NorthCrest Medical Center
Sleep Diagnostics
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Sleep & Medical History Questionnaire

Name: _____ Height: _____ Weight: _____

Occupation:_____ Person referring you for sleep testing:_____

Please answer the following questions as accurately as possible. Do not leave any questions unanswered. You may if so desired qualify your response by writing comments in the margin. Reply in the context of the last 12 months unless otherwise indicated. You may wish to consult your spouse or bed partner in answering some questions. Your response to these questions will provide us with information about your sleep habits and associated problems. This information is part of your medical records and is strictly confidential.

CHIEF COMPLAINT

1. Briefly describe the nature of your chief complaint:

   _____

   _____

2. How long have you had this problem? _____
3. Briefly describe how this problem has affected your life?

   _____

   _____

SLEEP HABITS AND SLEEPINESS

The key that follows will guide in answering the questions: **1= Rarely or Never 2= Sometimes 3= Frequently**

I feel the amount of sleep I get at night is inadequate.	1	2	3
I feel I get too much sleep at night.	1	2	3
What time do you go to bed at night?			
What time do you wake up for the day in the morning?			
Do you vary this pattern on weekends?	YES		NO
No matter how much sleep I receive I wake up feeling sleepy.	1	2	3
Do you have problems with performance at work due sleepiness or fatigue?	1	2	3
Do you sleep with another person?	YES		NO
I tend to fall asleep while reading.	1	2	3
I tend to fall asleep while watching T.V.	1	2	3
I tend to fall asleep while driving.	1	2	3
I tend to fall asleep while eating.	1	2	3
I tend to fall asleep while talking.	1	2	3
I tend to fall asleep while working.	1	2	3
I tend to fall asleep during sexual intercourse.	1	2	3

SYMPTOMS ASSOCIATED WITH DISORDERS OF EXCESSIVE SOMNELENCE

Do you snore?	YES		NO
Do you hold your breath or gasp for air in your sleep?	YES		NO
I have difficulty breathing at night.	1	2	3
My sleep is disturbed by unusual movements or tossing and turning at nights.	1	2	3
I sweat excessively during the night.	1	2	3
I awaken at night or morning with headaches.	1	2	3
I experience asthma attacks during sleep.	1	2	3
My legs seem to kick or contract rhythmically during sleep.	1	2	3
I am subject to unremitting, irrepressible sleep attacks.	1	2	3
I experience muscular weakness secondary to strong emotional stimuli.	1	2	3
I seem to experience dream imagery immediately upon falling asleep.	1	2	3
I am unable to move immediately upon falling asleep or waking up.	1	2	3
Napping is not refreshing to me.	1	2	3

SYMPTOMS ASSOCIATED WITH DISORDERS OF INITIATING AND MAINTAINING SLEEP

I have a problem falling asleep at night	1	2	3
On the average, How long does it take you to fall asleep at night?			
I require special conditions to fall asleep at night.(music,tv etc.)	1	2	3
As I try to fall asleep I have ruminative thoughts race through my head.	1	2	3
I awaken with racing thoughts, dread or worry	1	2	3
How many times do you wake up during the night?			
How long do you spend awake during the night?			
Is your sleep disturbed by medical problem? Explain if yes.	YES		NO
I awaken with unusual sensations, aches, pains and headaches.	1	2	3
As a child, did you have a problem with falling asleep or awakening in the morning?	1	2	3
Do you have trouble going back to sleep if you wake up during the night?	1	2	3
Do external noises during the night bother you, such as planes, trains or barking dogs?	1	2	3
I tend to fall asleep when not trying or in an environment other than my bedroom.	1	2	3
As bedtime approaches I find I become anxious.	1	2	3
When I am awake during the night I tend to lie in bed until I fall back asleep.	1	2	3
As a consequence of my poor sleep at night, I feel fatigued or “washed out” during the day.	1	2	3
I experience crawling, creeping sensation in my legs which delay sleep onset.	1	2	3

PARASOMNIAS

Do you now or did you as a child exhibit some form of rhythmic movement during your sleep? (i.e. head banging)	1	2	3
Do you now, or did you as a child, awaken in a room other than the one you went to sleep in?	1	2	3
Are you currently or have you ever been a sleepwalker?	1	2	3
Have you ever physically "acted out" the contents of a dream while asleep?	1	2	3
Do you now or did you as a child ever wet the bed?	1	2	3
Do you or have you ever suffered from nightmares?	1	2	3
Do you currently or have you ever woke with a loud scream, in apparent inconsolable fear, exhibiting agitated automatic behavior.	1	2	3
Do you now or have you ever had seizures in your sleep?	1	2	3
I awaken in a state of panic or distress.	1	2	3
I talk in my sleep.	1	2	3
I grind my teeth during sleep.	1	2	3
I feel groggy or "sleep drunk" when I awaken in the morning.	1	2	3

SYMPTOMS RELATED TO SLEEP SCHEDULE

Do you work a swing shift? If yes does it rotate in a clockwise direction?	1	2	3
Is your bedtime regular?	1	2	3
Do you fall asleep at an earlier hour than desired, sleep normally, and then awaken in the early morning hours.	1	2	3
Do you feel sleepy late at night, and then receive inadequate sleep due to a necessary early morning wake up time?	1	2	3
If you were able to sleep longer would you feel rested?	YES		NO
Do you sleep in a several small periods of time during a 24-hour period?	1	2	3

EMOTIONAL AND SOCIAL ASSESSMENT

Do you have significant stress in your life at the present time?	1	2	3
Do you present feel sad or depressed?	1	2	3
Have you ever considered or attempted suicide?	1	2	3
Have you ever been seen by a psychologist or psychiatrist?	1	2	3

MEN ONLY

Do you have a problem with obtaining an erection?	1	2	3
Are you awakened from sleep by painful erection?	1	2	3

WOMEN ONLY

Are you pregnant?	YES	NO
Are you past menopause?	YES	NO
Have you had a hysterectomy?	YES	NO

MEDICAL HISTORY

Please document any surgery or illness you have had and the date in which it occurred.

Occurrence	*Date*

MEDICATIONS

Please document any prescription or over the counter medication you are currently taking.

Medications	*Dosage*

REVIEW OF SYSTEMS

Please provide pertinent personal information related to the following systems. Do you have a history of any of the following?

Problem areas	**Date**
Neurological (i.e. seizures, brain tumor, etc)	
Endocrine (i.e. diabetes, etc.)	
Heent (i.e. head, eyes, ears, nose, throat, etc.)	
Cardiovascular (i.e. high blood pressure, etc.)	
Skeletal (i.e. arthritis, etc.)	
Bowel and Bladder (i.e. diverticulitis, etc.)	
Disease (i.e. cancer, AIDS, etc.)	
Muscular (i.e. dystrophy, etc.)	
Respiratory (i.e. emphysema, etc.)	
Gastrointestinal (i.e. acid reflux, ulcers, etc.)	

PLEASE DOCUMENT BELOW HOW MUCH YOU CONSUME OF EACH ITEM:

Example: Water 3 glasses (PER DAY)

*COFFEE_____ (PER DAY) *Decaf. or Regular (circle one)*

BEER_____ (PER DAY)

CIGARS_____ (PER DAY)

LIQUOR_____ (PER DAY)

*SODA_____ (PER DAY) *Caf. Free or Regular (circle one)*

PIPES_____ (PER DAY)

TEA _____ (PER DAY)

CIGARETTES_____ (PACKS PER DAY)

SNUFF_____ (AMOUNT PER DAY)

Patient Name _____ Date _____

Epworth Sleepiness Scale (ESS)

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 these activities recently, think about how they would have affected you.

Use this 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

It is important that you circle a number (0 to 3) on each of the questions.

Situation	Chance of Dozing (0 to 3)
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place - for example, a theater or meeting	0 1 2 3
A passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3

Total Score:

Fatigue Severity Scale (FSS)

This scale reflects the fatigue you felt in the past week and how it impacts you.
The lower numbers indicate less fatigue while the higher numbers indicate more fatigue. It is important that you circle a number (1 to 7) for every question.

During the past week:	No Yes
I felt fatigued and had less motivation	1 2 3 4 5 6 7
I felt fatigued and did not desire to exercise	1 2 3 4 5 6 7
I felt fatigued often	1 2 3 4 5 6 7
I felt fatigue that interfered with my physical functioning	1 2 3 4 5 6 7
I felt fatigued which caused me frequent problems	1 2 3 4 5 6 7
I felt fatigued which prevented sustained physical functioning	1 2 3 4 5 6 7
I felt fatigued and couldn't carry out certain duties and responsibilities	1 2 3 4 5 6 7
Fatigue was among my three most disabling symptoms	1 2 3 4 5 6 7
Fatigue interfered with my work, family or social life	1 2 3 4 5 6 7

Total Score: