

Z Sleep Diagnostcs

Name: _____ Date of Birth: ____/____/____

Pre-study Questionnaire

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0= would never dose 1= slight chance 2= moderate 3= high

- _____ Sitting and reading
- _____ Watching TV
- _____ Sitting, inactive in a public place
- _____ As a passenger in a car for more than an hour without a break
- _____ Lying down to rest in the afternoon when circumstances permit
- _____ Sitting and talking with someone
- _____ Sitting quietly after lunch without alcohol
- _____ In a car, while stopping for a few minutes in traffic

_____ **Total**

Sleep Schedule

What time do you go to bed on **weekdays**? _____ AM or PM Do you take naps? yes no
What time do you get up on **weekdays**? _____ AM or PM If yes, how often do you nap?
What time do you go to bed on **weekends**? _____ AM or PM _____ times per week
What time do you get up on **weekends**? _____ AM or PM

Are you a shift worker? yes no If yes, what kind of shift do you work?

Check for each problem you *currently have*:

- | | |
|------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> loud snoring | <input type="checkbox"/> teeth grinding |
| <input type="checkbox"/> frequent awakenings at night | <input type="checkbox"/> morning headaches |
| <input type="checkbox"/> choking for breath at night | <input type="checkbox"/> morning dry mouth |
| <input type="checkbox"/> I've been told I stop breathing when asleep | <input type="checkbox"/> sleep walking |
| <input type="checkbox"/> leg-kicking during sleep | <input type="checkbox"/> sleep terrors |
| <input type="checkbox"/> crawling feeling in legs when trying to sleep | <input type="checkbox"/> tongue biting in sleep |
| <input type="checkbox"/> trouble falling asleep | <input type="checkbox"/> bed wetting |
| <input type="checkbox"/> trouble staying asleep | <input type="checkbox"/> acting out dreams |
| <input type="checkbox"/> fear of being unable to fall asleep | <input type="checkbox"/> feeling paralyzed when falling asleep |
| <input type="checkbox"/> racing thoughts when trying to sleep | <input type="checkbox"/> dreamlike images when falling asleep |
| <input type="checkbox"/> waking too early | <input type="checkbox"/> uncontrollable daytime sleep attacks |
| <input type="checkbox"/> sweating a lot at night | <input type="checkbox"/> falling asleep unexpectedly |
| <input type="checkbox"/> waking up with heartburn | <input type="checkbox"/> falling asleep at work |

- | | | | |
|--------------------------|-------------------------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | waking up to urinate | <input type="checkbox"/> | falling asleep while driving |
| <input type="checkbox"/> | nightmares | <input type="checkbox"/> | I use sleeping pills to aid in sleep |
| <input type="checkbox"/> | muscle tension when trying to fall asleep | <input type="checkbox"/> | I use alcohol to help me sleep |
| <input type="checkbox"/> | pain interfering with sleep | <input type="checkbox"/> | I get "weak knees" when I laugh |

Please list hospitalizations within the last five years.

Reason for hospitalization:	Date
<hr/>	
<hr/>	
<hr/>	

1. List your current average for each category

- _____ cups of regular coffee per day
- _____ cups of tea per day
- _____ ounces of soda or other caffeinated beverage per day
- _____ cans of beer per day (12 oz)
- _____ glasses of wine per day
- _____ alcoholic drinks per day (1-2 oz straight or mixed)

2. Do you use tobacco products? Yes No Quit (How long ago _____ months/years)
 If so, how much per day? _____

3. What is your relationship status?

- Single Married Divorced Widowed Separated Living with someone

4. What is your occupation?

History and Physical

Patient Name: _____ Age: _____ Sex: _____

**Please print legibly*

Height: _____ Weight: _____

Presenting Symptoms

- Snoring
- Difficulty Sleeping
- Observed Apneas
- Excessive Daytime Sleepiness
- Memory Loss
- Other _____
- Hypoxia
- Choking/Gasps during sleep
- Leg Restlessness
- Falling asleep while driving

Health History

- | | | |
|-----------------------------------------------|--------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Runny or blocked nose |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Emphysema or COPD | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hormonal Problem |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Urological Problem |
| <input type="checkbox"/> Heart Disease or CHF | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Problems w/alcohol |
| | <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Problems w/Drugs |

Medications: (use back if needed)

_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____

Supplemental Oxygen _____ LPM

Do you currently use CPAP at home? _____ Pressure _____ Mask _____ Years

Special Needs:

- Walker Wheelchair Incontinent

Office Use Only

Information Obtained By: _____ Scheduled Test Date: _____

Approved for PSG/Titration/MSLT: _____ Date: _____