Date: _____

Name: _____ DOB: _____ Age: _____ ☐ Male ☐ Female

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

Please circle the most appropriate answer using the scales listed below.

**Answer all the questions, even if you have not done some of these things recently.**

| **0 = would never** | **1 = slight chance** | **2 = moderate chance** | **3 = high chance** |
|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| How likely are you to doze off or fall asleep **while sitting and reading?** | **0** | **1** | **2** | **3** |
| How likely are you to doze off or fall asleep **while watching television?** | **0** | **1** | **2** | **3** |
| How likely are you to doze off or fall asleep **while in a theater or meeting?** | **0** | **1** | **2** | **3** |
| How likely are you to doze off or fall asleep **while traveling as a passenger?** | **0** | **1** | **2** | **3** |
| How likely are you to doze off or fall asleep **while resting in the afternoon?** | **0** | **1** | **2** | **3** |
| How likely are you to doze off or fall asleep **while sitting and talking with someone?** | **0** | **1** | **2** | **3** |
| How likely are you to doze off or fall asleep **while sitting quietly after a meal?** | **0** | **1** | **2** | **3** |
| How likely are you to doze off or fall asleep **while sitting in a car stopped in traffic?** | **0** | **1** | **2** | **3** |

Patient Name: _____ Phone Number: _____
Present Occupation: _____
Referring Doctor: _____ Date of Study: _____

1. What are your sleep-related problems or symptoms? (for example – excessive snoring, insomnia, daytime sleepiness)

2. How does this problem affect your daily activities and life in general?

**SNORING HISTORY**

Do you snore? ☐ Yes ☐ No ☐ Sometimes
Has there been a recent change in your snoring? ☐ Yes ☐ No
**** If yes, please explain**

Does your snoring disturb others? ☐ Yes ☐ No
Have you awakened yourself with your snoring? ☐ Yes ☐ No
Have you awakened feeling short of breath or with a choking feeling? ☐ Yes ☐ No
Has anyone observed pauses in your breathing while you were sleeping? ☐ Yes ☐ No

**SLEEP HISTORY**

What time do you go to bed on workdays? _____ am/pm What time do you get up on workdays? _____ am/pm
What time do you go to bed on days off? _____ am/pm What time do you get up on days off? _____ am/pm
How long does it take you to fall asleep? _____ hours _____ minutes
How many hours of sleep do you think you need per night? _____
Do you wake up too early and are not able to go back to sleep? ☐ Yes ☐ No ☐ Sometimes
If yes: Number of awakenings per night: _____
Usual length of awakenings? _____
Specific Causes: _____

**DO YOU?**

Talk in your sleep? ☐ Yes ☐ No ☐ Don't know
Walk in your sleep? ☐ Yes ☐ No ☐ Don't know
Often have frightening dreams? ☐ Yes ☐ No
Do you ever "Act out" your dreams? ☐ Yes ☐ No
Consider yourself a light sleeper? ☐ Yes ☐ No
Consider yourself a restless sleeper? ☐ Yes ☐ No
During the first 30 minutes after waking up, do you **usually** feel:
☐ very groggy ☐ somewhat groggy ☐ alert ☐ slightly drowsy, but awake
Do you wake up with a headache? ☐ Yes ☐ No
Do you have a regular bed partner? ☐ Yes ☐ No
Do you have a creepy, crawling sensation in your legs when you First sit quietly in a chair or lie down? ☐ Yes ☐ No
Do you jerk while you are sleeping? ☐ Yes ☐ No
Your usual sleeping position is on your : ☐ Back ☐ Stomach ☐ Side(s) ☐ No usual
Has there been a recent change in your sleepiness? ☐ Yes ☐ No

**SLEEP HISTORY CONTINUED (next page):**

**SLEEP HISTORY (continued)**

Have you ever fallen asleep while driving? ☐ Yes ☐ No

Have you ever fallen asleep while eating? ☐ Yes ☐ No

When do you function best? (check one) ☐ Morning ☐ Mid-day ☐ Afternoon ☐ Early evening ☐ Night

Are naps refreshing? ☐ Yes ☐ No ☐ Sometimes

Do you dream during your naps? ☐ Yes ☐ No ☐ Sometimes

Have you ever felt paralyzed or unable to move when waking up or falling asleep? ☐ Yes ☐ No

Have you ever noticed loss of muscle tone after emotional changes such as:

Fear, anger, or excitement ☐ Yes ☐ No

Do you ever see things in the room, that aren't really there while going to sleep or waking up? ☐ Yes ☐ No

**MEDICAL HISTORY**

Have you ever had a tonsillectomy? ☐ Yes ☐ No

Have you ever had sinus or nasal surgery? ☐ Yes ☐ No

Have you ever broken your nose or facial bones? ☐ Yes ☐ No

Have you ever had any type of head injury? ☐ Yes ☐ No

Have you ever had a seizure? ☐ Yes ☐ No

Current weight: _____ 6 months ago _____ 1 yr ago _____ 5 yrs ago _____ 10 yrs ago

Height: _____

**DO YOU?**

Smoke cigarettes? ☐ Yes ☐ No

Packs per day: _____ How long? _____

Have you smoked in the past? ☐ Yes ☐ No

Drink beer or wine? How much? _____ Drink liquor? How much? _____

Drink caffeinated Tea, Coffee, or Soft drinks? How much? _____

Has there been any recent change in the intake of the items just mentioned? ☐ Yes ☐ No

**PLEASE LIST ALL PRESENT MEDICATIONS (including vitamins and aspirins)**

**Give name and amount taken:**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. 10.

**Please list any additional medical information that you feel we need to be aware of:**

_____

_____

_____

_____

_____

_____

Do you use home oxygen? ☐ Yes ☐ No

Patient Signature: _____ Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost::

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)