



## EPWORTH SLEEPINESS SCALE

SLEEP-WAKE  
DISORDERS  
CENTER

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

How likely are you to doze off or fall asleep in the following situations in contrasts to feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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

### SITUATION

### CHANCE OF DOZING

- Sitting and reading \_\_\_\_\_
  - Watching TV \_\_\_\_\_
  - Sitting, inactive in a public place  
(e.g. 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 to someone \_\_\_\_\_
  - Sitting quietly after a lunch without alcohol \_\_\_\_\_
  - In a car, while stopped for a few minutes in traffic \_\_\_\_\_
- Add total score:** \_\_\_\_\_



Please describe each night's sleep until you are seen in the Sleep Center by completing the Sleep Log Assessment form that is attached. On the day of your appointment, please bring in your Sleep Log Assessment form.

### **DIRECTIONS FOR COMPLETING THE FORM**

- Under "Bedtime" - State approximately what time you actually got IN bed to go to sleep (lights out).
- Under "Time till asleep" - State approximately how many minutes you felt it took you to actually go to sleep once you got in bed.
- Under "Wake-up Time" - State what time you actually got OUT of the bed to begin the day (lights on).
- Under "Sleep rating" - State what number best corresponds to how well you felt you slept that night.
- Under "Number of awakenings" - State how many times you actually woke up during the night.
- Under "Daytime Naps" - State how many naps you took during the day BEFORE you went to bed.

**\*\*\*\*\* Remember to bring the sleep Log Assessment form back to the Sleep Center with you. \*\*\*\*\***

Thank you

# HAMPTON REGIONAL SLEEP/WAKE DISORDERS CENTER

## MEDICAL QUESTIONNAIRE

**Please complete the medical questionnaire and bring in with you the night of your sleep study.** All the information you provide will remain confidential and will help the physician in evaluating your sleep problem(s). Some of these questions may be better answered by your spouse, roommate or other family member.

**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **WORK PHONE:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**MARITAL STATUS:** \_\_\_\_\_ **# OF CHILDREN:** \_\_\_\_\_

**AGES OF CHILDREN:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_



1. Briefly describe your sleep problem.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How long have you had problems with your sleep?

\_\_\_\_\_  
\_\_\_\_\_

3. How would you describe your usual night's sleep?

4. Do you:

- |   |                |
|---|----------------|
| Sleep with someone else in your bed?            | ( ) YES ( ) NO |
| Sleep with someone else in your room?           | ( ) YES ( ) NO |
| Sleep with pets in your bed?                    | ( ) YES ( ) NO |
| Provide assistance to someone during the night? | ( ) YES ( ) NO |

5. What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_

6. Have you gained weight in the last year? If yes, by how many pounds? \_\_\_\_\_

Have you lost weight in the last year? If yes, by how many pounds? \_\_\_\_\_

7. What is your neck size? \_\_\_\_\_ inches

8. Do you use dentures? \_\_\_\_\_ Do you sleep with dentures? \_\_\_\_\_

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Medical History:

	<u>Type of Problem</u>	<u>Date</u>	<u>Physician, Clinic, Hospital</u>
Allergies (food, drugs, etc.)	_____	_____	_____
Blood pressure, Heart, Circulation	_____	_____	_____
Breathing (lungs)	_____	_____	_____
Eyes, Ears, Nose, Throat or Mouth	_____	_____	_____
Hormone Abnormalities (Diabetes, Hypoglycemia)	_____	_____	_____
Mental Health	_____	_____	_____
Stomach, Digestive	_____	_____	_____
Surgical Operations	_____	_____	_____
	_____	_____	_____
Urine, Kidney Sexual	_____	_____	_____

Name and address of family physician: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any prescribed medications you are presently taking:

<u>Name of Medication</u>	<u>Prescribing Physician</u>	<u>Dose per day</u>	<u>How long have you used?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any nonprescribed medications and dosages you are presently taking.

\_\_\_\_\_

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### Family Medical History

Please list any medical problems of family members. If deceased, please indicate cause of death and age of death.

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings (indicate brother or sister)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does anyone in your family have sleep problems? Explain below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any previous sleep studies? \_\_\_\_\_ If yes, when and where were your sleep studies done?

\_\_\_\_\_

8. How much of these beverages do you consume?

Coffee	_____ cups per day	_____ cups after 6 P.M.
Decaffeinated coffee	_____ cups per day	_____ cups after 6 P.M.
Tea	_____ cups per day	_____ cups after 6 P.M.
Carbonated drinks	_____ cups per day	_____ cups after 6 P.M.
Beer, wine, liquor	_____ cups per day	_____ cups after 6 P.M.

9. How many cigarettes, cigars, or pipefuls of tobacco do you smoke per day?

\_\_\_\_\_

11. Do you smoke marijuana? If yes, how often \_\_\_\_\_

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What time is your usual bedtime? \_\_\_\_\_ and risetime? \_\_\_\_\_

Does your sleep schedule differ on the weekends? \_\_\_\_ If so, describe in what way?

\_\_\_\_\_

Does your job require shift changes? If so, describe schedule \_\_\_\_\_

\_\_\_\_\_

Does your job require frequent travel? If so, describe \_\_\_\_\_

\_\_\_\_\_

When do you function best? ( ) morning ( ) afternoon ( ) evening

When do you function worst? ( ) morning ( ) afternoon ( ) evening

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**SLEEP PROBLEMS AND COMPLAINTS:**

- 1. Do you feel that you get too little sleep at night? ( ) yes ( ) no
- 2. Do you have problems with falling asleep at night? ( ) yes ( ) no
- 3. Do you have problems with waking up in the morning? ( ) yes ( ) no
- 4. Is the quality of your sleep unsatisfactory? ( ) yes ( ) no
- 5. Is your sleep often restless or disturbed? ( ) yes ( ) no
- 6. Have you ever had a seizure during sleep? ( ) yes ( ) no
- 7. Do you often have frightening dreams or nightmares? ( ) yes ( ) no
- 8. Do you have night terrors or wake up screaming? ( ) yes ( ) no
- 9. Do you sleep walk? ( ) yes ( ) no
- 10. Do you grind your teeth during sleep? ( ) yes ( ) no
- 11. Do you wake up during the night feeling thirsty? ( ) yes ( ) no
- 12. Do you wake up during the night feeling hungry? ( ) yes ( ) no

13. Do you urinate more than once during the night? ( ) yes ( ) no
14. Do you wet the bed? ( ) yes ( ) no
15. Are you bothered by itching sensations at night? ( ) yes ( ) no
16. Do you sweat excessively during sleep? ( ) yes ( ) no
17. Do you wake up at night with heartburn? ( ) yes ( ) no
18. Do you have headaches at night or in the morning? ( ) yes ( ) no
19. Do you have chest pain during the night? ( ) yes ( ) no
20. Do you have pain in the neck, spine, muscles or joints during the night? ( ) yes ( ) no
21. Have you ever been told that you bang your head against the bed at night? ( ) yes ( ) no
22. Have you ever been told that you make rolling or rocking movements during sleep? ( ) yes ( ) no
23. Do you ever fall out of bed? ( ) yes ( ) no
24. Are you bothered by leg cramps or pains at night? ( ) yes ( ) no
25. Have you ever been told that your legs twitch or jerk during the night? ( ) yes ( ) no
26. Do you wake up with feelings of restlessness in your legs or "pins and needles" sensations in your legs? ( ) yes ( ) no
27. Are you aware of breathing abnormalities or problems with breathing associated with your sleep? ( ) yes ( ) no
35. Have you ever been told that you snore? ( ) yes ( ) no
28. Do you sometimes wake up feeling like you are choking or gasping for breath? ( ) yes ( ) no
29. Do you feel paralyzed when falling asleep or waking up? ( ) yes ( ) no
30. Do you consider that your sleep/wake schedule is usually irregular? ( ) yes ( ) no
31. Did you have a problem with sleep as a child? ( ) yes ( ) no
32. Do you sleep a lot or take many naps during the day? ( ) yes ( ) no
33. Do you feel extremely drowsy or sleepy during the day? ( ) yes ( ) no
34. Do you drink a lot of coffee or caffeinated beverages during the day in order to stay awake? ( ) yes ( ) no
35. Do you feel extremely tired or fatigued during the day even when you are not sleepy? ( ) yes ( ) no
36. Do you have feelings during the day that you just do not want to do anything? ( ) yes ( ) no
37. Is your daytime performance in work or recreation less efficient that you would like it to be? ( ) yes ( ) no
38. Do you feel distracted and unable to concentrate during the day? ( ) yes ( ) no
39. Do you have uncontrollable urges to fall asleep during the day or do you find yourself falling asleep when you do not want to? ( ) yes ( ) no
40. Have you had accidents or near-accidents when driving because you felt extremely sleepy or were having trouble concentrating? ( ) yes ( ) no
41. Have you been in unusual, unpleasant, or embarrassing situations because you felt extremely sleepy or were having trouble concentrating? ( ) yes ( ) no
42. Would you like to be able to nap at particular times during the day? ( ) yes ( ) no

43. Do you often feel depressed or sad during the day? ( ) yes ( ) no
44. Do you sometimes have feelings during the day that your personality has changed, or do you tend to be unusually irritable and "just not yourself?" ( ) yes ( ) no
45. Do you frequently feel anxious or worried during the day? ( ) yes ( ) no
46. Do you tend to awaken suddenly during the night or in the morning with an unpleasant feeling of fear, anxiety, worry, depression, unhappiness or confusion? ( ) yes ( ) no
47. Do you tend to lie awake at night feeling depressed, worried, anxious, fearful, unhappy, or confused? ( ) yes ( ) no
48. Do you frequently feel disoriented or confused during the day? ( ) yes ( ) no
49. Do you frequently feel fearful during the day? ( ) yes ( ) no
49. Do you have times during the day when your memory completely fails you? ( ) yes ( ) no
50. Have you ever "come to" and found that you had performed some complex activity (like driving a car) without remembering it? ( ) yes ( ) no
51. Do you sometimes have illusions that something is happening that really isn't? ( ) yes ( ) no
52. Do you have hallucinations or dream-like mental images when you are falling asleep or waking up? ( ) yes ( ) no
53. Do you have attacks of sudden physical weakness or paralysis during the day when laughing, angry or other emotional situations? ( ) yes ( ) no
54. Do you have significant muscular weakness, incoordination or dizziness during the day? ( ) yes ( ) no
55. Are you short of breath during the day? ( ) yes ( ) no
56. Do you have any ear, nose, throat or lung disease? ( ) yes ( ) no
57. Do your ankles swell up during the day? ( ) yes ( ) no
58. Do you have high blood pressure? ( ) yes ( ) no
59. Do you have anemia or any other blood problems? ( ) yes ( ) no
60. Do you have chest pain during the day? ( ) yes ( ) no
61. Do you have thyroid problems? ( ) yes ( ) no
62. Do you have low blood sugar? ( ) yes ( ) no
63. Do you have diabetes? ( ) yes ( ) no
64. Do you have severe headaches during the day? ( ) yes ( ) no
65. Do you ever suffer from fainting spells or loss of consciousness during the day? ( ) yes ( ) no
66. Have you ever had a significant head injury? ( ) yes ( ) no
67. Have you ever been interviewed by a psychiatrist or clinical psychologist? ( ) yes ( ) no
68. Have you ever taken thyroid pills? ( ) yes ( ) no
69. Have you ever used hallucinogenic drugs? ( ) yes ( ) no
70. Have you ever used narcotics or "street drugs?" ( ) yes ( ) no

Please list any disabilities: \_\_\_\_\_

\_\_\_\_\_

Please specify any special needs we should be aware of to make your stay with us better. (example: wheelchair, bedside commode, etc.)

\_\_\_\_\_

\_\_\_\_\_

Please add any other information you feel is pertinent to your sleep study.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_