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
What time do you get up on **weekdays**? ______ AM or PM
What time do you go to bed on **weekends**? ______ AM or PM
What time do you get up on **weekends**? ______ AM or PM

Do you take naps? □ yes □ no
If yes, how often do you nap?
_________ times per week

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

Check for each problem you *currently have*:

O loud snoring
O frequent awakenings at night
O choking for breath at night
O I've been told I stop breathing when asleep
O leg-kicking during sleep
O crawling feeling in legs when trying to sleep
O trouble falling asleep
O trouble staying asleep
O fear of being unable to fall asleep
O racing thoughts when trying to sleep
O waking too early
O sweating a lot at night
O waking up with heartburn
O waking up to urinate
O nightmares
O muscle tension when trying to fall asleep
O pain interfering with sleep
O teeth grinding
O morning headaches
O morning dry mouth
O sleep walking
O sleep terrors
O tongue biting in sleep
O bed wetting
O acting out dreams
O feeling paralyzed when falling asleep
O dreamlike images when falling asleep
O uncontrollable daytime sleep attacks
O falling asleep unexpectedly
O falling asleep at work
O falling asleep while driving
O I use sleeping pills to aid in sleep
O I use alcohol to help me sleep
O I get "weak knees" when I laugh

Please list hospitalizations within the last five years.

Reason for hospitalization: Date

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?

O Single O Married O Divorced O Widowed O Separated O Living with someone

4. What is your occupation?

SLEEP DIARY

WEEK OF ______________________________

NAME ____

DATE	LIGHTS OUT TIME	APPROXIMATE SLEEP ONSET TIME	AWAKENING TIME IN MORNING	NUMBER OF AWAKENINGS AT NIGHT	NUMBER AND TIME OF NAPS

INSTRUCTIONS:

On each day please do the following:

1. Fill in today's date on appropriate line.
2. Write the time at which you turn the light out to go to sleep and then put the diary next to your bed.
3. When you awaken in the morning, write down your awakening time.
4. Write down the number of naps you took yesterday.

History and Physical

Patient Name: ___________________________________ Age: _____________ Sex: ______________

Height: __________________ Weight: ____________________

Presenting Symptoms

- o Snoring
- o Difficulty Sleeping
- o Observed Apneas
- o EDS
- o Memory Loss
- o Other____
- o Hypoxia
- o Choking/Gasps during sleep
- o Leg Restlessness
- o Falling asleep while driving

Health History

O Diabetes
O Anemia
O High Blood Pressure
O Acid Reflux
O Stroke
O Kidney Disease
O Heart Disease or CHF
O Thyroid Disease
O Heart Attack
O Angina
O Emphysema or COPD
O Arthritis
O Asthma
O Back Pain
O Tuberculosis
O Head Trauma
O Severe Headaches
O Epilepsy
O Runny or blocked nose
O Fainting
O Hormonal Problem
O Depression
O Urological Problem
O Anxiety Disorder
O Problems w/alcohol
O 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:** ________________________