HIGHLANDS MEDICAL CENTER
SLEEP DISORDERS CENTER

EPWORTH SLEEPINESS SCALE

Patient Name: _____ **Date:** _____

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (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	**0**	**1**	**2**	**3**
Watching T.V.	**0**	**1**	**2**	**3**
Sitting inactive in a public place (i.e. theatre or 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 lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic.	**0**	**1**	**2**	**3**

TOTAL SCORE_____

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Sleep Questionnaire

If you have a bed partner please get their feedback as well.

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: ☐ M ☐ F Married: ☐ Yes ☐ No

Referring Physician: _____ Occupation: _____

Do you sleep with a bed partner? ☐ Yes ☐ No Pharmacy:_____

What problem(s) brings you in for a sleep evaluation? _____
_____
_____

MEDICAL HISTORY:

List any **current medical problems** that you have:

1._____
2._____
3._____
4._____
5._____
6._____

List any previous **surgeries** and the year performed:

1._____
2._____
3._____
4._____

MEDICATIONS:

List any medications you are currently taking and the reason they have been prescribed:

	Medicine	Dose	Frequency	Reason
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

ALLERGIES:

List any medications or other things that you are **allergic to**:

_____
_____

Have you ever used any ***sleeping*** medications? ☐ Yes ☐ No If yes, list them below:

	Medicine	Dates Used	Dose	Frequency
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

OSA SCREEN:

1. Do you snore? ☐ Yes ☐ No If yes, for how long have you been snoring? _____
2. Has anyone ever told you that you experience episodes where you appear to stop breathing while asleep? ☐ Yes ☐ No
3. Estimate the percent of time you sleep on your:

   Back _____ Side _____ Stomach _____ (Total should be 100%)

Do you experience:

1. Morning headaches: ☐ Yes ☐ No

   If Yes, how often? _____ How long do they last? _____
2. Dry mouth upon awakening? ☐ Yes ☐ No
3. Fitful/restless sleep: ☐ Yes ☐ No
4. Gasping/snorting sounds at night: ☐ Yes ☐ No
5. What is your body weight now? _____ 5 years ago: _____ The most you weighed: _____
6. Do you get up to urinate during the night? ☐ Yes ☐ No If Yes, how many times? _____
7. Have you had your tonsils removed? ☐ Yes ☐ No
8. Have you had any sinus surgeries? ☐ Yes ☐ No

SLEEP/WAKE SCHEDULE:

1. Please put in the times that you:

	Go to bed	Turn lights out	Fall asleep	Finally awaken	Get out of bed
On work days	_____	_____	_____	_____	_____
On non–work days	_____	_____	_____	_____	_____

2. How many times do you wake up during the night? _____
3. How long does it take you to fall asleep? Initially? _____ If awaken, how long to go back to sleep? _____
4. What causes the awakenings? _____
5. How do you feel when you wake up in the morning? _____
6. Are you a shift worker? ☐ Yes ☐ No

   What are your work days and hours that you work?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
_____	_____	_____	_____	_____	_____	_____

PLMS/RLS SCREEN:

1. Has anyone told you that you jerk or kick your legs at night? ☐ Yes ☐ No
2. Do you ever experience an uncomfortable sensation in your legs, often described as crawling or creeping, which makes it difficult to keep them still while at rest? ☐ Yes ☐ No

   If yes, is it relieved by movement or heat? ☐ Yes ☐ No
3. Do you experience leg cramps at night? ☐ Yes ☐ No

HABITS:

1. Do you use or smoke tobacco? ☐ Yes ☐ No
   a. How much do you smoke each day? _____
   b. For how many years have you smoked? _____
   c. When do you last smoke before bed? _____
2. Do you drink alcohol? ☐ Yes ☐ No
   a. If yes, how many days per week do you drink?_____
   b. What do you typically drink and how much?_____
   c. Do you drink to help yourself to sleep? ☐ Yes ☐ No
3. Do you drink caffeinated beverages or eat foods that contain caffeine or chocolate (such as coffee, tea, soft drinks, etc.)?
   ☐ Yes ☐ No
   a. If yes, describe the specific food/drink, how much, and how often: _____
4. Have you ever used non-prescription recreational drugs? ☐ Yes ☐ No
   a. If yes, please describe: _____

NARCOLEPSY-SCREEN:

1. Have you ever experienced episodes in which you were unable to move upon awakening (paralysis)? ☐ Yes ☐ No
2. Have you ever, during periods of intense emotion (laughter, anger, etc.), suddenly felt weak
   (such as weakness in the knees, sagging of the jaw/head, or even total body paralysis)? ☐ Yes ☐ No
3. Have you ever experienced vivid or life-like images while falling asleep or upon awakening? ☐ Yes ☐ No

SLEEP HYGIENE:

1. Do you exercise? ☐ Yes ☐ No If yes, at what time and what days? _____
2. Do you eat within 3 hours of bed? ☐ Yes ☐ No If yes, is it a snack or a full meal? _____
3. What activities do you engage in while in the bedroom setting, aside from sex or sleep?
   (such as work, watching TV, reading, etc.)? _____
4. Do you have periods (2-3 times per week) of extended amounts of time in bed? ☐ Yes ☐ No
5. Is your bed comfortable? ☐ Yes ☐ No
6. Does anything prevent you from falling asleep or remaining asleep (e.g. noise, light, temperature, bed partner, pain, etc.)?
   _____
7. Are there any stressors that keep you up at night? _____
8. Do you worry or replay the day's events while trying to fall asleep? ☐ Yes ☐ No

CIRCADIAN RHYTHM ASSESSMENT:

1. When do you feel you function best: (circle one) Morning Afternoon Evening No time of the day
2. If you could go to sleep whenever you wanted and awake whenever you wanted, what times would that be?
   Sleep Time _____am/pm Wake up Time _____am/pm
3. Do you sleep better away from home (vacation, business trips, etc.) ☐ Yes ☐ No

EDS SCREENING/DAYTIME:

1. Do you take naps? ☐ Yes ☐ No If yes, how often? _____ How long do your naps last? _____
2. How do you feel after waking from a nap (circle)? More rested Less rested About the same
3. How is your daytime concentration (circle)?
   Poor Average Excellent
4. How is your short-term memory (circle)?
   Poor Average Excellent
5. Do you feel fatigue or have no energy during the day (This should not include feeling sleepy)? ☐ Yes ☐ No

PARASOMNIA SCREEN:

1. Do you do any of the following?

a. Act out in your dreams: ☐ Yes ☐ No

b. Grind your teeth at night: ☐ Yes ☐ No

c. Walk in your sleep: ☐ Yes ☐ No

   If yes, how frequently? _____

d. Talk in your sleep: ☐ Yes ☐ No

e. Have you ever had a convulsion (fit, epilepsy) at night? ☐ Yes ☐ No

FAMILY HISTORY:

Has anyone in your family ever had a sleep problem?

(If yes, list relationship to you, such as grandfather, sister, etc.)

Describe sleep problems: _____

_____

MEDICAL/PHYSICAL Review of System:

Do you have any of the following? (If yes, please circle)

1. Pulmonary:
   Asthma Emphysema Chronic Bronchitis
2. Cardiovascular:
   High blood pressure Chest pain Irregular heart beat Mitral valve prolapsed
   Heart attacks Heart failure Heart murmur
3. Upper Airway:
   Deviated septum Overbite Enlarged tongue
   Recurrent ear infections Recurrent sinus infections Allergies (if so, please list)

   _____
4. Endocrine:
   Diabetes Acromegaly Thyroid problems
   Changes in texture of hair or skin Intolerance to heat or cold

MEDICAL/PHYSICAL Review of System (continued):

5. Gastrointestinal:

Hiatal hernia Hepatitis Ulcers

Pancreatitis Gastritis Gallstones

Gall bladder problems Indigestion/GERD (Day: _____ Night: _____)

6. Urinary:

Enlarged prostate Kidney stones Frequent urination Recurrent urinary tract infections

7. Arthritis/Autoimmune:

Osteoarthritis Fibromyalgia Rheumatoid arthritis Chronic fatigue syndrome

Other pain problems: Shoulders ☐ Yes ☐ No Legs /Arms ☐ Yes ☐ No

Back ☐ Yes ☐ No *If yes, circle area of pain*: neck mid back lower back

8. Neurologic:

Head Injury Stroke Headaches Paralysis Epilepsy

Loss of consciousness Polio Other: _____

9. Previous Infections:

Mononucleosis Diptheria Rheumatic Fever Malaria

10. Other:

Swelling of ankles Blood clots in leg (For women) Are you post-menopausal? ☐ Yes ☐ No

PAST PSYCHIATRIC HISTORY:

Have you ever been treated by a mental health clinician (such as a psychiatrist, psychologist, social worker, etc.)? ☐ Yes ☐ No

If yes, please describe when and for what reason: _____

_____

_____

_____

Patient Signature: _____ Date: _____