# Sleep Disorders Center

Accredited by the American Academy of Sleep Medicine

<table>
<thead>
<tr>
<th>Patient Name: ____________________________</th>
<th>Age: ____</th>
<th>Gender: M/F</th>
<th>Date:__________</th>
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</table>

- **What is your chief complaint?**
  - [ ] Loud snoring
  - [ ] Pauses in breathing while asleep
  - [ ] Restless legs once in bed
  - [ ] Limb jerking while asleep
  - [ ] Excessive daytime sleepiness or fatigue
  - [ ] Difficulty falling or staying asleep (insomnia)
  - [ ] I have unwanted behavior while asleep

- **At what age did your sleep problem start?** ________ years old

- **Tell us about your sleep:**
  - [ ] I retire between ____________ am/pm
  - [ ] I awaken between ____________ am/pm
  - [ ] On average I get ________ hours of sleep per night
  - [ ] On average I awaken ________ times per night
  - [ ] Do you have difficulty **falling** asleep? Yes / No
    If yes how many times per week: ________
  - [ ] Do you have difficulty **staying** asleep? Yes / No
    If yes how many times per week: ________

- **When you go to bed and before you fall asleep:**
  - [ ] I read in bed
  - [ ] I watch TV in bed
  - [ ] I play with my phone/Ipad/PC
  - [ ] I eat in bed
  - [ ] I have sex
  - [ ] I have racing thoughts/I worry
  - [ ] I hear voices, sounds or I have imageries and visions (hallucinations)
  - [ ] I have an uncomfortable sensation in my legs with an urge to move them
  - [ ] I speak with my bed partner for over 10 minutes
  - [ ] Pets (your cat or dog)
  - [ ] Cough
  - [ ] Pain
  - [ ] Palpitations/heart beating fast (racing)
  - [ ] Bed partner (moving, snoring, waking up)
  - [ ] Shortness of breath

- **What disturbs your sleep?**
  - [ ] Noise
  - [ ] Heat or cold
  - [ ] Kids
  - [ ] I have to use the bathroom
    - (How many times per night? ________)
  - [ ] GERD/Heartburn

- **While asleep:**
  - [ ] I snore loudly
  - [ ] I have been witnessed to have pauses in breathing
  - [ ] I am very restless, tossing and turning
  - [ ] I have vivid dreams
  - [ ] I have nightmares
  - [ ] I wake up with a choking or a gasping sensation
  - [ ] I have nasal congestion
I feel that my body is paralyzed for few minutes but my brain is awake
I talk in my sleep
I act out my dreams, sometimes violently

• When I wake up in the morning:
  I feel groggy and un-refreshed
  I have a dry mouth
  I have a headache

• How badly do you feel that daytime fatigue or sleepiness affects your? (circle one)
  Work: Not at all    Mildly    Moderately    Severely
  Social interactions: Not at all    Mildly    Moderately    Severely
  Driving: Not at all    Mildly    Moderately    Severely
  Academics: Not at all    Mildly    Moderately    Severely

• I take ___ minutes nap ____ times per week. Do you feel that the nap is refreshing?   Yes   No

• Did you ever have a car or motor vehicle accident due to sleepiness?   Yes   No

• What is your current:  Weight: _____ lbs    Height: ___ft ___ in    Neck Collar: _____ inches
  I gained / lost weight in the last year (circle one).   How much??   _____ lbs.

• I drink:
  ____ cups of coffee a day
  ____ cups of tea a day
  ____ sodas a day
  ____ alcoholic drinks a day

• I smoke:
  Cigarettes:   never  daily  occasionally
  Pipe or cigar:  never  daily  occasionally
  Marijuana :   never  daily  occasionally

• What medical conditions do you suffer from? (check what applies)
  High blood pressure
  Atrial Fibrillation or abnormal cardiac rhythm
  Heart disease
  High Cholesterol
  Diabetes Mellitus
  COPD/Emphysema
  Allergies
  Thyroid dysfunction (low thyroid)

• Does anyone in your family suffer from obstructive sleep apnea?
  Yes   Who?? _____________________
  No
EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven’t done some of the things recently, think about how they would affect you.

Use the following scale to choose the most appropriate number for each situation:

0: Would never dose off
1: Slight chance of dozing off
2: Moderate chance of dozing
3: High chance of dozing

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<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING (0-3)</th>
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<tbody>
<tr>
<td>Sitting or Reading</td>
<td></td>
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<tr>
<td>Watching Television</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place (theater, meeting…)</td>
<td></td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
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<tr>
<td>Lying down to rest in the afternoon</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch (when you’ve had no alcohol)</td>
<td></td>
</tr>
<tr>
<td>In a car while stopped in traffic</td>
<td></td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td></td>
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