

ST JOSEPH HOSPITAL

SLEEP DISORDERS CENTER

Accredited by the American Academy of Sleep Medicine

Patient Name: _____

Age: _____

Gender: Male / Female

• **What is your chief complaint?**

- | | |
|---|--|
| <input type="checkbox"/> Loud snoring | <input type="checkbox"/> Excessive daytime sleepiness or fatigue |
| <input type="checkbox"/> Pauses in breathing while asleep | <input type="checkbox"/> Difficulty falling or staying asleep (insomnia) |
| <input type="checkbox"/> Restless legs once in bed | <input type="checkbox"/> I have unwanted behavior while asleep |
| <input type="checkbox"/> Limb jerking 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:**

- | | |
|---|---|
| <input type="checkbox"/> I read in bed | <input type="checkbox"/> I hear voices, sounds or I have imageries and visions (hallucinations) |
| <input type="checkbox"/> I watch TV in bed | <input type="checkbox"/> I have an uncomfortable sensation in my legs with an urge to move them |
| <input type="checkbox"/> I play with my phone/Ipad/PC | <input type="checkbox"/> I speak with my bed partner for over 10 minutes |
| <input type="checkbox"/> I eat in bed | |
| <input type="checkbox"/> I have sex | |
| <input type="checkbox"/> I having racing thoughts/I worry | |

• **What disturbs your sleep?**

- | | |
|--|---|
| <input type="checkbox"/> Noise | <input type="checkbox"/> Pets (your cat or dog) |
| <input type="checkbox"/> Heat or cold | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Pain |
| <input type="checkbox"/> I have to use the bathroom
o (How many times per night? _____) | <input type="checkbox"/> Palpitations/heart beating fast (racing) |
| <input type="checkbox"/> GERD/Heartburn | <input type="checkbox"/> Bed partner (moving, snoring, waking up) |
| | <input type="checkbox"/> Shortness of breath |

• **While asleep:**

- | | |
|--|---|
| <input type="checkbox"/> I snore loudly | <input type="checkbox"/> I have nasal congestion |
| <input type="checkbox"/> I have been witnessed to have pauses in breathing | <input type="checkbox"/> I feel that my body is paralyzed for few minutes but my brain is awake |
| <input type="checkbox"/> I am very restless, tossing and turning | <input type="checkbox"/> I talk in my sleep |
| <input type="checkbox"/> I have vivid dreams | <input type="checkbox"/> I wet my bed |
| <input type="checkbox"/> I have nightmares | <input type="checkbox"/> I walk in my sleep |
| <input type="checkbox"/> I wake up with a choking or a gasping sensation | |
| <input type="checkbox"/> 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
- My bed sheets are all messed up
- I feel that I need more sleep
- I hit the snooze button several times

• **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 to 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)

- Acid reflux (GERD)
- Asthma
- Depression
- Anxiety
- Chronic pain
- Intestinal disturbances
- History of stroke
- Congestive heart failure

• **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 doze off**
- 1: Slight chance of dozing off**
- 2: Moderate chance of dozing**
- 3: High chance of dozing**

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