

Epworth Sleepiness Scale

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

- 0 = would *never* doze or sleep.
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____

GENERAL SLEEP HABITS

1. How many hours do you usually get per night? _____
2. Do you usually: (check all that apply to you)
 - sleep with someone else in your bed
 - sleep with someone else in you room
 - provide assistance to someone during the night(child,invalid,bed partner,animal)
 - sleep in a quiet comfortable bed. If not,explain _____
 - use one pillow. If not,explain _____
3. What time do you usually go to bed on
Weekdays? _____ Weekends? _____
4. How long does it take you to fall asleep? _____
5. As you fall asleep or as you awaken do you have any hallucinations or nightmares?
No ___ Yes ___ If yes,please explain _____
6. Before falling asleep, do your legs feel restless or uncomfortable,or during sleep do you kick your legs? If yes, describe _____
7. Do you snore, stop breathing, gasp for air, or turn blue in your sleep? No ___ Yes ___
Explain, how often does this occur? _____
8. Do you ever awaken paralyzed or unable to move your arms and legs? No ___ Yes ___
If yes please describe _____
9. How many times do you typically wake up at night? _____
10. If you wake up, on the average, how long do you stay awake? _____
11. If you awake during the night (after you first fall asleep) which part(s) of your sleep period is it? soon after falling asleep
 middle of the night
 early morning
12. What do you usually do when you awaken during the night? _____
13. What time do you usually awaken in the mornings?Weekdays _____ Weekends _____
14. Do you ever awaken with a headache at night or in the morning? No ___ Yes ___
15. On the average, how long do you stay in bed after you wake up in the morning? _____
16. Upon awakening in the morning do you feel rested? No ___ Yes ___
17. Is your sleep often disturbed by:(check all that apply to you)
 - heat bed partner other _____
 - cold not being in your own bed
 - noise any physical pain you have
 - light any shortness of breath
18. Are your sleep habits on weekends different from the rest of the week? No ___ Yes ___
Describe _____
19. Do your sleep problems disturb your sex life? _____
20. Is your present social life satisfactory? No ___ Yes ___
21. Does your sleep problems require you to cut back on social activities? No ___ Yes ___
If so, how? _____

PAST MEDICAL HISTORY

1. How would you rate your overall health?

Excellent _____ Good _____ Fair _____ Poor _____

2. Have you ever been diagnosed or treated for any of the following? If yes, when?

- | | |
|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Cardiac Arrhythmia (heart irregularities) | <input type="checkbox"/> Gastric Reflux |
| <input type="checkbox"/> Coronary Arteries (hardening of the arteries) | <input type="checkbox"/> Hypothyroidism (low) |
| <input type="checkbox"/> Angina (heart pain) | <input type="checkbox"/> Hay fever or allergic rhinitis |
| <input type="checkbox"/> Myocardial Infarction (heart attack) | <input type="checkbox"/> Vocal Cord Disease |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Polycythemia (excessive red blood clots) | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other lung disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Edema | <input type="checkbox"/> Other Neurological Disorder |
| <input type="checkbox"/> High Cholesterol | Specify: _____ |

3. List any other medical illness you have or for which you have been treated. Also list any hospitalizations and reasons:

4. List any surgeries you have had and include "minor" operations. (such as tonsillectomy and adenoidectomy (T and A).

Operation	Date
_____	_____
_____	_____
_____	_____
_____	_____

5. Have you had any serious accidents? (explain)

6. Have you ever had a blood transfusion? (explain)

7. Have you ever had any exposure to dangerous chemicals? (explain)

Please circle illnesses which have occurred in your **BLOOD** relatives and indicate who:

Sleep Disorders (including apnea, sleep walking, narcolepsy, night terrors, etc.)

Hypertension Stroke Allergies (asthma, hay fever, eczema)

Cardiac Disease Diabetes Cancer (describe) _____

Other: _____

MEDICATIONS

List all medication, including over the counter medication that you take (even if it is not on a regular basis).

Medication	Dosage	Time/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies: _____

REVIEW OF SYMPTOMS:

1. Have you gained/lost weight in the last 12 months? No ___ Yes ___ How much? _____
2. Do you regularly have a problem breathing through you nose? No ___ Yes ___
Please Circle One: Some Moderate Severe
3. If you are male have you had a problem with impotency? No ___ Yes ___
4. Do you have any difficulties with physical exertion such as unusual shortness of breath, difficulty breathing, or discomfort, which is brought on by physical effort? No ___ Yes ___
 Describe: _____
5. Do you have chronic cough? No ___ Yes ___ Describe: _____
6. Do you have excessive phlegm or sputum? No ___ Yes ___ Describe: _____
7. Do you have episodes of wheezing or chest tightness? No ___ Yes ___ Describe: _____
8. Have you had swelling of your ankles or feet? No ___ Yes ___ When? _____
9. Do you have difficulty with swallowing food, indigestion, heartburn, or regurgitation of acid back into the back of your chest or mouth? No ___ Yes ___ Describe _____
10. Have you had any changes in your usual bowel habits recently, such as constipation, change in color, shape, etc? No ___ Yes ___ Describe _____
11. Do you have difficulty passing urine such as burning, blood, or poor stream? No ___ Yes ___
 Describe: _____

12. Have you experienced any neurological problem such as persistent loss of sensation, loss of muscle strength, poor circulation, clumsiness, balance difficulty, or memory loss?
No ___ Yes ___ Describe: _____
13. Do you have any persistent arthritis, joint pains, or musculoskeletal discomfort?
No ___ Yes ___ Describe: _____
14. Do you have excessive dry skin? No ___ Yes ___ Describe: _____
15. Do you have a strong preference for cool or warm environment? No ___ Yes ___ Which? _____
16. Please describe any other persistent symptoms, which seem important to you? _____

PRESENT ILLNESS

1. What is the primary reason for this examination? _____

2. Please describe your problem in your own words. If possible, specify how long you have had trouble and what has been done about it so far. How has it affected the quality of your life? _____

3. Has it been a continuous or intermediate problem?
 almost every night
 every few nights
 every few week/months
 other _____
4. How long has this problem bothered you?
 longer than two years within the last 3 months
 1 to 2 years within the last month
 several months
5. On a scale below please estimate the severity of your problem(s).
 mildly upsetting extremely severe
 moderately severe totally incapacitating
 very severe
6. How strongly do you want help with you problem?
 very much
 much
 moderately
 could do without

REVIEW OF SLEEP DISORDER SYMPTOMS: (Please rate the following)

	Never	Rarely	Sometimes	Frequently	Constantly
Have trouble sleeping when you have a cold	_____	_____	_____	_____	_____
Sweat excessively during the night	_____	_____	_____	_____	_____
Notice your heart pounding or beating irregularly during night	_____	_____	_____	_____	_____
Feel afraid of falling asleep	_____	_____	_____	_____	_____
Have nightmares	_____	_____	_____	_____	_____
Fall asleep while driving	_____	_____	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____	_____	_____
Fall asleep during physical effort	_____	_____	_____	_____	_____
Fall asleep while laughing or crying	_____	_____	_____	_____	_____
Experience loss of muscle tone when extremely emotional	_____	_____	_____	_____	_____
Remember you dreams	_____	_____	_____	_____	_____
Have thoughts racing through your mind	_____	_____	_____	_____	_____
Feel sad and depressed	_____	_____	_____	_____	_____
Have muscular tension	_____	_____	_____	_____	_____
Notice parts of your body startle and jerk	_____	_____	_____	_____	_____

Have you **ever** consulted with any of the following to help with a sleep problem or daytime sleepiness?

<input type="checkbox"/> General Practitioner	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Nurse
<input type="checkbox"/> Obstetrics/Gynecology	<input type="checkbox"/> Osteopath	<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Clergy
<input type="checkbox"/> Other Internist	<input type="checkbox"/> Counselor	<input type="checkbox"/> Psychiatrist	
<input type="checkbox"/> Other Physician	<input type="checkbox"/> Clinical Psychologist		

What treatment have you received? _____

Thank you for completing this questionnaire, please bring it with you to your appointment.