

Methodist Medical Sleep Diagnostic Center

944 Oak Ridge Turnpike Oak Ridge, TN 37830. Phone (865) 835-3810. Fax (865) 835-3811

SLEEP SCREENING QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____ Age: _____

Referring Physician? : _____ Family Physician: _____

What is the sleep problem? : _____

Have you had a sleep evaluation before? : Yes No

If yes, where and when? _____

Do you currently use a CPAP or Bi-LEVEL machine? _____

Pharmacy used: _____

Do you give permission to communicate medical information to your spouse/significant other or leave information on your answering machine? YES _____ NO _____

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to 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

<u>Situation</u>	<u>Chance of Dozing</u>			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (ie: a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Score: _____

Allergies: _____

Past Medical History:

Medications:

Social History:

Smoking: Never _____ Number of packs per day _____ for _____ years. Quit Year _____

Alcohol Use: Never _____ Number of drinks per day _____

Illicit Drug Use: _____

Caffeine Use: _____

Are you currently: _____ Married _____ Widowed _____ Divorced _____ Partnered

Do you live alone? N Y If no, who lives with you: _____

Education: High school, college, etc.: _____

Do you work outside the home? Yes _____ No _____ Retired _____ Disabled _____

Type of work: _____

Family History:

	Relationship
Obstructive Sleep apnea	_____
Narcolepsy	_____
Insomnia	_____

Please circle all that apply within the *last month*:

- | | | |
|---------------------------------|---------------------------|------------------------------|
| Fevers / chills/ sweats | Cough | Rash |
| Fatigue (tiredness) | Wheezing | Itchiness/ Numbness/Tingling |
| Loss of appetite | Shortness of Breath | Muscle Weakness |
| Weight gain/loss | Nausea/Vomiting | Headaches |
| Eye trouble | Diarrhea/Constipation | Seizures |
| Postnasal drip | Swallowing problems | Blood clots/bleeding |
| Seasonal allergies | Heartburn/Indigestion | Swollen glands |
| Chest pain/ angina | Bladder/ Urinary problems | Depression/Anxiety |
| Palpitations / rapid heartbeats | Diabetes | Menstrual Problems |
| Ankle or leg swelling | Thyroid problems | Impotence |
| Dizzy Spells | Pain | |

Any other problems not listed? _____

Please check all that apply:

I have been told that I snore. _____

I have been told that I stop breathing in my sleep. _____

I wake up thrashing and hitting and have hurt myself or my partner. _____

I experience achy or "crawling" sensations in my leg. _____

I have experienced vivid dream-like scenes when falling asleep and/or waking up. _____

Sometimes I am unable to move when falling asleep and/or waking up. _____

When I am angry, surprised or sad, I feel like I'm going limp. _____

I have difficulty falling asleep. _____

Thoughts race through my mind. This prevents me from falling asleep. _____

What medications have you taken to help you fall asleep? _____

I sleep walk. _____ I talk in my sleep. _____ I grind my teeth at night. _____ I have driven while drowsy. _____

What time do you go to bed? _____ wake up? _____ How long are your naps? _____ How often? _____

FOR OFFICE USE ONLY

MA Signature: _____

Date: _____

BP: _____

HR: _____

RR: _____

NECK: _____

HT: _____

WT : _____

BMI : _____

Oxygen _____ % on RA or _____ LPM