This questionnaire will provide information about your sleep problem to our Sleep Specialist for a better understanding of your complaint. Please answer each question as completely as possible and circle questions that you would like to discuss in further detail with the physician.

Date Completed: ______________________

Patient Name: ____________________________ Age: _________ Gender: ☐ Male ☐ Female

SS#: ________________________________ Date of Birth: __________________________________

Height: _______ ft. ______ in. Weight: _________ lbs. Shirt Collar Size: ______________________

Home Phone: ________________________________ Cell Phone: ________________________________

Referring Physician: ____

Please give a brief description of the symptoms that are concerning for a sleep disorder (poor sleep quality, sleepiness, etc.)

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How long have these symptoms been a problem?

A. SLEEP HISTORY (may elaborate in space provided at the end of this section)

1. What time do you go to bed on weekdays? _______ AM/PM On weekends? _________ AM/PM
2. What time do you wake up on weekdays? _______ AM/PM On weekends? _________ AM/PM
3. When you go to bed, how long does it usually take to fall asleep? ________________ Minutes
4. How many times do you awaken on an average night? _______ times.
5. When awakenings occur, are they associated with:
   - ☐ the need to urinate
   - ☐ snoring
   - ☐ pain
   - ☐ difficulty reinitiating sleep
   - ☐ gasping or choking
6. Upon your final awakening, do you experience:
   - ☐ feeling of refreshment
   - ☐ headache
   - ☐ sleepiness / fatigue
   - ☐ mouth or throat dryness or irritation
7. On the average, how long are you awake in the morning before you actually get out of bed? __________ Mins.

A. SLEEP HISTORY (Cont'd)

8. Do you take naps during the day? ☐ Yes ☐ No
   If yes, what time? ____________________ For how long? __________ Minutes
9. Does your bed partner describe:
   ☐ Snoring ☐ Limb jerking
   ☐ Pauses in breathing pattern (apneas) ☐ "Restlessness" with tossing and turning
10. Do you feel that you suffer from insomnia? ☐ Yes ☐ No
    (If yes, please describe below)
11. What position do you usually sleep in?
    ☐ On Side ☐ On stomach
    ☐ On back ☐ Combination of all three
12. Have you ever had a previous sleep study? ☐ Yes ☐ No
    If so, when? ____________________ Where? ____________________
13. Have you ever used nasal CPAP therapy? ☐ Yes ☐ No
    Duration of treatment? ____________________ Pressure setting: __________
    Have you ever used nocturnal oxygen therapy? ☐ Yes ☐ No

Additional Information:

____

____

____

B. SLEEPINESS

1. Do you wake feeling tired or wanting more sleep regardless of how much sleep you get?
   ☐ Yes ☐ No ☐ Sometimes
2. Do you struggle to stay awake during the day? ☐ Yes ☐ No ☐ Sometimes
3. Have you ever dozed off while driving? ☐ Yes ☐ No
4. Do you fall asleep easily in social situations or meetings? ☐ Yes ☐ No ☐ Sometimes
5. Do you have feelings of depression throughout the day? ☐ Yes ☐ No ☐ Sometimes
6. Do you have difficulty concentrating during the day? ☐ Yes ☐ No ☐ Sometimes
7. Do you believe you have had a change in personality or increased irritability over the past year?
   ☐ Yes ☐ No ☐ Sometimes
8. Do you believe your "efficiency" performing at work or other tasks is affected by your sleepiness?
   ☐ Yes ☐ No ☐ Sometimes
9. Do you feel a lack of energy or fatigue throughout the day? ☐ Yes ☐ No ☐ Sometimes

B. SLEEPINESS (Cont'd)

10. Have you had:

Loss of sexual interest/libido? ☐ Yes ☐ No ☐ Sometimes

Erectile dysfunction? ☐ Yes ☐ No ☐ Sometimes

Additional Information:

____

____

____

C. SLEEP QUALITY

1. Do you experience dreams? ☐ Yes ☐ No ☐ Sometimes ☐ Infrequently
2. Do you experience night mares? ☐Yes ☐ No ☐ Sometimes ☐ Infrequently
3. Do your legs or arms bother you when resting or falling asleep or feel "restless" during the day?
   ☐Yes ☐ No ☐ Sometimes
4. Do you grind your teeth during sleep? ☐Yes ☐ No ☐ Sometimes
5. Do you have any unusual sleep behavior (sleep walking, sleep talking)?
   ☐Yes ☐ No
6. Have you ever awoken from sleep with a feeling of muscular paralysis?
   ☐Yes ☐ No
7. Have your dreams ever been so vivid that there was doubt upon awakening whether this was a dream or reality (even hours after awakening)? ☐Yes ☐ No
8. Have you ever developed muscular paralysis during wakefulness (particularly with periods of laughter or excitement)? ☐Yes ☐ No

D. MEDICAL HISTORY (please describe positive answers in space provided at the end of section)

1. Do you have a history of any of the following (please circle):
   a. Arthritis or fibromyalgia
   b. Cardiac problems or chest pain
   c. Diabetes
   d. Depression or any previous history of requiring care of psychiatrist
   e. Head injury
   f. High blood pressure
   g. Kidney problems
   h. Nasal or sinus problems
   i. Shortness of breath or lung disease
   j. Seizures
   k. Stroke

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D. MEDICAL HISTORY (Cont'd)

2. Please list major medical problems not listed above for which you hare followed by a physician or are receiving treatment.

____
____
____

3. Please list any operations you have had including any related to your nose or throat (including tonsillectomy)

____
____
____

4. Please list any medication you take on a regular basis (including sleep aids/stimulants).

Name	Dose	Reason for Taking

5. Please list allergies: ____

____
____
____
____

6. Please list any family medical history to any sleep disorders such as snoring, Sleep Apnea, Insomnia, and Narcolepsy.

____
____
____

7. Family History: Mother/Alive/Deceased Diagnosis ______________________
   Father/Alive/Deceased Diagnosis ______________________

8. a. What is your occupation? ______________________

   b. What hours do you work? ______________________

9. Have you ever worked shift work? ☐ Yes ☐ No

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D. MEDICAL HISTORY (Cont'd)

Additional Information: ____

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E. HABITS AFFECTING SLEEP (please further describe below if needed)

1. On the average, how many caffeinated beverages do you consume per week? ________________
2. Do you use any over the counter caffeine products to maintain wakefulness? ☐ Yes ☐ No
3. Do you exercise regularly? ☐ Yes ☐ No
4. Do you take any hypnotic medications to help initiate sleep? ☐ Yes ☐ No
5. Do you have a history of smoking? ☐ Yes ☐ No

   If yes, how many cigarettes do you smoke per day? ________________

   How long have you been smoking? ______________________________
6. Do you currently smoke? ☐ Yes ☐ No
7. On the average, how many alcoholic beverages do you consume per week?
8. Have you had any recent change in body weight? ☐ Yes ☐ No

   Gained ______ Lbs. Lost _______ Lbs. Over what period of time? ______________
9. Are there any distractions in your sleep environment (awakening children, nose, phone calls, etc.)? ☐ Yes ☐ No

Additional Information: ____

____

____

F. SYSTEM REVIEW (Please circle if you experience any of the following):

1. Chest Pain
2. Dizziness
3. Palpitations
4. Blackout spells
5. Headaches
6. Visual changes
7. Urinary problems
8. Constipation/diarrhea
9. Shortness of breath/wheezing
10. Cough
11. Heartburn or reflux
12. Nasal congestion
13. Trouble swallowing
14. Joint or muscle pain
15. Leg or ankle swelling
16. Calf pain with walking

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EPWORTH SLEEPINESS SCALE (ESS)

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* of each situation.

0 = Have never done

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	______________________
Watching TV	______________________
Sitting, inactive in a public place (e.g. a theater or meeting)	______________________
As a passenger in a car for an hour without a break	______________________
Lying down in the afternoon when circumstances permit	______________________
Sitting and talking to someone	______________________
Sitting quietly after a lunch without alcohol	______________________
In a car while stopped for a few minutes in traffic	______________________

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H. SLEEP APNEA RISK

1. Do you have a history or snoring?
   ( ) No = 0 ( ) Mild/Infrequent = 0 ( ) Moderate/Inconsistent = 2 ( ) Sever/Consistent = 8

2. Have you ever been told that you have "pauses" in breathing during sleep?
   ( ) No = 0 ( ) Yes/Infrequent = 2 ( ) Inconsistent, but most nights = 8 ( ) Severely so = 10

3. Are you overweight?
   ( ) No = 0 ( ) <20 lbs = 2 ( ) Between 20 – 50 lbs = 3 ( ) >50 lbs = 8

4. Evaluate your sleepiness from the ESS Score above.
   ( ) ≤8 = 0 ( ) 9-13 = 1 ( ) 14-18 = 6 ( ) ≥ 19 = 8

5. Does your medical history include:
   ( ) High blood pressure = 6
   ( ) Heart Disease = 1
   ( ) >3 awakenings/sleep period = 4
   ( ) Depression = 1
   ( ) Stroke = 1
   ( ) Morning Headaches = 1
   ( ) Excessive Fatigue = 1
   ( ) Diabetes, even borderline = 1

Total Score (Add each response above) ________________________