preparation will begin which involves attaching electrodes to your head, chest and legs. This procedure is non-invasive and will take approximately one hour. You will then be allowed to retire to your room and relax before bedtime. You are welcome to bring a family member with you but they will be asked to leave prior to the beginning of the test.

Bring all items required for an overnight stay. You will need to bring all personal toiletry items such as toothpaste, razor etc.

It is necessary for you to bring something to sleep in such as pajamas, shorts, sweats or a nightgown.

Every room has a comfortable bed and pillow. If you have a pillow you are more comfortable with, please bring it with you.

Please make sure you have eaten a good meal before you arrive. **Eliminate caffeine and alcohol the day of your study**.

Do not nap on the day of your study.

You will not be served dinner. If you are scheduled for an MSLT you will be served breakfast and lunch.

Sleep & Daytime Fatigue Center

- ✓ Bring any medications that you may need including inhalers, etc. with you on the night of the study. Do not take any optional medications such as sleeping pills, antihistamines or tranquilizers that you are not required to take on a daily basis. If uncertain about which medications you should take, please check with your physician or the Sleep Center.

- ✓ The technician will wake you around 5:30 a.m. You may want to ask your technician to wake you early so you will be able to go home to prepare for the day. If so, just let your technician know before you go to bed.

- ✓ Please complete the enclosed questionnaire and bring it with you the night of testing. We will request recent medical records from your physician. However, it would be helpful to bring any records you may have access to which pertain to your sleep problems, past or present.

- ✓ It is important that you are felling well the day of the study. If you become ill, have severe congestion or a migraine headache please call the sleep center and let us know. We will reschedule you for the next available date.

PLEASE DO NOT COME EARLY FOR YOUR TESTING. THE LAB OPENS AT 8:00 P.M. AND IF YOU COME EARLY YOU WILL HAVE TO WAIT IN YOUR VEHICLE.

Following the instructions above can help provide you with a more comfortable stay and will help us with the best accurate results. If this is not clear or if you have any additional questions, please do not hesitate to call The Sleep Center at 281-481-0091.

12322 East Freeway #B3

Houston, Texas 77015

281-481-0091

TEXAS INSTITUTE OF CHEST & SLEEP DISORDERS

12322 East Freeway Ste B3
Houston,Texas
(281)481-0091 (281) 481-0093

ACCREDITED
MEMBER CENTER

SLEEP INTERVIEW QUESTIONNAIRE

Date: _____ Referring Physician: _____

1. Name: Last_____ First _____ MI: ____ Male/Female
2. Marital Status: _____Religion_____ Race_____
3. Date of birth: ____/____/_____ Age: ___ SSN: ____-____-____ Occupation_____
4. Employer_____ Employer Address_____
5. Emergency Contact_____ Emergency Phone#_____

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits.

Section I: Main Complaint

6. What is your main sleep complaint? _____
7. How long has this been a problem? _____
8. Were there any events (weight gain, stress, illness, etc.) associated with the onset of your complaints? _____
9. Have you had a sleep study or home screen? No____ Yes ____ How long ago? ____ Where? _____
10. Have you ever used nasal CPAP or BiPAP? No____ Yes ____
    If so, how long? _____ Pressure setting _____ Mask _____

Section II: History of Sleep / Wake Disorder / Epworth Sleepiness Scale (ESS)

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

Situation	*Chance of Dozing*			
1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (e.g. theater or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
8. In a car, while stopped in traffic	0	1	2	3
				Total _____

Do you fall asleep or become sleepy when:	*Never*	*Sometimes*	*Often*	*Always*
1. Driving?	0	1	2	3
2. At work?	0	1	2	3
3. Do you take intentional naps?	0	1	2	3
4. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	0	1	2	3
5. Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3

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6. Do you feel unable to move (paralyzed) when falling asleep?	0	1	2	3

Do you fall asleep or become sleepy when:	*Never*	*Sometimes*	*Often*	*Always*
7. Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep that is relieved by moving or getting out of bed and walking?	0	1	2	3
8. How would you rate your overall sleepiness?	None	Mild	Moderate	Severe

While asleep do you:	*Never*	*Sometimes*	*Often*	*Always*
9. Snore?	0	1	2	3
10. Hold your breath? Or have you been told you stop breathing?	0	1	2	3
11. Toss and turn or have restless sleep?	0	1	2	3
12. Suddenly awaken choking or gasping for breath?	0	1	2	3
13. Awaken with heartburn or acid reflux? (acid taste in mouth)	0	1	2	3
14. Walk or talk in your sleep? (circle appropriate event)	0	1	2	3
15. Have nightmares?	0	1	2	3
16. Grind your teeth?	0	1	2	3
17. Have leg or arm jerks, twitches, or kicks?	0	1	2	3
18. Move about or engage in aggressive behaviors while asleep or awakening from sleep?	0	1	2	3
19. Wake up with a dry mouth?	0	1	2	3
20. Wake up with headaches?	0	1	2	3
21. Do you think you need a sleeping pill, either prescription drug or over-the-counter sleeping aids in order to fall asleep?	0	1	2	3
22. Do you consume wine or another alcoholic beverage in order to fall asleep?	0	1	2	3
23. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks?	0	1	2	3
24. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep?	0	1	2	3
25. Do you dread getting into bed because you think you will "never" fall asleep?	0	1	2	3

Section III: Sleep Habits

26. What time do you go to bed on weekdays? _____ weekends? _____
27. How long does it take you to fall asleep? _____
28. What percentage do you sleep on your Back ___% Stomach ___% Left/Right side ___/___%
29. a.) How often do you awaken at night? _____
    b.) How long do you stay awake? _____
    c.) What reason? (bathroom, etc.) _____
30. What time do you get up on weekdays? _____ weekends? _____
31. How many hours of sleep do you get in a typical night? _____
32. How do you feel in the morning?
    Very sleepy? _____ Sleepy, but wake up soon _____ Wide awake, ready to go _____
33. When do you function best? Morning: Best Medium Worst

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Afternoon:	Best	Medium	Worst
Evening:	Best	Medium	Worst

Section IV: Medical History

1. Please outline your medical history. Do you have or have ever been told you have:

- □ High Blood Pressure
- □ Sinus Problems
- □ Diabetes
- □ Arthritis
- □ Thyroid Problems
- □ Anemia
- □ Heart Disease
- □ Lung Disease
- □ Elevated Cholesterol
- □ Stroke
- □ GI Disease
- □ Cancer
- □ Frequent Nighttime Urination
- □ Depression and/or Anxiety
- □ Liver Disease
- □ Seizures or Epilepsy
- □ Migraine or Frequent Headaches
- □ Parkinson's
- □ Dementia (Alzheimer's, etc.)
- □ Prior History of Sleep Apnea
- □ Prior History of Restless Legs
- □ Obesity
- □ Abnormal Behavior During Sleep

Past Medical or Surgical History (include all hospitalizations within the past five years)

Problem	Date of onset	Treatment	Resolved/Current

2. List prescription and over-the-counter medications/drugs you are taking or recently have taken:

Name	Dosage	How often	Reason

3. Your weight? _____ Your height? _____
4. Do you smoke? _____ If yes, how long? _____ How much? _____/ day
5. Do you drink alcohol? ____ If yes, how long? _____ How much? ____/ day/wk/mo
6. Do you drink caffeinated beverages (coffee, tea, cola)? _____ How much? ____/ day/wk/mo

General History

1. Have you had any recent problems with your memory or concentration? _____
   If yes, explain: _____
2. Have you noticed any changes in your mood or irritability lately? _____
   If yes, explain: _____
3. Are you having any other problems (e.g. stress, anxiety, or pressures)? _____
   If yes, explain: _____
4. Have you been depressed lately? _____
   If yes, explain: _____
5. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc.)?_____
   If yes, explain: _____
   _____
6. Do you often travel across time zones, thereby affecting your sleep/wake schedule? _____
   If yes, explain: _____
   _____
7. Do you work night shifts and/or rotating shifts? _____
   If yes, explain:

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8. How did you hear about us? Physician referral/Friend/Web Page/Phone Book or advertisement in the

TO BE COMPLETED BY BED PARTNER

Check any of the following behaviors that you have observed the patient doing while asleep.

____ Loud Snoring
____ Sitting up in bed while asleep
____ Twitching of legs or feet
____ Pauses in breathing
____ Grinding teeth
____ Talking in sleep
____ Light Snoring
____ Rocking or banging head
____ Kicking legs while asleep
____ Getting out of bed while asleep
____ Becoming very rigid and/or shaking
____ Sleep Walking

How long have you been aware of the sleep behaviors that you have checked above?

Describe the behaviors checked above in detail. Include description of activity, time it occurs, frequency during the night and whether it happens every night.

Any additional comments:

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DAILY SLEEP LOG

Please complete this on a daily basis for seven consecutive days prior to your scheduled sleep study.

E: _____	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
t time did you go to bed last night							
long did it take you to fall							
many times did you wake up the night? A. Do you know . How much time were you ?							
t time did you wake up this g							
t time did you get out of bed?							
did you feel this morning?							
ou nap today? How long?							
ou taking sleep Medications? hat? How much?							
you had coffee, tea or cola oday? How Many?							
e you had any alcohol today?							
anything unusual or stressful today?							

ATTENTION SLEEP STUDY PATIENTS

PLEASE READ THIS CANCELLATION POLICY CAREFULLY

Cancellation Policy

You have been scheduled for a sleep study. If you are unable to keep your scheduled appointment, we respectfully request advance notification of at least 72 hours. Please call the doctor's office (281)481-0091 to RESCHEDULE YOUR APPOINTMENT. Your advance notification will allow the sleep center to schedule other patients who are waiting for sleep testing.

If advance notification is not received, regrettably, a cancellation fee of $110 will be billed to you for the missed appointment. This cancellation fee is not a covered expense by your insurance company!

The reason for this is as follows. Most sleep technicians are contracted employees and must be paid even if the scheduled patient does not keep the appointment. It is because of this industry standard that we must pass on a portion of the cost to our patients.

Thank you and we'll see you at the next appointment.

ATTENTION PATIENTS

If Dr. Lechin or Dr. Nasser sent you to have a test done, it is your responsibility to call our office after you have completed your test(s) so that we can schedule you for a follow up appointment to discuss your results.

Please be aware that we will not discuss any test results over the phone.

Si el Dr. Lechin o el Dr. Nasser lo envió para hacer una prueba Es su responsabilidad de llamar a nuestra oficina después de que usted haya terminado sus pruebas para poder programarle para una cita, para discutir sus resultados.

No discutiremos ningun resultado de la prueba sobre el teléfono.

Print Name: _____

Signature: _____ Date: _____

Thank you.