

****Have you ever had a sleep study, if so where and when? _____

****Please bring a copy of any past sleep studies.****

1. Duration/History of Sleep Problem

What is the primary complaint(s), you can choose more than one:

- | | |
|---------------------------------|------------------------------------|
| _____ Difficulty falling asleep | _____ Difficulty staying asleep |
| _____ Daytime sleepiness | _____ Snoring |
| _____ Restless legs at night | _____ Gasping/choking during sleep |
| _____ Activity during sleep | Other: _____ |

How long have you had, or have been told about, this problem? _____

Does anyone else in your family have a similar problem? _____

Did this problem start or get worse at the time of any significant stress, physical injury, or weight gain? _____

What have you already tried to reduce your sleep problem? _____

Have you tried any sleep medication or aids? _____

Any sleep disruptors? (bed partner, children, pets, pain, mattress, etc) _____

How do you sleep? (side, back, stomach) _____

2. Sleep Schedule (If retired please still complete)

What time do you go to bed on the days that you work? _____

What time do you get up on the days that you work? _____

What time do you go to bed on the days that you don't work? _____

What time do you get up on the days that you don't work? _____

How many hours do you sleep on the days that you work? _____ hours

How many hours do you sleep on the days that you don't work? _____ hours

How long does it take you to fall asleep? _____ mins

How many times do you (on average) wake up a night? _____

How long does it take you to fall back asleep? _____ mins

How many hours are you in bed? _____ hours

How many of those are do you think you are actually asleep? _____ hours

Do you work rotating shifts? _____ If yes, what shifts? _____

Do you take naps? YES NO If yes: Nap time _____ Nap length _____

Do you feel refreshed after naps? YES NO

3. While Trying to Fall Asleep

How often do you, or are told that you.... <i>(Please circle response)</i>	Never	Sometimes	Almost Always
Have mind racing?	1	2	3
Worry about not falling asleep?	1	2	3
Experience being awake, but being unable to move?	1	2	3
Experience restless legs?	1	2	3

4. While Asleep or in Bed

How often do you, or are told that you.... <i>(Please circle response)</i>	Never	Sometimes	Almost Always
Awaken frequently from sleep?	1	2	3
Snore?	1	2	3
Stop breathing?	1	2	3
Awaken due to coughing, heartburn or regurgitation?	1	2	3
Grind your teeth?	1	2	3
Sleep walk?	1	2	3
Sleep talk?	1	2	3
Have nightmares?	1	2	3
Wake up to use the bathroom more than once a night?	1	2	3
Thrash or have sudden violent body movements?	1	2	3
Experience dreamlike scenes or hallucinations?	1	2	3
Have night sweats?	1	2	3
Experience nasal congestion?	1	2	3
Experience seizures?	1	2	3
Experience heart palpitations?	1	2	3
Sleep eat?	1	2	3
Sleep kick?	1	2	3
Act out dreams?	1	2	3
Experience vivid dreams?	1	2	3

5. During Waking Hours

How often do you, or are told that you.... <i>(Please circle response)</i>	Never	Sometimes	Almost Always
Wake up refreshed?	1	2	3
Wake up with morning dry mouth?	1	2	3
Wake up with morning headaches?	1	2	3
Wake up with morning bad breath?	1	2	3
Wake up with morning sore throat?	1	2	3
Experience fatigue?	1	2	3
Experience memory problems?	1	2	3
Experience excessive sleepiness?	1	2	3
Experience sudden muscle weakness or feel as if you might fall down when angry or laughing?	1	2	3
Are irritable?	1	2	3
Are depressed?	1	2	3
Are anxious?	1	2	3
Are hyperactive?	1	2	3
Have problems concentrating?	1	2	3
Fall asleep when or where you should not?	1	2	3

6. Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling 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 imagine how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Situation	Chance of Dozing (0-3)	
Sitting and reading	_____	
Watching television	_____	
Sitting inactive in a public place (i.e. – movie, meeting)	_____	
As a passenger in a car for an hour without a break	_____	
Lying down to rest in the afternoon	_____	
Sitting talking to someone	_____	
Sitting quietly after lunch without alcohol	_____	
In a car, while stopped for a few minutes in traffic	_____	
<i>Please Total your score</i>	_____	

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