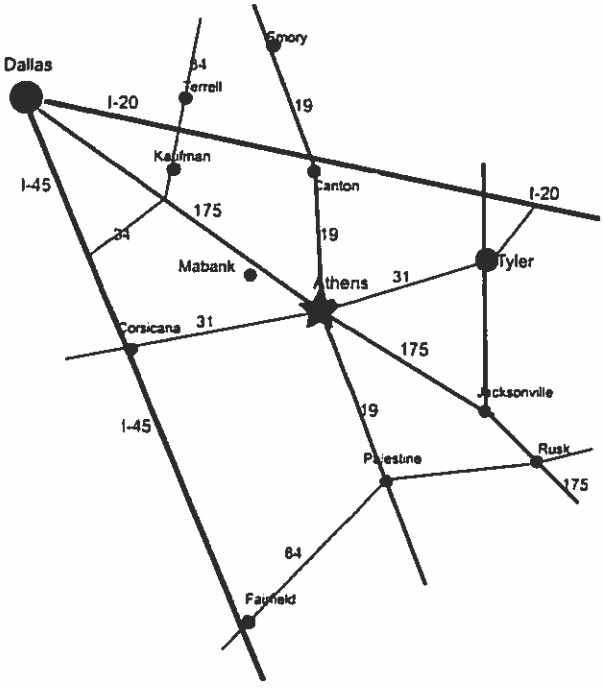
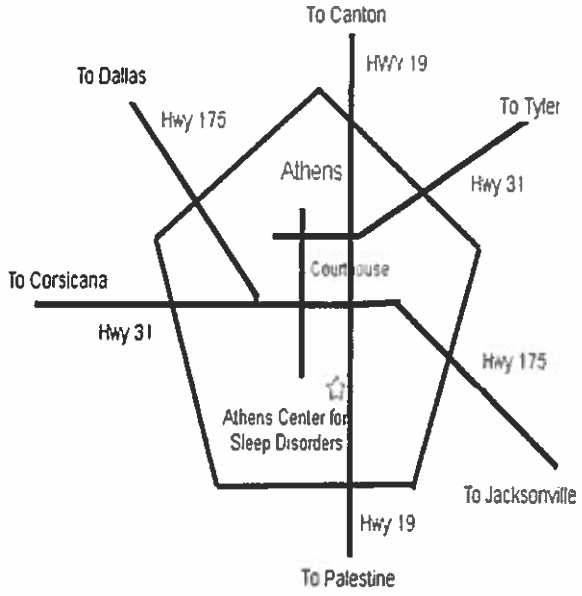
Your Sleep Appointment

We welcome you to the Athens Center for Sleep Disorders. Enclosed in this packet is some information about our center and Dr. Ronald Cates, M.D., Diplomate, American Board of Sleep Medicine. Also enclosed are: a ***5-page questionnaire for you*** to complete, and a ***one-page questionnaire (colored) for your bed partner***, or someone who has observed you sleeping, to complete. **Please have these completed in their entirety and bring them with you for your appointment.** These will help the doctor evaluate your condition in a more effective manner. If possible, please have your bed partner or the person who has observed you sleeping accompany you during your initial consultation. Their observations may be very helpful in answering some of the doctor's questions regarding your condition.

On the day of this first visit and consultation, you will be visiting with Dr. Ronald Cates or our nurse practitioner Cynthia Nixon. After the consultation and assessment, any testing that is needed, nighttime or daytime, will be scheduled for a date that is convenient for you.

If we can do anything to assist you in your sleep evaluation and treatment please do not hesitate to let us know, 903-675-1717. To learn more about Dr. Cates and our clinic visit our website: www.athenssleepcenter.com. We look forward to seeing you.





Athens Center for Sleep Disorders
704 South Palestine, Athens, Texas 75751 903-675-1717
Ronald D. Cates, M.D., P.A.
Fellow American Academy of Sleep Medicine

PATIENT INFORMATION

All information will be confidential. In order to serve you properly, we request the following information.

Patient Name_____Referred by:_____

SSN# _____Male __ Female __ Date birth_____

Email address_____ Race/Ethnicity_____

Home # _____Work # _____Cell# _____

Address _____ City _____State __ Zip _____

Emergency contact (name)_____(phone#)_____

(Relationship)_____

OFFICE USE:

UPDATED:_____By:_____

- **I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.**
- **I authorize the release to my DME provider or referring /consulting / primary care physician of any information that may be needed.**
- **I authorize ACSD to obtain a photograph for my medical records.**
- **I hereby authorize all payments of insurance benefits to go directly to the doctor even if it is made payable to me. I understand that any allowed charges not fully paid by my insurance will be my responsibility, and I will be billed accordingly.**
- **I authorize the sleep center staff to perform the necessary services I may need.**
- **I acknowledge that I have been given the option to read the ACSD "Notice of Privacy Practices."**

X_____

Patient Signature **Date**

X_____ _____

Witness Signature **Date**

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby request and authorize the release of medical records and related information:

FROM: Athens Center for Sleep Disorders
704 S Palestine Street
Athens, TX 75751
Fax# 903-675-3338

TO:_____

_____

_____

FROM: _____

_____

_____

TO: Athens Center for Sleep Disorders
704 South Palestine Street
Athens, TX 75751
Fax# 903-675-3338

_____
Patient's Printed Name

_____
Signature, Other than Patient

_____
Date of Birth

_____
Relationship to Patient

_____
Patient's Signature Date

_____
Witnessed Signature Date

Athens Center for Sleep Disorders

Patient Name_____ Date_____

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.

Please select one of the following numbers for each of the following situations.

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

_____ Sitting and reading.

_____ Watching TV.

_____ Sitting in a public place. (like a theatre, or work meeting)

_____ As a passenger in a car for an hour without a break.

_____ Laying down to rest in the afternoon when circumstances permit

_____ Sitting and talking to someone

_____ Sitting quietly after lunch (without alcohol)

_____ In a car, stopped a few minutes in traffic

_____ **TOTAL**

OFFICE USE ONLY

HT: _____

WT: _____

BP: _____/_____

PULSE: _____

BMI: _____

Manometer Read: _____

DME Provider: _____

PATIENT'S CURRENT PHARMACY: _____ **CITY:**_____

Athens Center for Sleep Disorders

704 South Palestine, Athens, Texas 75751 903-675-1717

Ronald D. Cates, M.D., P.A.

Fellow, American Academy of Sleep Medicine

We welcome you to the Athens Center for Sleep Disorders.

...The only accredited sleep disorders center with a full time sleep specialist in East Texas.

Attached is a questionnaire. ***Please complete in full prior to your visit.*** We ask that you have your bed partner (or a person who has observed you sleeping) accompany you during your initial consultation. Their observations may be very helpful in answering some of the doctor's questions. Your first visit will be with Dr. Ronald Cates, M.D and/or our specialty trained nurse practitioner, Cynthia Nixon, FNP-C, RN. They will specify what testing is needed. The testing will be scheduled for a date that is convenient for you.

If there is anything we can do to assist you in your sleep evaluation and treatment, please do not hesitate to let us know, 903-675-1717. We look forward to seeing you.
Please tell us how you learned of Athens Center for Sleep Disorders and what influenced you to make your appointment.

Please *CHECK* each of the ways you have heard or read about us.

_____**Physician's referral**

_____**Phone book**

_____**Sign in front of the center**

_____**Newspaper**

_____**Recommendation of a friend**

_____**Recommendation of family**

If family, who? _____

_____**Billboards**

_____**Radio: Station**_____

_____**TV: Station**_____

_____**Internet**

_____**Seminar**

_____**Other:** _____

Please *CHECK* the source thatinfluence you the most.

_____**Physician's referral**

_____**Phone book**

_____**Sign in front of the center**

_____**Newspaper**

_____**Recommendation of a friend**

_____**Recommendation of family**

If family, who? _____

_____**Billboards**

_____**Radio: Station**_____

_____**TV: Station**_____

_____**Internet**

_____**Seminar**

_____**Other:** _____

Sleep and Medical History Questionnaire

NAME: _____ AGE: _____ PRIMARY MD: _____ REFERRING MD: _____

1. *It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get an accurate picture of your medical background and the nature of your present sleep related problem(s). Please complete these questions as* ***thoroughly as possible.***
2. ** ***All answers should refer to a typical night (or day) of sleep.*** *It is understood that there are exceptional nights.* **
3. ** `If you ALREADY USE CPAP`... ***answer according to when WEARING THE MASK, not when without it.*** **

What is (are) your main sleep problem(s) or primary complaint(s)? (Check all that apply)

Physician comments

( ) Snore loudly	( ) Wake with Gasping/Choking	( ) Legs fidgety before sleep	( ) Too sleepy	( ) Hard to fall asleep
( ) Hold breath when sleeping	( ) Act out dreams	( ) Legs move/kick during sleep	( ) Too tired	( ) Hard to stay asleep
( ) Other:				( ) Usually feel un-restored

General Info:

- *For* ***how long*** *has this been a problem?* ( ) <1 month ( ) 1 - 6 months ( ) 6 mos – 2 yrs ( ) > 2 yrs
- *Rate the* ***severity*** *of this problem.* ( ) Mild ( ) Moderate ( ) Severe ( ) the problem is only for others
- *Does it seem to be* ***getting worse?*** ( ) No ( ) Yes ( ) Not Sure
- *Does your sleep problem* ***negatively impact*** ...

Physician comments

.... your quality of life?	( ) No	( ) Yes
.... your sex life?	( ) No	( ) Yes
....your social activities?	( ) No	( ) Yes
....your work/school performance?	( ) No	( ) Yes

Physician comments

- *Do you ever* ***avoid sleeping on your back?*** *If so, why?* _____
- *Have you ever undergone a* ***sleep test?*** ( ) No ( ) Yes

  If "Yes"...
  - Doctor and/or lab name and location: _____ Date: _____
  - Diagnosis: _____
  - Present sleep treatment: _____ Date started: _____ Age of current mask: _____
  - Prior sleep treatment: _____ Date stopped: _____ Age of current hose: _____

- *Do you use any* ***medication or other substance*** *(including alcohol) to help you sleep?* ( ) No ( ) Yes

  If "Yes"...
  - *please list name, dose, frequency, length of usage:* _____
  - *Is the substance beneficial?* ( ) Yes ( ) Only minimal help ( ) Was initially, not so much now ( ) No

Physician comments

UPDATED 02/13/13

Please answer accordingly ... (`If you already use CPAP...` answer according to when *wearing the mask).*

Rate how often *you or others* have noted that you:

	DK (Do Not Know)	N (Never)	O (Occasionally)	F (Frequently)
• Snore or snore loudly enough that others complain	DK	N	O	F
• Hold your breath or stop breathing while asleep	DK	N	O	F
• Awaken from sleep feeling short of breath, gasping, or choking	DK	N	O	F
• Have morning headaches that ***resolve within 2 hours without*** medicine	DK	N	O	F
• Must wake up to urinate more than only 2 or 3 times	DK	N	O	F
• Feel tired or exhausted during the day	DK	N	O	F
• Awaken feeling non-restored or un-refreshed	DK	N	O	F
• Tend to doze if you sit down or try to relax, either at work or at home	DK	N	O	F
• Have trouble at work or school because of sleepiness	DK	N	O	F
• Get sleepy while driving	DK	N	O	F
• Have had a wreck due to sleepiness	DK	N	O	F
• Experience decrease in memory, focus or concentration abilities	DK	N	O	F
• Become irritable or "crabby"	DK	N	O	F
• Fall asleep involuntarily, suddenly or in awkward situations	DK	N	O	F
• Suddenly get weak all over, buckle at the knees or feel facial floppiness ***immediately after a strong emotion*** such as laughing, crying, or anger	DK	N	O	F
• Feel totally paralyzed (fearfully unable to move) when waking or falling asleep	DK	N	O	F
• Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep (similar to hallucinations)	DK	N	O	F
• Find yourself doing complex tasks of which you were totally unaware (such as driving/navigating without conscious awareness)	DK	N	O	F
• Have nightmares or night terrors (not just "bad dreams")	DK	N	O	F
• Act out your dreams by actually performing the motions	DK	N	O	F
• Walk in your sleep, eat or smoke during the night without being aware	DK	N	O	F
• Do anything else considered "unusual" while asleep	DK	N	O	F

Physician comments

Physician comments

Physician comments

Physician comments

- **<u>While asleep</u>** ....
  - ✓ Do you ***recurrently*** move, flinch or jerk your legs or arms? DK N O F
  - ✓ Are your sheets in bad disarray when you wake? DK N O F

- **<u>Shortly before or at bedtime</u>** ....
  - ✓ Do you occasionally feel an overwhelming urge to move your legs? DK N O F
  - ✓ Does it typically happen in the evening? DK N O F
  - ✓ Does it typically happen when relaxed? DK N O F
  - ✓ Does it typically get better if you move about or walk? DK N O F
  - ✓ Does it typically disturb your abilities to fall asleep or stay asleep? DK N O F
  - ✓ Around what time do your legs become a problem with wanting to move? _____ am/pm
  - ✓ How often do you experience these symptoms? _____ days per **<u>week</u>** or **<u>month</u>** *(circle one)*

Physician comments

Sleep Routine: *[Please make a serious effort to simply **estimate** for an **average / typical night**]*

- Estimate total hours of **actual sleep per night** (*do not include time spent awake in bed*)... _____ hours
- At what time do you usually **commit to going to sleep** (*not simply getting in bed*) ... **on *WORK* days?** ____am/pm ; **on *OFF* days?** ____ am/pm
- At what time do you usually **wake for the final time and actually get out of bed** ... **on *WORK* days?** ____am/pm ; **on *OFF* days?** ____am/pm
- After finally committing to go to sleep, how long does it **usually** take to **fall asleep**? _____ mins/hours; Ideas as to why?_____
- Through most nights, how many **times do you wake**? ____ times; every _____ mins/hours; mostly because of _____
- Typically, how long before you are able to go **back to sleep**? _____ mins/hours
- In the past when you slept your best, how many hours of sleep did you require in order **to feel and perform your very best** ? ____ hours
- In a perfect world, what would be your choice for an **ideal hour** to go to bed? _____ To awaken? _____
- Do you currently work **night shifts**? **( ) No** **( ) Yes**
  - ✓ **IF "YES"** ...What are your **work hours** when on night shift? _____ pm until _____ am
    ...**Number of nights** per week? _____ ***OR*** _____ **# hours on** and _____ **# hours off**
    ...On **"off days"** or on **daytime work days**, do you keep the same sleep schedule as during night shifts? **( ) No** **( ) Yes**

Physician comments

Sleep "Hygiene" (habits):

- Do you ever ***doze, sleep, nap***, or try to rest during the wake portion of your day? **( ) No** **( ) Yes**
  - ✓ **IF "YES"** ...How many ***times per day*** ? ____ ; how many ***days per week*** ? ____ ; **~ Time of day** of last "doze" ? _____ am/pm
    ...On average, ***how long*** is your "doze" ? **( ) Less than 1 hr** **( ) 1 hr or more**
    ...After dozing, do you ***still remain tired*** ? **( ) No** **( ) Yes**
- Do you use any form of **nicotine** during the night or within **2 hours** of going to bed? **( ) No** **( ) Yes**
- Do you drink any form of **alcohol** within **4 hours** of going to bed? **( ) No** **( ) Yes**
- Do you usually **eat** anything other than a light snack within **2 hours** before bed? **( ) No** **( ) Yes**
- Do you usually ingest **coffee**, tea, cola or chocolate within **10 hours** before bed? **( ) No** **( ) Yes**
- Do you do physical **exercise** within **6 hours** before bed? **( ) No** **( ) Yes**
- Is the bedroom anything other than dark, cool and totally quiet except for "white noise"? **( ) No** **( ) Yes**
- Do you watch TV or read in bed before falling asleep? **( ) No** **( ) Yes**
- Check any condition that **routinely** applies to you:
  ( ) sleep by yourself ( ) sleep with someone else in your bed ( ) sleep with a pet in your room
  ( ) provide assistance to someone during the night (child, invalid, bed partner, animal)

Physician comments

Family History:

*[Amongst your **blood relatives**, check any diagnosed conditions]* **( ) Unknown, was adopted**

( ) ***OBSTRUCTIVE SLEEP APNEA***	( ) Restless Leg Syndrome	( ) Hypertension	( ) Hypothyroidism
( ) Narcolepsy	( ) Periodic Limb Movements	( ) Heart attack	( ) Hyperthyroidism (Grave's)
( ) Other Hypersomnia	( ) Sleep Walking	( ) Stroke	( ) Depression
( ) Other Sleep Disorder:_____	( ) Acting out dreams	( ) Diabetes	( ) Suicide

Physician comments

Social History:

Your present occupation:_____; **Marital Status:**

( ) Single
( ) Engaged
( ) Married
( ) Common Law
( ) Separated
( ) Divorced
( ) Widowed

Physician comments

or

( ) homemaker
( ) fully retired
( ) disabled
( ) none of the above

- **Others at home**: ( ) None ( ) Spouse/Significant other ( )Young children (ages:_____) ( ) Other adults
- **Favorite past time or hobby**: _____

○ ALCOHOL USAGE:

- ***Do you use alcohol?*** ( ) No ( ) Yes ( ) Quit
  - ➢ If **"Quit"**, when was your last drink? _____ If **"Yes"**, please complete the following questions....

Physician comments

Type used most often:	Amount	Frequency (circle appropriate)	Timing of last drink before bed (on avg)
( ) Beer	____ Cans	____ days per week / month / year	( ) Within 30 min. of bedtime
( ) Wine	____ Glasses	____ days per week / month / year	( ) 30 min. to 2 hours before bedtime
( ) Hard drink	____ Drinks (ozs)	____ days per week / month / year	( ) 2 hours to 4 hours before bedtime
			( ) More than 4 hours before bedtime

- ***Do you presently consider yourself an Alcoholic?*** ( )No ( )Yes; ***Were you an Alcoholic "in the past"?*** ( )No ( )Yes
  - ➢ If **"Yes"** to either of the above questions.... ***Date of your last drink?*** _____ ***Are you active in AA?*** ( )No ( )Yes

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○ TOBACCO USAGE: ***Do you use any tobacco products?*** ( ) No ( ) Yes ( ) Quit

- ➢ If **"Quit"**, when was your last usage?_____ If **"Yes"**, please complete the following questions....

Type used most often:	Amount	Frequency (circle one)	Timing of last usage before bed (on average)
( ) Cigarettes	____Packs	per day / week / month	( ) Within 30 min. of bedtime
( ) Cigars	____Cigars	per day / week / month	( ) 30 min. – 2 hours before bedtime
( ) Pipe	____Bowls	per day / week / month	( ) More than 2 hours before bedtime
( ) Snuff or chewable tobacco	____Cans/bags	per day / week / month	( ) Wake up during the night and use tobacco

o **CAFFEINE USAGE:** ***Do you use products with caffeine?*** ( ) No ( ) Yes ( ) Quit

➢ If **"Quit"**, when was your last usage? _____ If **"Yes"**, please complete the following questions....

Type most often used:	Amount	Frequency (circle one)	Timing of last usage before bed (on average)
( ) Coffee	____Cups	per day / week / month	( ) Within 1 hour of bedtime
( ) Tea	____Glasses	per day / week / month	( ) 1-10 hours before bedtime
( ) Dark cola	____Cans	per day / week / month	( ) More than 10 hours before bedtime
( ) Chocolate	____ Peices		( ) Wake up during the night and use caffeine

o **"RECREATIONAL" DRUGS / OTHER SUBSTANCES** *(not prescribed by physician)*: ***Current or recent use?*** ( ) No ( ) Yes

➢ If **"Yes"**, please describe what is/was used and how often it is/was used:_____

o **REGULAR EXERCISE:** ***Do you participate in regular exercise?*** ( ) No ( ) Yes

➢ If **"Yes"**, please complete the following questions....

What is(are) your predominant exercise(s)?...

Type(s) of exercise	
( ) Walking	( ) Aerobics
( ) Power-walking	( ) Swimming
( ) Jogging	( ) Weight-lifting
( ) Other :	

Please check what applies under each heading...

Duration	Frequency	Time of day of exercise
( ) <30 min.	( ) 7 days weekly	( ) Morning
( ) 30 min.-1 hour	( ) 4–6 days per week	( ) Mid-day
( ) >1 hour	( ) 1–3 days per week	( ) Early evening
	( ) <1 day per week	( ) Within 6 hours of bedtime

o **WEIGHT HISTORY:**

Physician comments

➢ *What is the **most** you have ever weighed in your **life**?* _____ Lbs. In ***what year***? _____

- *The effect of that maximum weight on your sleep quality?* *(Check all that apply)*

( ) Not sure	( ) **Sleep** seems to be ***better*** now	( ) **Snoring** is ***better*** now	( ) **Daytime alertness** is ***better*** now
( ) No difference	( ) **Sleep** seems to be ***worse*** now	( ) **Snoring** is ***worse*** now	( ) **Sleepiness** is ***worse*** now

➢ *Total weight **GAIN** over the last **12 months**?* _____ Lbs. *(Check all that apply)*

- *Suspected **Cause(s)**?* ( ) Eating | ( ) Lack of exercise | ( ) Lifestyle changes | ( ) Medical problem | ( ) Not sure

➢ *Total weight **LOSS** over the last **12 months**?* _____ Lbs. *(Check all that apply)*

- *Suspected **Cause(s)**?* ( ) Diet | ( ) Exercise program | ( ) Lifestyle changes | ( ) Illness | ( ) Gastric bypass | ( ) Not sure

- *The effect of this more recent weight change on your sleep quality?* *(Check all that apply)*

( ) Not sure	( ) **Sleep** seems to be ***better*** now	( ) **Snoring** is ***better*** now	( ) **Daytime alertness** is ***better*** now
( ) No difference	( ) **Sleep** seems to be ***worse*** now	( ) **Snoring** is ***worse*** now	( ) **Sleepiness** is ***worse*** now

➢ *What was your weight (approximately) at the time of your **last sleep test** (if applicable and if known)?* _____ Lbs.

Physician comments

MEDICAL HISTORY

Physician comments

Physician comments

Medical Conditions:

[Please check any condition that a doctor has diagnosed you with]

( ) **No medical problems**

( ) Anemia	( ) Acid reflux (GERD)	( ) Arthritis / chronic pain	( ) *Infection* of brain or spinal cor	( ) Alcoholism
( ) Angina/Coronary Art. Dis.	( ) Hiatal hernia	( ) Back or neck pain	( ) *Injury* to brain or spinal cord	( ) Drug abuse
( ) Heart attack	( ) Liver disease	( ) Chronic Fatigue Syn	( ) Neuropathy	( ) Depression
( ) Enlarged heart	( )TMJ (Jaw joint pain)	( ) Fibromyalgia	( ) other Nerve damage	( ) Bipolar Disorder
( ) CHF (cong. heart failure)	( ) other digestive probs	( ) Diabetes (I or II)	( ) Seizure or epilepsy	( ) Suicide attempt
( ) High blood pressure		( ) Hypothyroid (low)	( ) Stroke or TIA (mini-stroke)	( ) Anxiety / Panic attacks
( ) Atrial Fibrillation	( ) Asthma	( ) Hyperthyroid (high)	( ) other Brain or Nerve problems	( ) OCD
( ) Other abnl heart beat	( ) COPD or Emphysema	( ) Kidney disease		( ) ADD / ADHD
( ) Other heart problem	( ) Pulmonary Hypertension	( ) Cancer		( ) Other Psychiatric probs.
	( ) other Lung probs.	( ) Immune deficiency		

Physician comments

( ) Other_____

Allergies to Medication:

[List any medications to which you are allergic]

( ) **No known DRUG allergies**

_____ _____ _____

Current Medications:

*[Please list all medicines **prescribed** by your doctor and their dosages]*

( ) **No current medications**

_____ _____

_____ _____

_____ _____

_____ _____

Physician comments

Past Surgical History:

[Check applicable operations and approximate date of surgery]

( ) **No significant operations**

Operation	Year	Operation	Year
( ) Coronary artery (heart) bypass		( ) Tonsillectomy / adenoidectomy	
( ) Heart Artery Stent		( ) other Head, Neck or Throat surgery	
( ) Pacemaker / Defibrillator		( ) Back surgery	
( ) Carotid artery (neck) surgery		( ) Weight reduction procedure	
( ) other Chest or Lung surgery		( ) **Sleep Apnea or Snoring surgery**	

( ) Other_____

Physician comments

REVIEW OF SYSTEMS

Do you PRESENTLY or have you in the RECENT PAST suffered from any of the listed items?

(check any that apply)

CONSTITUTIONAL	EYES	ENDOCRINE
( ) Night sweats	( ) Dry eyes	( ) Excessive hunger or thirst
( ) Unexplained weight loss	( ) Eye pain	( ) Heat or cold intolerance
( ) Loss of appetite	( ) Chronically watery eyes	( ) Frequent daytime urination
( ) Chronic pain	( ) Red eyes when waking up	( ) Sexual dysfunction
RESPIRATORY	**HEART**	**PSYCHIATRIC**
( ) Trouble sleeping while lying flat	( ) Chest pain/pressure while asleep	( ) Frequent anxious or nervous feelings
( ) Trouble breathing while lying flat	( ) Chest pain/pressure with exertion	( ) Frequent feelings of depression
( ) Occasionally cough up blood	( ) Palpitations - heart pounding	( ) Personality changes
( ) Pain with breathing	( ) Fast heartbeat	( ) Hallucinations
( ) Chronic cough	( ) Irregular heartbeat	( ) Delusions
( ) Short - winded with mild exertion		
NERVOUS SYSTEM	**DIGESTIVE**	**EAR, NOSE, THROAT AND ALLERGY**
( ) Balance or coordination problems	( ) Chronic diarrhea or constipation	( ) Dry mouth
( ) Worsening headaches	( ) Chronic indigestion	( ) Daytime nasal congestion
( ) Weakness of a specific body area	( ) Fecal soiling of the bed	( ) Nighttime nasal congestion
( ) Gait disturbance	( ) Frequent nausea or vomiting	( ) Frequent sinus infections
( ) Numbness of a specific body area	( ) Frequent bloating	( ) Seasonal nasal allergies
( ) Speech disturbance	( ) Reflux that disturbs sleep	( ) Frequent nosebleeds
( ) Seizures	( ) Pain in jaw joint	( ) Chronically hoarse cough
( ) Fainting spells		( ) Grind teeth at night
( ) Severe memory problems	**GENITAL / URINARY**	
( ) Unusual body movements	( ) Blood in urine	**MUSCULOSKELETAL**
	( ) Frequent nighttime urination	( ) Joint pain or swelling
SKIN	( ) Bedwetting	( ) Muscle pain or weakness
( ) Dry skin	( ) MALE: Trouble with erection	( ) Leg cramps while asleep
( ) Rashes	( ) FEMALE: Nighttime hot flashes	
( ) Severe itching	( ) FEMALE: No periods any longer	

DATE that ***you*** completed this questionnaire: _____

Physician comments	Physician Signature and Date

Athens Center for Sleep Disorders

BED PARTNER QUESTIONNAIRE

♦♦PLEASE ASK SOMEONE WHO HAS WATCHED YOU SLEEP TO COMPLETE THIS FORM♦♦

OBSERVER'S NAME: _____ RELATIONSHIP TO PATIENT: _____ DATE: _____

I have observed this person's sleep: Once or Twice Often Almost Every Night

Check any of the following behaviors that you have observed this person doing while asleep. **Circle** those that you consider severe problems for this person.

light snoring
loud snoring
loud snorts
pause in breathing (how long?_____seconds)
choking
gasping for air
twitching, moving or kicking of legs
twitching or flinging of arms
grinding teeth
bed-wetting
other_____

sleep talking
sitting up in bed not awake
getting out of bed not awake
head rocking or banging
awakening with pain
becoming very rigid and/or shaking
biting tongue
crying out
apparently sleeping even if he/she behaves otherwise

If snores, what makes it worse? sleeping on his/her back sleeping on his/her side alcohol fatigue

Does snoring sometimes require you or your partner to sleep separately? Yes No

Does this person drink alcohol or use street drugs? Yes No

MODIFIED EPWORTH SLEEPINESS SCALE

As an observer, please complete the following information on your estimation of the chances on his/her dozing in the following situations. (Even if none of these things have occurred recently, try to work out how they would have affected him/her.) Use the scale below to choose the most appropriate number for each situation.

0= Would never dose
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Situation	Chance of Dozing
Sitting & Reading	_____
Watching TV	_____
Sitting in a public place (i.e. theatre)	_____
As a passenger in a car for over 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 car while stopping for a few minutes in traffic	_____

TOTAL: _____