Advantage Sleep Centers

Patient Name: _____ **Date:** _____

Please consult your bed partner when answering the following questions. Answer the questions as if you are describing your typical night or sleep pattern. In answering questions about frequency, you will need to check one of the following choices: *nightly, weekly, rarely, never.*

1. Are you allergic to any drugs? _____
2. Describe your sleep problem:
   _____
   _____
   _____
3. When did your sleep problem begin?
   _____ (mo/yr)
4. Have you ever had a sleep study performed?
   ☐ Yes ☐ No
5. My bed or sleeping surface is:
   ☐Standard Mattress ☐Waterbed ☐Futon
   ☐Other: _____
6. Sleep Habits:
   My ideal amount of sleep is _____ hours.

	During the week	During the weekend
I go to bed at (time)		
I get up at (time)		
I sleep (hours)		

It usually takes me _____ minutes to fall asleep.

I usually wake up _____times a night.
Please explain what wakes you up:
_____
_____
_____

If I wake up at night, it usually takes _____ minutes to fall back asleep.
I cannot get back to sleep once I wake up
☐ Yes ☐ No
I can sleep 2 hours or more at a time: (circle one)

Nightly Weekly Rarely Never

7. My occupation is: _____
   My job requires shift work ☐ Yes ☐ No
   My work hours are: _____

8. I snore:
   Nightly Weekly Rarely Never

9. My snoring started at age: _____
10. I snore in all positions: ☐ Yes ☐ No
11. My snoring has been described as:

Mild Moderate Loud

12. I stop breathing at night:
    ☐ Don't Know ☐ Yes ☐ No
13. I have problems with my nose or nasal breathing:
    ☐ Yes ☐ No
    If "YES", please explain:_____
    _____
14. I have had nasal surgery: ☐ Yes ☐ No
    If "YES", please explain:_____
    _____
15. I have had a tonsillectomy: ☐ Yes ☐ No

Nightly Weekly Rarely Never

16. I wake up gasping, short of breath, wheezing or feeling I cannot breathe: ☐ ☐ ☐ ☐
17. I wake up coughing ☐ ☐ ☐ ☐
18. I wake up with my heart beating irregularly ☐ ☐ ☐ ☐
19. I wake up with chest pain ☐ ☐ ☐ ☐
20. I wake up with heartburn or a sour acid taste in my mouth ☐ ☐ ☐ ☐
21. I wake up with a headache ☐ ☐ ☐ ☐
22. I have a bed wetting problem ☐ ☐ ☐ ☐
23. I fight sleep or fall asleep uncontrollable while sitting at meetings, watching TV, at the movies, in the car… ☐ ☐ ☐ ☐
24. I fight sleep while at work or school ☐ ☐ ☐ ☐

Nightly Weekly Rarely Never

25. I fight sleep while driving ☐ ☐ ☐ ☐
26. I have actually fallen asleep while driving a car ☐ Yes ☐ No
27. It seems that my mood, memory or thought processes have changed ☐ Yes ☐ No
28. Drowsiness is the greatest in the:

Morning Afternoon Evening

29. After a typical night's sleep, I feel:

Refreshed rested drowsy tired

Nightly Weekly Rarely Never

30. I have been told I toss and turn to an extreme amount: ☐ ☐ ☐ ☐
31. I flail or kick while sleeping ☐ ☐ ☐ ☐
32. I have the feeling of "restless" legs ☐ ☐ ☐ ☐
33. I am troubled at night by uncomfortable sensations in my legs ☐ ☐ ☐ ☐
34. I wake up with muscle or joint aches or pains ☐ ☐ ☐ ☐
35. Immediately after falling asleep, I dream ☐ ☐ ☐ ☐
36. I dream during my naps ☐ ☐ ☐ ☐
37. I experience vivid dream-like scenes upon waking up or falling asleep ☐ ☐ ☐ ☐
38. I have been told that I behave strangely when not fully Awake ☐ ☐ ☐ ☐
39. I feel like I cannot move after lying down, before going to sleep, when waking up or going to sleep ☐ ☐ ☐ ☐
40. I feel sudden weakness in the knees, neck, jaw or arms when angry, sad, laughing or emotional

Daily Weekly Rarely Never

41. I have episodes of doing strange things without realizing it at the time or lose a period of time:

Daily Weekly Rarely Never

42. I take daytime naps ☐ Yes ☐ No
43. After a nap, I feel:

Refreshed rested drowsy tired

Nightly Weekly Rarely Never

44. I sleepwalk: ☐ ☐ ☐ ☐
45. I talk or scream in my sleep ☐ ☐ ☐ ☐
46. I am disturbed by nightmares ☐ ☐ ☐ ☐
47. I grind my teeth when asleep ☐ ☐ ☐ ☐
48. Within the last year, depression, anxiety or stress has interfered with my sleep ☐ Yes ☐ No
49. At bedtime I have difficulty falling asleep because of worries or thoughts racing through my mind ☐ Yes ☐ No
50. My sleep problem, in addition to those previous, has resulted in:

    _____
    _____

51. I exercise ☐ Yes ☐ No
    If "YES", what kind, what time of day, and how often?

    _____
    _____

52. Is there any history in your family of difficulties with sleep, excessive daytime sleepiness or snoring? ☐ Yes ☐ No
    If "YES", explain:

    _____
    _____

53. Please list medicines tried for improving sleep or staying awake:

Drug and Dose	***Frequency***	***Started***	***Ended***

54. What methods have you tried to help you sleep at night night or stay awake during the day (besides drugs mentioned in 52)

_____

_____

55. I now smoke _____cigarettes per day.

56. I now drink _____cup(s) of caffeinated coffee, caffeinated tea or caffeinated cola per day.

57. What time of day to you drink these caffeinated beverages and how many?

_____

_____

58. I consume some alcohol _____days per week
59. What time of day do you drink these alcoholic beverages and how many?

_____

_____

60. I have a history of high blood pressure ☐ Yes ☐ No
If "YES", are you on medication for this?
☐ Yes ☐ No

61. I have a history of heart attack ☐ Yes ☐ No

62. I have a history of congestive heart failure
☐ Yes ☐ No

63. I have a history of cardiac arrhythmia ☐ Yes ☐ No
If "YES", are you on medication for this?
☐ Yes ☐ No

64. I have a history of high/low blood sugar ☐ Yes ☐ No
If "YES", are you on medication for this?
☐ Yes ☐ No

65. I have a history of lung disease ☐ Yes ☐ No
If "YES", are you on medication for this?
☐ Yes ☐ No

66. I have a history of Arthritis and Rheumatism
☐ Yes ☐ No
If "YES", are you on medication for this?
☐ Yes ☐ No

67. I have a history of hiatal hernia or reflux esophigitis
☐ Yes ☐ No
If "YES", are you on medication for this?
☐ Yes ☐ No

68. I have a history of thyroid disease ☐ Yes ☐ No
If "YES", are you on medication for this?
☐ Yes ☐ No

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Use the following scale to choose the most appropriate number for each situation.

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Chance of Dozing	*0*	*1*	*2*	*3*
Sitting and reading----------	☐	☐	☐	☐
Watching television----------	☐	☐	☐	☐
Sitting inactive in a public place (i.e. a theater or 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 with someone.	☐	☐	☐	☐
Sitting quietly after lunch without alcohol ----------	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic ----------	☐	☐	☐	☐