

Gordon Dowds, M.D., Inc.  
Roger Amerian, M.D., Inc.  
Fax: (818) 716-1875

West Valley Sleep Disorders Center  
7320 Woodlake Ave, Suite 200  
West Hills, Ca. 91307  
(818) 715-0096

---

**AFTER 8:00 PM CALL (818) 716-7924**  
**INSTRUCTIONS FOR A SLEEP STUDY**

---

Dear \_\_\_\_\_,

Your STUDY/CONSULT is scheduled for \_\_\_\_\_ at \_\_\_\_\_.

**TO ENTER GO TO THE NORTH SIDE OF THE BUILDING BY THE PARKING AND ON THE RIGHT SIDE OF THE DOOR PRESS 200 ON THE KEY PAD. When you hear the buzz, go to the sliding doors. Take the elevator to 2<sup>nd</sup> floor suite 200. If you are early you may have to wait a few minutes. Our Technician does not arrive until 8:30 PM. Please be considerate of other patients and ARRIVE ON TIME WITH YOUR FORMS COMPLETED. Please bring any insurance authorizations, your insurance card, and any co-pays due at time of appointment.**

**DO NOT TAKE A NAP THE DAY OF THE STUDY, OR CONSUME ALCOHOL. Try to stick to your normal daily activities. If you take medications please take them as prescribed. Please inform the front office if you take any type of sleeping medications that were prescribed or that are over the counter. You may wish to bring a book, as we do not have TV's. Bring something comfortable to sleep in.**

**Please shower and wash and dry your hair before you arrive. Do not apply creams or hair products as these may interfere with our sensors and recording equipment.**

**Men should shave, if you have a beard or mustache you need not shave.**

**Please note the technician will remain in the lab for the entire study. This is for your safety, comfort and to assure accurate recording of your data.**

**THERE WILL BE A \$50.00 CANCELLATION FEE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT AND DO NOT GIVE A 24 HOUR NOTICE.**

**ONCE AGAIN THE AFTER HOURS PHONE NUMBER IS (818) 716-7924**

**THANK YOU FOR YOUR COOPERATION.**

## Directions to the West Valley Sleep Disorders Center

1. Coming from the Los Angeles area. Take the 101 fwy west (towards Ventura) exit Shoup ave, go right north on shoup to Sherman way. Turn left on Sherman way till you hit Medical Center Drive, then make a right. Make a quick left on Sherman Place. Our building will be on the right hand side. We are the building up on the hill with the long ramp driveway.
2. Coming from the Ventura area. Take the 101 east, exit Fallbrook ave, towards Sherman way then take a left. Continue directions from above. (#1)
3. Coming from the Simi Valley area. Take the 118 east, exit Topanga cyn, go towards Sherman way and make a right. Continue directions from above. (#1)

If you have any trouble finding us,  
please call (818)716-7924 after 8pm **ONLY**

(818)715-0096 hours : 9am-5pm

7320 Woodlake Ave suite 200, West Hills, Ca 91307

**Please use  
black pen  
And bubble  
in only  
Example**

**Lets see what your sleep problems are**

1. Do you snore?  Yes  No
2. Do you keep other awake by snoring?  Yes  No
3. Do you snore every night?  Yes  No
4. How loud do you snore?  Locomotive  Bear  Purr

## Lets see what your sleep problems are

1. Do you snore?  Yes  No
2. Do you keep other awake by snoring?  Yes  No
3. Do you snore every night?  Yes  No
4. How loud do you snore?  Locomotive  Bear  Purr

### EPWORTH 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. Use the following scale to choose the most appropriate number for each situation.

#### Situation:

Sitting and reading?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

Watching TV?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

Sitting inactive in a public place?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

As a passenger in a car for an hour without a break?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

Lying down to rest in the afternoon?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

Sitting and talking to someone?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

Sitting quietly after a lunch without alcohol?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

In a car, while stopped for a few minutes in traffic?

would never doze  slight chance of dozing  moderate chance of dozing  high chance of dozing

1. Do you feel like you have no energy?  Yes  No
2. Are you more then 10lbs overweight?  Yes  No
3. Are you tired all the time?  Yes  No
4. Are you being treated for high blood pressure?  Yes  No

# SLEEP QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Current Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_

My main Sleep complaint is:

---

---

---

Duration of sleep problems: \_\_\_\_\_

I go to bed at: \_\_\_\_\_

I wake up at: \_\_\_\_\_

Fill in true or false to the following statements as they currently apply to you. If you don't know give your best guess.

- |   |                            |                             |
|---|----------------------------|-----------------------------|
| I fall asleep in less than 10 minutes                         | <input type="radio"/> True | <input type="radio"/> False |
| I wake up more than three times per night                     | <input type="radio"/> True | <input type="radio"/> False |
| I wake up un-refreshed  | <input type="radio"/> True | <input type="radio"/> False |
| I have difficulty waking up in the morning                    | <input type="radio"/> True | <input type="radio"/> False |
| I nap as often as I can                                       | <input type="radio"/> True | <input type="radio"/> False |
| I am a very loud snorer                                       | <input type="radio"/> True | <input type="radio"/> False |
| I am a restless sleeper                                       | <input type="radio"/> True | <input type="radio"/> False |
| I stop breathing during sleep                                 | <input type="radio"/> True | <input type="radio"/> False |
| I awake with a choking sensation                              | <input type="radio"/> True | <input type="radio"/> False |
| I am a deep sleeper   | <input type="radio"/> True | <input type="radio"/> False |
| I sweat a lot during sleep                                    | <input type="radio"/> True | <input type="radio"/> False |
| I wake up with headaches                                      | <input type="radio"/> True | <input type="radio"/> False |
| I have high blood pressure                                    | <input type="radio"/> True | <input type="radio"/> False |
| I have gained more than ten pounds in the last year           | <input type="radio"/> True | <input type="radio"/> False |
| I cough up mucous or sputum at night                          | <input type="radio"/> True | <input type="radio"/> False |
| I have to sleep with more than two pillows                    | <input type="radio"/> True | <input type="radio"/> False |
| I snore if I sleep on my back                                 | <input type="radio"/> True | <input type="radio"/> False |
| I doze off when I am a passenger in a car                     | <input type="radio"/> True | <input type="radio"/> False |
| I doze off when watching a movie or TV                        | <input type="radio"/> True | <input type="radio"/> False |
| I doze off during meetings or lectures                        | <input type="radio"/> True | <input type="radio"/> False |
| I doze off when bored in social gatherings                    | <input type="radio"/> True | <input type="radio"/> False |
| I doze off while reading                                      | <input type="radio"/> True | <input type="radio"/> False |
| I doze off while eating                                       | <input type="radio"/> True | <input type="radio"/> False |
| I doze off while talking                                      | <input type="radio"/> True | <input type="radio"/> False |
| I doze off while driving                                      | <input type="radio"/> True | <input type="radio"/> False |
| I doze off at work  | <input type="radio"/> True | <input type="radio"/> False |
| I have driven miles past my destination with little awareness | <input type="radio"/> True | <input type="radio"/> False |
| I find myself sometimes doing things that make no sense       | <input type="radio"/> True | <input type="radio"/> False |
| I disturb the sleep of my bed partner                         | <input type="radio"/> True | <input type="radio"/> False |

I get more than eight hours of sleep per day	<input type="radio"/>	True	<input type="radio"/>	False
I have hallucination upon awakening	<input type="radio"/>	True	<input type="radio"/>	False
I dream a lot	<input type="radio"/>	True	<input type="radio"/>	False
I have attacks of sudden muscle weakness	<input type="radio"/>	True	<input type="radio"/>	False
I have dreams or hallucinations while awake	<input type="radio"/>	True	<input type="radio"/>	False
I am unable to move on awakening	<input type="radio"/>	True	<input type="radio"/>	False
I have refreshing naps	<input type="radio"/>	True	<input type="radio"/>	False
I was a hyperactive child or teenager	<input type="radio"/>	True	<input type="radio"/>	False
I fall asleep in more than 45 minutes	<input type="radio"/>	True	<input type="radio"/>	False
I sleep with earplugs or eye shades	<input type="radio"/>	True	<input type="radio"/>	False
I have trouble falling asleep	<input type="radio"/>	True	<input type="radio"/>	False
I have trouble returning to sleep after waking up	<input type="radio"/>	True	<input type="radio"/>	False
I wake up long before it is necessary	<input type="radio"/>	True	<input type="radio"/>	False
I don't feel sleepy at bedtime	<input type="radio"/>	True	<input type="radio"/>	False
I sleep better in unfamiliar settings	<input type="radio"/>	True	<input type="radio"/>	False
I sleep better during weekends or vacations	<input type="radio"/>	True	<input type="radio"/>	False
I am afraid of going to sleep	<input type="radio"/>	True	<input type="radio"/>	False
I use sleeping pills	<input type="radio"/>	True	<input type="radio"/>	False
I am a light sleeper	<input type="radio"/>	True	<input type="radio"/>	False
I am disturbed by my bed partner in my sleep	<input type="radio"/>	True	<input type="radio"/>	False
I try hard to fall asleep	<input type="radio"/>	True	<input type="radio"/>	False
I don't know why I cant sleep	<input type="radio"/>	True	<input type="radio"/>	False
I sleep in a noisy bedroom	<input type="radio"/>	True	<input type="radio"/>	False
I have thoughts racing through my mind when I try to fall asleep	<input type="radio"/>	True	<input type="radio"/>	False
I get less than five hours of sleep per day	<input type="radio"/>	True	<input type="radio"/>	False
I kick, twitch, or jerk my legs during sleep	<input type="radio"/>	True	<input type="radio"/>	False
I have restlessness in my legs if I lay down	<input type="radio"/>	True	<input type="radio"/>	False
I am unable to keep my legs still when falling asleep	<input type="radio"/>	True	<input type="radio"/>	False
I grind my teeth in my sleep	<input type="radio"/>	True	<input type="radio"/>	False
I have jaw aches when I wake up in the morning	<input type="radio"/>	True	<input type="radio"/>	False
I talk in my sleep	<input type="radio"/>	True	<input type="radio"/>	False
I sleep walk	<input type="radio"/>	True	<input type="radio"/>	False
I have hurt myself or others while dreaming	<input type="radio"/>	True	<input type="radio"/>	False
I had bedwetting as an adult	<input type="radio"/>	True	<input type="radio"/>	False
I bang, twist or shake my head during sleep	<input type="radio"/>	True	<input type="radio"/>	False
I suddenly wake up with intense anxiety or dread	<input type="radio"/>	True	<input type="radio"/>	False
I often have nightmares	<input type="radio"/>	True	<input type="radio"/>	False
I suddenly scream in my sleep	<input type="radio"/>	True	<input type="radio"/>	False
I work night shifts	<input type="radio"/>	True	<input type="radio"/>	False
I have a very irregular bedtime	<input type="radio"/>	True	<input type="radio"/>	False
I am a late sleeper	<input type="radio"/>	True	<input type="radio"/>	False
I don't get sleepy until long past midnight	<input type="radio"/>	True	<input type="radio"/>	False
I get sleepy early in the evening	<input type="radio"/>	True	<input type="radio"/>	False
I function the best in the evening	<input type="radio"/>	True	<input type="radio"/>	False
I have chest pain during the night	<input type="radio"/>	True	<input type="radio"/>	False
I have bitter taste or sour mouth taste in the morning	<input type="radio"/>	True	<input type="radio"/>	False
I have seizures during sleep	<input type="radio"/>	True	<input type="radio"/>	False
I have back pain that wakes me up	<input type="radio"/>	True	<input type="radio"/>	False
I awake with blood on my pillow	<input type="radio"/>	True	<input type="radio"/>	False
I have bitten my tongue during sleep	<input type="radio"/>	True	<input type="radio"/>	False
I awake with heartburn	<input type="radio"/>	True	<input type="radio"/>	False
I have a relative that died during sleep	<input type="radio"/>	True	<input type="radio"/>	False
I have a relative that falls asleep during the day	<input type="radio"/>	True	<input type="radio"/>	False

- I have a relative that snores loudly  True  False
- I have a relative that sleepwalks and or talks in there sleep  True  False
- I drink more than three cups of coffee or tea per day  True  False
- I smoke more than ten cigarettes per day  True  False
- I have more than two drinks on the evening  True  False
- I am currently sick  True  False
- I worry a lot  True  False
- I feel anxious  True  False
- I recently lost someone I love  True  False
- I recently lost someone very dear to me  True  False
- I feel sad and depressed  True  False
- I feel tired and unable to cope with my work  True  False
- I have thoughts about death  True  False
- I have an inadequate sex life because of my sleep problems  True  False
- I am forgetting things more easily  True  False
- I have to clear my throat frequently  True  False
- I often have a stuffy nose  True  False
- I suffer from asthma  True  False
- I have high blood pressure  True  False
- I have difficulty in breathing  True  False
- I suffer from chronic pain  True  False
- I have swollen ankles  True  False
- I suffer from indigestion  True  False
- I suffer from diarrhea  True  False
- I have constipation  True  False
- I suffer from arthritis (joint aches)  True  False
- I have a sever bodily disability or deformity  True  False
- I had my tonsils taken out  True  False
- I have to get up every night to urinate  True  False
- I get up more than once to urinate  True  False
- I have lack of energy  True  False
- I have recently had a fever  True  False
- I have rapid or irregular heartbeats  True  False
- I have sexual problems  True  False

Please list all medications you are currently taking (including non-prescription vitamins, aspirin, etc.) dose, and purpose. Write on the back of this page if necessary.

Name	Dose	Why are you taking this medications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all previous illnesses, injuries, and hospitalizations.

Diagnosis	Year
_____	_____
_____	_____

\_\_\_\_\_  
\_\_\_\_\_  
Please give this page (ONLY) to you spouse or roommate to fill out.  
SPOUSE OR ROOMMATE QUESTIONNAIRE

Name: \_\_\_\_\_

Date: \_\_\_\_\_

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

- |                                    |  |
|------------------------------------|--|
| Loud snoring                       | <input type="radio"/> Yes <input type="radio"/> No |
| Light snoring                      | <input type="radio"/> Yes <input type="radio"/> No |
| Twitching of legs or feet          | <input type="radio"/> Yes <input type="radio"/> No |
| Pause in breathing                 | <input type="radio"/> Yes <input type="radio"/> No |
| Grinding of teeth                  | <input type="radio"/> Yes <input type="radio"/> No |
| Talking while asleep               | <input type="radio"/> Yes <input type="radio"/> No |
| Sleep walking                      | <input type="radio"/> Yes <input type="radio"/> No |
| Bed wetting                        | <input type="radio"/> Yes <input type="radio"/> No |
| Sitting in bed but not awake       | <input type="radio"/> Yes <input type="radio"/> No |
| Head rocking or banging            | <input type="radio"/> Yes <input type="radio"/> No |
| Kicking with legs during sleep     | <input type="radio"/> Yes <input type="radio"/> No |
| Getting out of bed but not awake   | <input type="radio"/> Yes <input type="radio"/> No |
| Biting tongue                      | <input type="radio"/> Yes <input type="radio"/> No |
| Becoming very rigid and/or shaking | <input type="radio"/> Yes <input type="radio"/> No |
| Seizures                           | <input type="radio"/> Yes <input type="radio"/> No |
| Abnormal behavior                  | <input type="radio"/> Yes <input type="radio"/> No |
| Screaming but not awake            | <input type="radio"/> Yes <input type="radio"/> No |
| Difficult to wake up               | <input type="radio"/> Yes <input type="radio"/> No |

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

\_\_\_\_\_  
\_\_\_\_\_

Describe the sleep behavior(s) checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night. Use additional pages if necessary.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you heard loud snoring, do you remember hearing short pauses in the snoring followed by "snorts"?

\_\_\_\_\_  
\_\_\_\_\_

Thank you

Signature: \_\_\_\_\_

# MEDICAL QUESTIONNAIRE

- |  |                            |                             |
|--|----------------------------|-----------------------------|
| I have unusual thirst                            | <input type="radio"/> True | <input type="radio"/> False |
| I have loss of appetite                          | <input type="radio"/> True | <input type="radio"/> False |
| I have heat or cold intolerance                  | <input type="radio"/> True | <input type="radio"/> False |
| I have skin rashes or sores                      | <input type="radio"/> True | <input type="radio"/> False |
| I have easy bruising or bleeding                 | <input type="radio"/> True | <input type="radio"/> False |
| I have swollen glands or other lumps             | <input type="radio"/> True | <input type="radio"/> False |
| I have blood spitting                            | <input type="radio"/> True | <input type="radio"/> False |
| I have difficulty breathing                      | <input type="radio"/> True | <input type="radio"/> False |
| I have wheezing                                  | <input type="radio"/> True | <input type="radio"/> False |
| I have swelling of the legs                      | <input type="radio"/> True | <input type="radio"/> False |
| I have pain or drainage from the ears            | <input type="radio"/> True | <input type="radio"/> False |
| I have sinus trouble                             | <input type="radio"/> True | <input type="radio"/> False |
| I have a sore throat                             | <input type="radio"/> True | <input type="radio"/> False |
| I have nausea and/or vomiting                    | <input type="radio"/> True | <input type="radio"/> False |
| I frequently suffer from stomach pain            | <input type="radio"/> True | <input type="radio"/> False |
| I have bloody or black bowel movements           | <input type="radio"/> True | <input type="radio"/> False |
| I frequently suffer from indigestion             | <input type="radio"/> True | <input type="radio"/> False |
| I have constipation                              | <input type="radio"/> True | <input type="radio"/> False |
| I have diarrhea                                  | <input type="radio"/> True | <input type="radio"/> False |
| I have breast lumps or discharge                 | <input type="radio"/> True | <input type="radio"/> False |
| I have loss of control or urination              | <input type="radio"/> True | <input type="radio"/> False |
| I have infection or stones in the kidney         | <input type="radio"/> True | <input type="radio"/> False |
| I have infection of the bladder                  | <input type="radio"/> True | <input type="radio"/> False |
| I have blood in the urine                        | <input type="radio"/> True | <input type="radio"/> False |
| I have difficulty starting or stopping urination | <input type="radio"/> True | <input type="radio"/> False |
| I have trouble thinking clearly                  | <input type="radio"/> True | <input type="radio"/> False |
| I have convulsions                               | <input type="radio"/> True | <input type="radio"/> False |
| I have blackouts                                 | <input type="radio"/> True | <input type="radio"/> False |
| I have frequent or sever headaches               | <input type="radio"/> True | <input type="radio"/> False |
| I have frequent faints                           | <input type="radio"/> True | <input type="radio"/> False |
| I have unusual thoughts, feeling or smells       | <input type="radio"/> True | <input type="radio"/> False |
| I have loss of taste                             | <input type="radio"/> True | <input type="radio"/> False |
| I have loss or blurred vision                    | <input type="radio"/> True | <input type="radio"/> False |
| I have double vision                             | <input type="radio"/> True | <input type="radio"/> False |
| I have pain or numbness in the face              | <input type="radio"/> True | <input type="radio"/> False |
| I have hearing loss and ringing in my ears       | <input type="radio"/> True | <input type="radio"/> False |
| I have dizziness                                 | <input type="radio"/> True | <input type="radio"/> False |
| I have trouble swallowing                        | <input type="radio"/> True | <input type="radio"/> False |
| I have slurred speech                            | <input type="radio"/> True | <input type="radio"/> False |
| I have weakness                                  | <input type="radio"/> True | <input type="radio"/> False |
| I have muscle cramps, jerks, or twitching        | <input type="radio"/> True | <input type="radio"/> False |
| I have muscle sores or shrinkage                 | <input type="radio"/> True | <input type="radio"/> False |
| I have shaking                                   | <input type="radio"/> True | <input type="radio"/> False |
| I have in-coordination                           | <input type="radio"/> True | <input type="radio"/> False |
| I have loss of balance                           | <input type="radio"/> True | <input type="radio"/> False |
| I have loss of feeling                           | <input type="radio"/> True | <input type="radio"/> False |
| I have numbness                                  | <input type="radio"/> True | <input type="radio"/> False |
| I have tingling                                  | <input type="radio"/> True | <input type="radio"/> False |
| I have trouble understanding what others say     | <input type="radio"/> True | <input type="radio"/> False |

I have trouble reading or writing

True  False

**Women only section**

My periods are irregular

True  False

I am menopausal

True  False

I am pregnant

True  False

My sleep changes with my periods

True  False

I have pre-menstrual syndrome

True  False

I have lack of sexual desire

True  False

**Men only section**

I have difficulties to obtain an erection

True  False

I have difficulties to maintain an erection

True  False

I don't wake up with erections anymore

True  False

My erections are painful

True  False

I have lack of sexual desire

True  False

My sexual problems started suddenly

True  False

Please leave any additional comments or concerns.

---



---



---



---



---



---



---



---



---



---

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Thank you for answering this questionnaire. If you have any additional question, please feel free to call us at 818-715-0096.