

MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

The following questions are about complaints and problems associated with sleep. Please fill out the questionnaire to the best of your ability. It is very helpful for the sleep medicine provider who will be evaluating you.

Name: _____

Occupation (currently or prior to retirement): _____

Who lives with you: _____

Why have you come to see the sleep specialist? What sleep problem are you having? How long have you had this problem?

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life recently. Even if you have not done some of these things recently, try to answer how they would affect you. Use the following scale to choose the most appropriate number for each situation:

0 = would **NEVER** doze

2 = **MODERATE** chance of dozing

1 = **SLIGHT** chance of dozing

3 = **HIGH** chance of dozing

SITUATION	NUMBER 0-3
Sitting and reading	
Watching television	
Sitting inactive in a public place (ex: meeting or church)	
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 a meal (when you have not had alcohol)	
In a car, while stopped for traffic	
TOTAL	

Have you ever had a sleep study? Yes / No If yes: When and where? _____

Comments: _____

Medical History: Do you have any of the following?:

Seizures: Yes ___ No ___ Congestive Heart Failure (CHF): Yes ___ No ___
 COPD: Yes ___ No ___ Other: Yes ___ No ___ If Yes, explain: _____

MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

Psych History:

PTSD : Yes ___ No ___ Depression : Yes ___ No ___
 Anxiety: Yes ___ No ___ Chronic Pain: Yes ___ No ___

Childhood: Did you have childhood sleep problems of any type? Yes / No
 If yes please describe: _____

Sleep Environment and Schedule:

Do you have a comfortable bedroom or sleep environment? Yes / No If no, why not?

Pre-bedtime rituals: TV / Reading / _____

Computer _____

What medications/herbals do you take before bedtime?

Do you take any pain medication? If yes what pain med _____

Do you take any nasal decongestant pills daily or nightly (for example, pseudoephedrine/Sudafed)? Yes or no?

Sleep Schedule:

<u>Weekday</u>	<u>Weekend</u>
Time you are in bed? _____ AM/PM	_____ AM/PM
Time it takes to fall asleep? _____ minutes or hours	
Time you get up? _____ AM/PM	_____ AM/PM
How many times do you wake during your sleep period? _____	
What wakes you up? _____	
How long does it take to fall back asleep after waking up? _____ minutes or hours	
How many hours do you actually sleep each night? _____ Average (hours)	
How do you feel upon awakening after your sleep period? " _____ "	

Do you take naps? Yes / No How many times per week? _____

On the average, how long are the naps? _____ hrs.

How do you feel after taking a nap? " _____ "

Work schedule When does your usual work (shift) start? _____ AM or PM

When does your usual work shift end? _____ AM or PM

Do you do 3rd shift work (overnight)? Yes ___ No ___

Social History and Other Substances history

Caffeine: Regular coffee _____ cups/day

Decaffeinated coffee _____ cups/day

Soft drinks with caffeine? Yes ___

No ___ If yes, how many? _____ per day

Do you drink tea with caffeine? Yes ___

No ___ If yes, how many cups/glasses _____ per day?

What time in the day do you have your last caffeinated beverage? _____

MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

Tobacco: Ever smoked? Yes ___ No ___ If yes, how long? _____; Highest # of packs per day: _____

Do you still smoke? Yes ___; No ___ If no, when did you quit? _____

Alcohol: Daily alcohol intake? If so when and how much? _____

Do you take any other substances (e.g. cocaine, marijuana) Yes ___ No ___

If yes, what substance and how often? _____

Family History Do any member of your family have any of the following?

Insomnia _____

Narcolepsy _____

Snoring _____

Sleep Apnea _____

Restless leg syndrome _____

Sleep walking _____

Other – Describe _____

Snoring

Has anyone told you that you snore loudly? Yes ___ No ___

Do you snore every night? Yes ___ No ___

Have you awakened with a dry mouth or dry mouth in the morning? Yes ___ No ___

Has anyone told you that you quit breathing or hold your breath at night? Yes ___ No ___

Have you ever awakened gasping for breath? Yes ___ No ___

Do you ever wake at night with coughing, choking, or respiratory discomfort? Yes ___ No ___

Do you have trouble breathing through your nose at night? Yes ___ No ___

Do you have morning headaches? Yes ___ No ___

Reflux

Do you often wake with a sour taste or burning sensation in your chest? Yes ___ No ___

Drowsiness/ Sleepiness / Consequences of sleepiness

Are you frequently fatigued or drowsy during the day? Yes ___ No ___

Have you had any accidents at work due to sleepiness? Yes ___ No ___

Have you had any near traffic accidents due to sleepiness? Yes ___ No ___

Insomnia

Do you have difficulty initiating sleep at night? Yes ___ No ___

Do you have difficulty staying asleep at night? Yes ___ No ___

Do you have pain that bothers you at night? Yes ___ No ___

Are you a night owl? Yes ___ No ___

Restless Legs Syndrome/ Periodic Limb Movement Disorder

Do you frequently kick and jerk your legs at night while trying to fall asleep? Yes ___ No ___

MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

Do you have discomfort in your legs while trying to fall asleep? Yes ___ No ___ Does
 moving your legs give you relief of discomfort? Yes ___ No ___
 Do you have tingly or discomfort in your legs during the day? Yes ___ No ___
 Do you have discomfort in your legs when sitting for long periods? Yes ___ No ___

Excessive Daytime Somnolence/Narcolepsy

Do you have sudden episodes of sleep during the day? Yes ___ No ___
 Have you ever had periods in which you feel paralyzed while going to sleep or waking up? Yes ___ No ___
 Have you ever had visual hallucinations or dream-like mental images when falling asleep? Yes ___ No ___
 Have you ever experienced sudden, uncontrollable muscle weakness during strong emotions? Yes ___ No ___
 ___ (such as your mouth dropping open or legs going limp during laughter or anger)
 Do you experience muscle weakness when you laugh? Yes ___ No ___
 If yes, during your episodes of muscle weakness, can you hear? Yes ___ No ___

Parasomnias

Do you sleep walk? Yes ___ No ___
 Do you wet the bed at night? Yes ___ No ___ Do you talk in your sleep? Yes ___ No ___
 Do you ever wake up screaming? Yes ___ No ___
 Do you have frequent nightmares or vivid dreams? Yes ___ No ___
 Do you grind your teeth in your sleep? Yes ___ No ___
 Do you act out in your dreams or have woken up with bruises in the morning? Yes ___ No ___

Exercise

Do you exercise regularly? Yes ___ No ___
 Weight: Gained _____ lbs. or Lost _____ lbs. over _____ months