What follows is a list of suggested preparations, which should make your testing run smoothly.

1. Avoid napping the day of your test.
2. Bring comfortable, loose fitting pajamas. **(Sleeping in underwear only is not permissible)**
3. Avoid caffeine or alcohol after 2:00 p.m. the day of your test.
4. Wash and dry your hair prior to arrival; do not apply any hair spray or other hair gels after drying.
5. Take your medicine(s) as prescribed unless otherwise instructed by your physician.
6. FEMALES - Make sure your face is free of excess make-up or oils.
7. MALES - Please shave any recent facial stubble growth - full beards can be worked around.
8. You may bring your own pillow if so desire.
9. Our laboratory is equipped with a bathroom.

If you are a diabetic please bring your glucometer and any testing supplies you may need to test your glucose levels during the night of your study.

We look forward to serving you and hope to accommodate you in a courteous and professional manner.

Oklahoma Sleep Associates Sleep Questionnaire

Patient Name: _____ Date: _____

Address: _____ Home Phone:_____

City/State/Zip: _____ Work Phone:_____

Date of Birth: _____/_____/_____ Age:_____years Sex: ___ Male ___ Female

Height: _____feet _____inches Weight :_____lbs. Neck Circumference: _____inches

SSN: _____-_____-_____ Occupation: _____

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 frankly and accurately as possible as they related to the last 12 months. Do not leave any questions unanswered. You may add comments to any of your answers in the margin beside the question. All information will be kept strictly confidential.

01. Briefly describe the nature of your chief complaint: _____

_____

_____

02. How long have you had this problem? ___ About _____Months ___ About _____Years

03. How long has this problem affected your life? ___ About _____Months ___ About _____Years

04. Briefly describe any serious illness or major medical procedure you have experienced and the date they were incurred:

_____

_____

_____

05. List medications you are currently taking: _____

_____

_____

_____

06. Have you ever been diagnosed or treated for Obstructive Sleep Apnea? ___ Yes ___ No

If yes, what type of treatment was prescribed or performed?_____

07. I feel that I get enough sleep at night.	Never	Sometimes	Often	Frequently	Always
08. I feel that I get too much sleep at night.	Never	Sometimes	Often	Frequently	Always
09. What time do you go to bed at night?	_____:_____				
10. What time do you wake up in the morning?	_____-_____				
11. Do you vary this pattern on weekends?	Never	Sometimes	Often	Frequently	Always
12. No matter how much sleep I get, I wake up feeling sleepy.	Never	Sometimes	Often	Frequently	Always
13. Do you have a problem with your performance at work because your sleepy or tired?	Never	Sometimes	Often	Frequently	Always
14. Do you snore?	Never	Sometimes	Often	Frequently	Always
15. Does your snoring disturb others?	Never	Sometimes	Often	Frequently	Always
16. Do you hold your breath or gasp for air in your sleep?	Never	Sometimes	Often	Frequently	Always

17. Do you have trouble breathing at night?	Never	Sometimes	Often	Frequently	Always
18. Is your sleep disturbed by tossing and turning at night?	Never	Sometimes	Often	Frequently	Always
19. Do you sweat excessively during the night?	Never	Sometimes	Often	Frequently	Always
20. Do you awaken with headaches in the morning?	Never	Sometimes	Often	Frequently	Always
21. Do you have asthma attacks during sleep?	Never	Sometimes	Often	Frequently	Always
22. Do your legs seem to kick constantly during sleep?	Never	Sometimes	Often	Frequently	Always
23. Do you experience creeping sensations in your legs at night and feel as though you must move them?	Never	Sometimes	Often	Frequently	Always
24. Are there times where you feel as if you must fall asleep and cannot stop it from happening (sleep attack)?	Never	Sometimes	Often	Frequently	Always
25. Do you feel muscle weakness or have collapsed from feeling strong emotions (i.e., laughter, scared, excitement)?	Never	Sometimes	Often	Frequently	Always
26. Do you sometimes feel unable to move when waking up or falling asleep (paralyzed feeling)?	Never	Sometimes	Often	Frequently	Always
27. Do you experience, vivid dream-like imagery when falling asleep or waking-up?	Never	Sometimes	Often	Frequently	Always
28. Do naps make you feel refreshed?	Never	Sometimes	Often	Frequently	Always
29. Do you have a problem falling asleep at night?	Never	Sometimes	Often	Frequently	Always
30. Do you require special conditions to fall asleep at night?	Never	Sometimes	Often	Frequently	Always
31. When trying to sleep, do you have anxious thoughts or racing thoughts in your mind?	Never	Sometimes	Often	Frequently	Always
32. Do you awaken with anxiousness, dread, or worry?	Never	Sometimes	Often	Frequently	Always
33. Is your sleep disturbed by a medical condition?	___ Yes	___ No			
If yes, please list medical condition:_____					
34. Do you awaken because of aches, pains, or headaches?	Never	Sometimes	Often	Frequently	Always
35. Do you have trouble going back to sleep if you wake up during the night?	Never	Sometimes	Often	Frequently	Always
36. Are you bothered by outside noises during the night, such as planes, trains, or barking dogs?	Never	Sometimes	Often	Frequently	Always
37. Do you fall asleep when not trying, or in a place other than your bedroom?	Never	Sometimes	Often	Frequently	Always
38. As bedtime approaches, do you become anxious?	Never	Sometimes	Often	Frequently	Always
39. When you awaken at night, do you lie there until you fall back asleep?	Never	Sometimes	Often	Frequently	Always

40. Due to poor sleep, do you feel fatigued or "washed out" during the day?	Never	Sometimes	Often	Frequently	Always
41. Are you are have you ever been a sleepwalker?	Never	Sometimes	Often	Frequently	Always
42. According to your bed partner, have you ever seemed to act out a dream while asleep?	Never	Sometimes	Often	Frequently	Always
43. Have you ever had seizures in your sleep?	Never	Sometimes	Often	Frequently	Always
44. Do you awaken in a state of panic or distress?	Never	Sometimes	Often	Frequently	Always
45. Do you talk in your sleep?	Never	Sometimes	Often	Frequently	Always
46. Do you grind your teeth when asleep?	Never	Sometimes	Often	Frequently	Always
47. Do you feel "groggy" or "sleep drunk" when you wake up in the morning?	Never	Sometimes	Often	Frequently	Always
48. Do you work a swing shift?	Never	Sometimes	Often	Frequently	Always
49. Do you go to bed at the same time each day?	Never	Sometimes	Often	Frequently	Always
50. Do you fall asleep earlier than you want to, sleep normally then wake in the early morning hours?	Never	Sometimes	Often	Frequently	Always
51. Do you feel sleepy late at night, then receive less sleep due to a necessary early wake up time?	Never	Sometimes	Often	Frequently	Always
52. If you sleep longer, do you feel more rested?	Never	Sometimes	Often	Frequently	Always
53. Do you sleep in several small periods throughout the day?	Never	Sometimes	Often	Frequently	Always
54. Do you have significant stress in your life at present?	Never	Sometimes	Often	Frequently	Always
55. Do you feel depressed or sad at present?	Never	Sometimes	Often	Frequently	Always
56. Do you take medication to stay awake or fall asleep?	___ Yes	___ No			
57. Do you eat 1-2 hours before sleep?	___ Yes	___ No			
58. Do you exercise before going to sleep?	___ Yes	___ No			

EPWORTH SLEEPINESS SCALE:

How likely are you to fall asleep or doze in the circumstances listed below? (When rating these situations, give highest consideration to recent events. If you have never experienced one of the situations, estimate how you might have reacted.)

0 = No Chance 1 = Slight Chance 2 = Moderate Chance 3 = High Chance

Situation	Chance of dozing
Sitting and reading	_____
Watching television	_____
Sitting, inactive in a public place (e.g. theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking quietly to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____ Total:_____

Oklahoma Sleep Associates Beck Inventory

Patient Name: _____ Date: _____

CHOOSE ONE STATEMENT UNDER EACH LETTER THAT BEST DESCRIBES YOU FOR THE LAST SEVEN DAYS. CHECK THE NUMBER TO THE LEFT OF THE STATEMENT YOU HAVE CHOSEN.

___ 0 I do not feel sad.
___ 1 I feel sad.
___ 2 I am sad all the time and I can't snap out of it.
___ 3 I am so sad or unhappy that I can't stand it.

___ 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 that the future is hopeless and that things cannot improve.

___ 0 I do not feel like a failure.
___ 1 I feel I have failed more than the average person.
___ 2 As I look back on my life, all I can see is a lot of failure.
___ 3 I feel I am a complete failure as a person.

___ 0 I get as much satisfaction out of things as I use to.
___ 1 I don't enjoy things the way I use to.
___ 2 I don't get real satisfaction out of anything anymore.
___ 3 I am dissatisfied or bored with everything.

___ 0 I don't feel particularly guilty.
___ 1 I feel guilty a good part of the time.
___ 2 I feel quite guilty most of the time.
___ 3 I feel guilty all of the time.

___ 0 I don't 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.

___ 0 I don't feel disappointed in myself.
___ 1 I am disappointed in myself.
___ 2 I am disgusted with myself.
___ 3 I hate myself.

___ 0 I don't feel I am any worse than anybody else.
___ 1 I am critical of myself for my weaknesses/mistakes.
___ 2 I blame myself all the time for my faults.
___ 3 I blame myself for everything bad that happens.

___ 0 I don't have any thoughts of killing myself.
___ 1 I have thoughts of killing myself, but I would not carry them out.
___ 2 I would like to kill myself.
___ 3 I would kill myself if I had the chance.

___ 0 I don't cry anymore than usual.
___ 1 I cry more now than I use to.
___ 2 I cry all the time now.
___ 3 I used to be able to cry, but now I can't cry even though I want to.

___ 0 I am no more irritated now than I ever am.
___ 1 I get annoyed or irritated more easily than I use to.
___ 2 I feel irritated all the time now.
___ 3 I don't get irritated at all the things that use to irritate me.

___ 0 I have not lost interest in other people.
___1 I am less interested in other people than I use to be.
___ 2 I have lost most of my interest in other people.
___ 3 I have lost all of my interest in other people.

___ 0 I make decisions about as well as I ever could.
___ 1 I put off making decisions more than I use to.
___ 2 I have greater difficulty in making decisions than I use to.
___ 3 I can't make decisions at all anymore.

___ 0 I don't feel I look any worse than I use to.
___ 1 I am worried that I am looking old or unattractive.
___ 2 I feel that there are permanent changes in my appearance that makes me look unattractive.
___ 3 I believe that I look ugly.

Oklahoma Sleep Associates Beck Inventory

___ 0 I can work about as well as before
___ 1 It takes an extra effort to get started at doing something.
___ 2 I have to push myself very hard to do anything.
___ 3 I can't do any work at all.

___ 0 I can sleep as well as usual.
___ 1 I don't sleep as well as I use to.
___ 2 I wake up 2-3 hours earlier than usual and find it hard to get back to sleep.
___ 3 I wake up several hours earlier than I use to and cannot get back to sleep.

___ 0 I don't get more tired than usual.
___ 1 I get tired more easily than I use to.
___ 2 I get tired from doing almost anything.
___ 3 I am too tired to do anything.

___ 0 My appetite is no worse than usual.
___ 1 My appetite is not as good as it use to be.
___ 2 My appetite is much worse now.
___ 3 I have no appetite at all anymore.

___ 0 I haven't lost much weight, if any, lately.
___ 1 I haven't lost more than 5 pounds.
___ 2 I have lost more than 10 pounds.
___ 3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less.
___ Yes ___ No

___ 0 I am no more worried about my health than usual.
___ 1 I am worried about physical problems such as aches and pains; or upset stomach or constipation.
___ 2 I am very worried about physical problems and its hard to think of much.
___ 3 I am so worried about my physical problems that I am not able to do much of anything.

___ 0 I have not noticed any recent change in my interest in sex.
___ 1 I am less interested in sex than I use to be.
___ 2 I am much less interested in sex now.
___ 3 I have lost interest in sex completely.