SLEEP QUESTIONNAIRE

Patient Name: _____ Sex: _____ Age: _____ Date: _____

Referring Physician: _____ Family Physician (PCP): _____

My main sleep complaint(s) is:

_____

Review of Systems (circle Yes if you have these on a regular and consistent basis)

Y / N Frequent headaches
Y / N Epilepsy/Seizures
Y / N Weight change of more than 5-10 lbs.
Y / N Frequent heartburn/indigestion
Y / N Urinating more than 2 times per night

Family History

Has an immediate blood relative had any of the following?

Yes	No		Who?	Yes	No		Who?
❑	❑	Cancer	_____	❑	❑	Stroke	_____
❑	❑	Diabetes	_____	❑	❑	Anxiety/Depression	_____
❑	❑	Hypertension	_____	❑	❑	Sleep Apnea	_____
❑	❑	Heart disease	_____	❑	❑	Narcolepsy	_____
❑	❑	Thyroid disease	_____	❑	❑	Other: _____	_____

Medical History

Current Medications

Medication	Dose	#Times per	Day	Medication	Dose	# Times Per	Day

Allergies to medications: _____

List surgeries and the corresponding years

_____ _____

_____ _____

Habits

Do you smoke now? ❑ Yes ❑ No

Smoked in the past? ❑ Yes ❑ No

If Yes, what and how much?

Do you drink alcohol? ❑ Yes ❑ No

If Yes, what and how much?

Do you drink caffeine (tea/coffee/soda)? ❑ Yes ❑ No

If Yes, what and how much?

Social History

Employment Status: ❑ Employed ❑ Unemployed ❑ Retired ❑ Student

Marital Status: _____

Occupation: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best 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 meeting)	_____
Sitting as a passenger in a car, for an hour without a break	_____
Lying down to rest in the afternoon when your schedule permits it	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in the traffic	_____

Reference: Johns, MW. A new method for measuring daytime sleepiness: the Epworth Sleepiness Scale. SLEEP. 1991;14:540-5.

AllCare SLEEP CENTER

BERLIN QUESTIONNAIRE

SLEEP EVALUATION

1 Complete the following:
Age _____ Male/Female _____

Category 1

2 Do you snore?
- ❑ Yes
- ❑ No
- ❑ Don't Know

If you Snore:

3 Your Snoring is?
- ❑ Slightly louder than breathing
- ❑ As loud as talking
- ❑ Louder than talking
- ❑ Very loud, can be heard in adjacent rooms

4 How often do you snore?
- ❑ Nearly every day
- ❑ 3-4 times a week
- ❑ 1-2 times a week
- ❑ 1-2 times a month
- ❑ Never or nearly never

5 Has your snoring ever bothered other people?
- ❑ Yes
- ❑ No

6 Has anyone noticed that you quit breathing during your sleep?
- ❑ Nearly every day
- ❑ 3-4 times a week
- ❑ 1-2 times a week
- ❑ 1-2 times a month
- ❑ Never or nearly never

Category 2

7 How often do you feel tired or fatigued after your sleep?
- ❑ Nearly every day
- ❑ 3-4 times a week
- ❑ 1-2 times a week
- ❑ 1-2 times a month
- ❑ Never or nearly never

8 During your wake time, do you feel tired, fatigued or not wake up to par?
- ❑ Nearly every day
- ❑ 3-4 times a week
- ❑ 1-2 times a week
- ❑ 1-2 times a month
- ❑ Never or nearly never

9 Have you ever nodded off or fallen asleep while driving a vehicle?
- ❑ Yes
- ❑ No

If yes, how often does it occur?
- ❑ Nearly every day
- ❑ 3-4 times a week
- ❑ 1-2 times a week
- ❑ 1-2 times a month
- ❑ Never or nearly never

Category 3

10 Do you have high blood pressure?
- ❑ Yes
- ❑ No
- ❑ Don't Know

Height:_____ Weight:_____

SLEEP LOGS

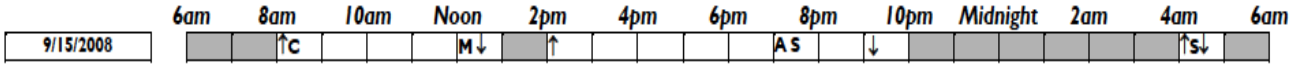
NOTE: If you have regular sleep habits you do not need to fill this page out.

Name: _____

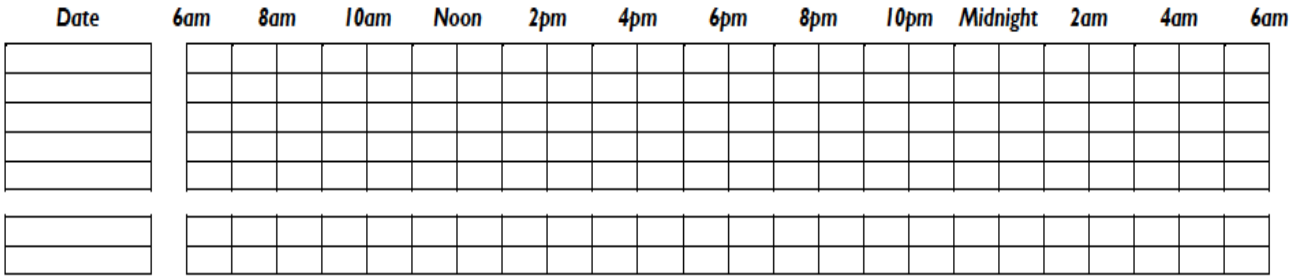
INSTRUCTIONS: Complete these logs in the morning and the evening. Do not complete them during the night. Write additional comments on the back. Bring these logs with you for your appointment or mail them to your doctor.

1. Leave the boxes BLANK to show when you are awake.
2. SHADE or color the boxes to show when you are asleep.
3. ARROW DOWN -↓- when you lie down to sleep.
4. ARROW UP -↑- when you wake up (include naps).
5. "M" for meals, "S" for snacks, "C" for caffeine, "A" for alcohol.
6. Include notes below each week or on the back.

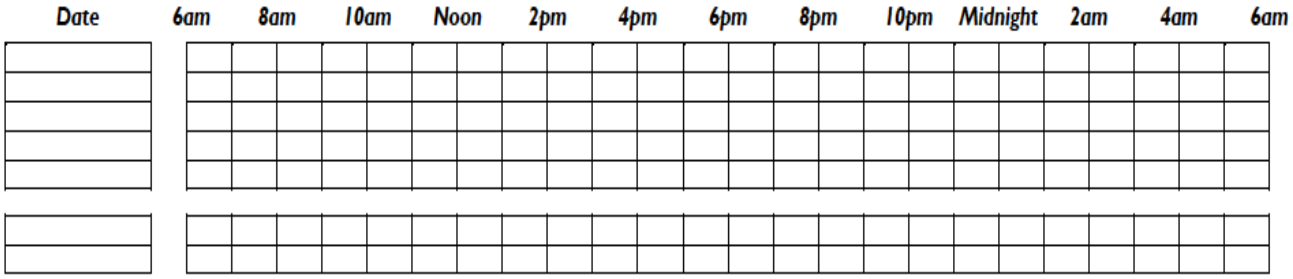
EXAMPLE:



FIRST WEEK



SECOND WEEK



BED PARTNER QUESTIONNAIRE

NOTE: If you have a bed partner, please ask them to fill this part out for you.

Name of Patient: _____ **Date:** _____

Check any of the following behaviors that you have observed the patient doing ***while asleep***:

- ❑ Loud snoring
- ❑ Light snoring
- ❑ Twitching of legs or feet
- ❑ Pauses in breathing
- ❑ Grinding teeth
- ❑ Sleep talking
- ❑ Sleepwalking
- ❑ Bed wetting
- ❑ Sitting up in bed while still asleep
- ❑ Head rocking or banging
- ❑ Kicking with legs
- ❑ Getting out of bed while still asleep
- ❑ Biting tongue
- ❑ Becoming very rigid and/or shaking

How long have you been aware of the sleep behavior(s) that you checked above? _____

_____

_____

Describe the behavior(s) checked above in more detail. Include a description of the activity, the time during the night, and whether it occurs every night. _____

_____

_____

If you have heard loud snoring, describe it in more detail. Include descriptions of any pauses in breathing or occasional loud "snorts" that you may have noticed. _____

_____

_____