Buxmont Pulmonary & Sleep Medicine

SLEEP QUESTIONNAIRE

PATIENT NAME:_____DATE OF BIRTH:_____
AGE:_____ DATE:_____

EPWORTH SLEEPINESS SCALE

How LIKELY are you to DOZE off or FALL ASLEEP in the following situations, in contrast to just feeling tired? Please check ONE box per line.

CHANCE OF DOZING OFF:

NEVER(0)	RARELY(1)	FREQUENTLY(2)	ALWAYS(3)	
				SITTING AND READING
				WATCHING TV
				SITTING INACTIVE IN A PUBLIC PLACE. FOR EXAMPLE, IN THE THEATRE OR AT A MEETING
				AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK
				LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUMSTANCES PERMIT
				SITTING AND TALKING TO SOMEONE
				SITTING QUIETLY AFTER A LUNCH (WITHOUT HAVING A DRINK OF ANY ALCOHOL
				IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC

TOTAL SCORE _____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

PATIENT NAME_____

YOUR SLEEP SCHEDULE

YOUR BEDTIME ON WEEKDAYS _____ AM OR PM

TIME YOU GET UP ON WEEKDAYS _____ AM OR PM

YOUR BEDTIME ON WEEKENDS _____ AM OR PM

TIME YOU GET UP ON WEEKENDS _____ AM OR PM

DO YOU NAP? YES_____ NO_____

HOW OFTEN DO YOU NAP? _____ TIMES PER WEEK

DO YOU FEEL REFRESHED AFTER NAPS? YES_____ NO_____

ARE YOU A SHIFT WORKER? YES_____ NO_____

IF YES, WHAT KIND OF SHIFT DO YOU WORK? _____

HAVE YOU EVER HAD A SLEEP STUDY BEFORE? YES_____ NO_____

IF YES, PLEASE INDICATE WHEN AND WHERE.

_____

DO YOU CURRENTLY USE A CPAP OR BiPAP MACHINE AT HOME?

YES_____ NO_____

IF SO, WHAT ARE YOUR CURRENT PRESSURE SETTINGS? _____

ARE YOU ON HOME OXYGEN? YES_____ NO_____

IF SO, WHAT LITER FLOW OF OXYGEN?_____

DO YOU USE OXYGEN FOR SLEEP ONLY? _____

DO YOU USE OXYGEN REGULARLY? _____

HEALTH HISTORY

PATIENT NAME_____

HOW WOULD YOU RATE YOUR CURRENT GENERAL HEALTH? (CIRCLE ONE)

VERY POOR POOR AVERAGE GOOD VERY GOOD

DO YOU OR HAVE YOU EVER HAD IN THE PAST?	YES	NO
HIGH BLOOD PRESSURE		
DIABETES		
STROKE		
CONGESTIVE HEART FAILURE		
HEART DISEASE		
ATRIAL FIBRILLATION		
COPD OR EMPHYSEMA		
ASTHMA		
NASAL ALLERGIES		
PROSTATE PROBLEMS		
HORMONAL PROBLEMS		
ACID REFLUX		
KIDNEY DISEASE		
THYROID DISEASE		
HEAD TRAUMA		
SEVERE HEADACHES		
SEIZURES		
FAINTING SPELLS		
DEPRESSION		
ANXIETY DISORDER		
PROBLEM WITH ALCOHOL		
PROBLEM WITH DRUGS		

DO YOU SMOKE? YES_____ NO_____

IF SO, HOW MUCH? _____

IF YOU QUIT, HOW LONG AGO DID YOU QUIT? _____

DO YOU DRINK TEA, COFFE OR OTHER CAFFEINATED BEVERAGES? YES_____ NO_____

IF SO, HOW MANY CUPS PER DAY? _____

DO EITHER OF YOUR PARENTS, BROTHERS, OR SISTERS HAVE ANY SLEEP DISORDERS?

YES_____ NO_____

SLEEP PROBLEMS CHECKLIST

PATIENT NAME_____

WHAT PROBLEM CAUSES YOU TO SEEK HELP? _____
_____

HOW DOES THIS PROBLEM AFFECT YOURL LIFE? _____
_____

DO YOU HAVE ANY OF THE FOLLOING PROBLEMS?	YES	NO
LOUD SNORING		
FREQUENT AWAKENINGS AT NIGHT		
CHOKING FOR BREATH AT NIGHT		
GASPING FOR AIR AT NIGHT		
STOP BREATHING WHILE ASLEEP		
RESTLESS SLEEP		
AWAKEN UN-REFRESHED		
CRAWLING FEELINGS IN YOUR LEGS WHEN TRYING TO SLEEP		
LEG KICKING DURING SLEEP		
LEG CRAMPS DURING SLEEP		
TROUBLE FALLING ASLEEP		
TROUBLE STAYING ASLEEP		
RACING THOUGHTS WHEN TRYING TO SLEEP		
FEAR OF BEING UNABLE TO SLEEP		
SLEEP TALKING		
SLEEP WALKING		
SWEATING A LOT AT NIGHT		
WAKING UP WITH HEART BURN		
NIGHMARES		
TEETH GRINDING		
MORNING HEADACHES		
MORNING DRY MOUTH		
SLEEP TERRORS		
TONGUE BITING DURING SLEEP		
ACTING OUT DREAMS		
SUDDEN WEAKNESS IN ARMS, LEGS, AND JAW WITH CHANGES IN EMOTIONS SUCH AS LAUGHTER		
UNCONTROLLABLE SLEEP ATTACKS		
FALLING ASLEEP AT WORK		
RECENT CHANGE IN SLEEP SCHEDULE		
USE SLEEPING PILLS		
PAIN INTERFERING WITH SLEEP		
WAKING UP TO URINATE		