BEACON HEALTH SYSTEM

Adult Sleep Evaluation Questionnaire

Demographics

Name (Last, First) ______________________ DOB ___/___/___ Age _____ Date Completed __________

Address ______________________ City ______________________ Zip __________

Phone # ______________________ Email Address ______________________

Primary Care Physician ______________________ Ordering Physician ______________________

Please state in your own words the reason you are having a sleep study: ______________________

____

About Falling Asleep

What time do you usually go to bed? __________ AM/PM

What time do you usually fall asleep? __________ AM/PM

When falling asleep or trying to fall asleep, how often do you experience the following?

	Never	Occasionally	Frequently
Have thoughts racing through you mind?	☐	☐	☐
Feel unable to move?	☐	☐	☐
Have creeping or crawling sensations or aching in your legs?	☐	☐	☐
Have vivid dream-like scenes when you know you are awake?	☐	☐	☐
Have any pain or discomfort?	☐	☐	☐

About Sleeping

How many times do you usually awaken at night? ______ times

How long are you awake during the night? __________ hrs. __________ minutes

My sleep is frequently disturbed by: **(check all that are true)**

- ☐ indigestion/gas/heartburn
- ☐ shortness of breath
- ☐ frightening dreams
- ☐ creeping/crawling/aching in legs
- ☐ movement of bed partner
- ☐ need to urinate
- ☐ cold
- ☐ thirst
- ☐ light
- ☐ heat
- ☐ noise
- ☐ hunger
- ☐ cough
- ☐ choking
- ☐ chest pain
- ☐ asthma

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Adult Sleep Evaluation Questionnaire Cont.

About Waking Up

What time do you usually have your final awakening? ______ AM ______ PM

What time do you get out of bed after your final awakening? ______ AM ______ PM

Select Yes or No for each of the following:

Yes	No	
❑	❑	Do you have a difficult time waking up?
❑	❑	Do you feel unable to move when you wake up?
❑	❑	Do you wake up confused or disoriented?
❑	❑	Do you wake up with a headache?
❑	❑	Do you wake up sick to your stomach?
❑	❑	Do you wake up with a dry mouth?

About Daytime Functioning

How many naps do you take per week? ______________

How long do you sleep during a nap? ____________ Hours ________ Minutes

Are the naps refreshing? ❑ Yes ❑ No

How often do you? (check one for each statement)	Never	Occasionally	Frequently
Feel tired during the day	❑	❑	❑
Fall asleep unintentionally?	❑	❑	❑
Feel weakness in muscles when surprised, angry or laughing?	❑	❑	❑
Fallen asleep while driving?	❑	❑	❑

Tell us about your daily use of the following:

	Typical Day	**After 6pm**
• Coffee		
• Coffee Decaf		
• Tea		
• Tea Decaf		
• Alcohol		
• Tobacco		

Please list all medications you have taken within the last 30 days

Medicine Name	**Dose**	**Frequency taken**

What are your usual work hours? Start ______________ AM/PM Ends ______________ AM/PM

Have you had a sleep study before? _________ If yes, when? ___________ Where? ________________________________

Have you had a previous ear, nose, or throat surgery? ________ If yes, when? __________ Where? ______________________

Do you have any condition or illness which causes you problems and/or pain? _________ If yes, What? __________________

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Adult Sleep Evaluation Questionnaire Cont.

Past Medical History

Please check any problems or illnesses you have or have had:

- ☐ heart disease
- ☐ heart attack
- ☐ fainting
- ☐ epilepsy/seizures
- ☐ hernias
- ☐ back problems
- ☐ allergies
- ☐ arthritis
- ☐ high blood pressure
- ☐ headaches
- ☐ dizziness
- ☐ hemophilia
- ☐ prostate trouble
- ☐ gout
- ☐ bronchitis
- ☐ heartburn/gas
- ☐ low blood pressure
- ☐ black outs
- ☐ ringing in ears
- ☐ ulcers
- ☐ mental illness
- ☐ asthma
- ☐ kidney trouble
- ☐ hearing trouble
- ☐ bladder trouble
- ☐ pneumonia
- ☐ impotence
- ☐ muscle cramps
- ☐ eye trouble
- ☐ meningitis
- ☐ depression
- ☐ tuberculosis

☐ Other ______________________________

Surgeries & Hospitalizations: Please list any hospitalization and/or surgery you have had. Include where, what, why, and when.

____

____

____

Please explain how your sleep problem has affected your life: ______________________________

____

____

The Epworth Sleepiness Scale

The following questionnaire will help you measure your general level of daytime sleepiness. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high likelihood that you would doze or fall asleep in that situation.

Use the 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 Television	0 1 2 3
Sitting inactive in a public place, for example, a theater 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	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:	

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Observed Sleep Questionnaire

Patient ______________________________ Relationship to Patient ______________________________

How long have you slept together? ______________________________

How long has it been since you noticed a problem?______________________________

Check any of the following that you have observed your partner doing while sleeping:

- ☐ Awakening with Pain
- ☐ Becoming rigid or shaking
- ☐ Bed wetting
- ☐ Biting tongue
- ☐ Choking
- ☐ Crying out
- ☐ Getting out of bed, but not awake
- ☐ Grinding teeth
- ☐ Head rocking/banging
- ☐ Light snoring
- ☐ Loud snoring
- ☐ Pauses in breathing
- ☐ Sitting up in bed, but not awake
- ☐ Sleep walking
- ☐ Twitching/kicking arms
- ☐ Twitching/kicking legs

Other Comments: ____

____

____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? ☐ Yes ☐ No

If yes, please explain: ____

____

____

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Sleep Diary

Keep for two weeks if possible

Name ______________________________

DAY	MEDICATION FOR SLEEP	BEDTIME	NUMBER OF AWAKENINGS	A.M. WAKE TIME	TOTAL TIME IN BED
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					