HARRIS
REGIONAL HOSPITAL

Sleep Disorders Center
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The purpose of this questionnaire is to assess and determine the nature of your sleep problem. It is very important to be as accurate as possible in answering the questions. Your spouse or bed partner may be able to assist you. This information will become part of your medical record and will remain confidential.

Name:_____
Last **First** **Middle**

Address:_____
Street

_____
City **State** **Zip Code**

Phone #: Home_____**Cell:**_____**Work:**_____

Birth Date: _____ **Age:** _____ **Sex: Male Female**

Marital Status:_____**Height:**_____**Weight:**_____**Occupation:**_____

Referring Physician : _____

Medication:

Please list all medications that you are currently taking. Provide name and dosage

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

7. _____ **8.** _____

Allergies:

_____

_____

_____

Please fill questionnaire out completely and bring with you to your sleep study appointment.

Summary of your sleep problems:

Describe your sleep problem in your own words: For example, excessive snoring, insomnia, daytime sleepiness.

_____
_____
_____
_____

How long have you had these sleep related problems?

_____
_____
_____

How do these problems affect your daily activities and life in general?

_____
_____
_____

Medical History/Conditions:

List any current medical conditions for which you are being treated.

Problem or diagnosis **Physician**

_____
_____
_____
_____
_____

Do you smoke? ☐**YES**☐**NO** **If yes, how many packs per day?** _____

If yes, how long have you smoked? _____

If you are a former smoker, when did you quit? _____

If you are a former smoker, how much did you smoke? _____

Do you use Oxygen at home? ☐**Yes** ☐**No**

If yes, At night only?_____ **or 24 hours a day?** _____

Sleep History:

When is your normal bedtime? _____ (Workdays) _____ (Days Off)

When is your normal wake time? _____ (Workdays) _____ (Days Off)

Approximately how long does it take you to fall asleep? _____

How many hours of sleep do you think you need per night? _____

Favorite sleeping position? Back ◯ Stomach ◯ Left Side ◯ Right Side ◯

Are you unable to sleep on your back ? ☐ **Yes** ☐ **No**

If yes, please explain:

_____

_____

_____

Please answer the following questions by circling the appropriate answers.

Do you have awakenings during your sleep?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Following awakenings, do you have trouble going back to sleep?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you talk in your sleep?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you walk in your sleep?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you consider yourself a light sleeper?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you consider yourself a restless sleeper?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you awaken with morning headaches?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you awaken to go to the restroom?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you have leg jerks during your sleep?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do your legs feel restless when you try to fall asleep?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Do you snore?	**Yes** ☐ **No** ☐ **Sometimes** ☐
Is snoring worse while on your back?	**Yes** ☐ **No** ☐ **Sometimes** ☐

Please answer the following questions by circling the appropriate answer

Is snoring worse while on your side?	**Yes ☐ No ☐ Sometimes ☐**
Do you wake up choking or gagging?	**Yes ☐ No ☐ Sometimes ☐**
Have you been told that you quit breathing while sleeping?	**Yes ☐ No ☐ Sometimes ☐**
Do you get sleepy while driving?	**Yes ☐ No ☐ Sometimes ☐**
Do you get sleepy during the day?	**Yes ☐ No ☐ Sometimes ☐**
Do you feel tired or exhausted during the day?	**Yes ☐ No ☐ Sometimes ☐**
Do you take daytime naps?	**Yes ☐ No ☐ Sometimes ☐**
Do you dream during naps?	**Yes ☐ No ☐ Sometimes ☐**
Are daytime naps refreshing?	**Yes ☐ No ☐ Sometimes ☐**
Do you have difficulty sleeping at night after napping during the day?	**Yes ☐ No ☐ Sometimes ☐**
Have you ever felt paralyzed or unable to move when waking or falling asleep?	**Yes ☐ No ☐ Sometimes ☐**
Do you feel weak or feel like you are falling asleep when you laugh or get angry?	**Yes ☐ No ☐ Sometimes ☐**
Do you have difficulty breathing through your nose?	**Yes ☐ No ☐ Sometimes ☐**
Do you wake up with Acid taste in your mouth?	**Yes ☐ No ☐ Sometimes ☐**
Have you had a recent weight gain?	**Yes ☐ No ☐**
Have you ever had a tonsillectomy or nasal surgery?	**Yes ☐ No ☐**
Do you have seizures?	**Yes ☐ No ☐**
Have you ever had a head injury?	**Yes ☐ No ☐**
Do you drink alcohol?	**Yes ☐ No ☐**

If yes: How much? _____ How Often? _____

Epworth Sleepiness Scale

Name: _____ Date: _____

Your Age: _____ Your Sex: ☐ Male ☐ Female

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

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

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

0 = would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	Chance of Dozing
Sitting and reading …….	**0 1 2 3**
Watching TV ……..	**0 1 2 3**
Sitting, inactive in a public place ……..	**0 1 2 3**
As a passenger in a car for an hour without a break….	**0 1 2 3**
Lying down to rest in the afternoon when circumstances permit…..	**0 1 2 3**
Sitting and talking to someone ……..	**0 1 2 3**
Sitting quietly after a lunch without alcohol ……	**0 1 2 3**
In a car, while stopped for a few minutes in traffic…….	**0 1 2 3**

Total: _____