Mary Washington Healthcare

Sleep and Wake Disorders Center

Patient Name: ______________________________ Date of Birth: ______ /______ /______

Primary Care Physician: ________________________ Referring Physician: ___________________

Sleep Questionnaire: **Height_____ Weight_____ Neck circumference______**

☐ Snoring	☐ Frequent urination at night	☐ Teeth Grinding If yes, do you wear mouth guard? __ Yes __ No
☐ Pauses in breathing	☐ Bedwetting	
☐ Snorting	☐ Night sweats	☐ Daytime Sleepiness
☐ Wake up choking or SOB	☐ Unrefreshed upon awakening	☐ Falling out of bed
☐ Dry Mouth	☐ Low energy	☐ Sleep walking
☐ Difficulty falling asleep	☐ Vivid hallucinations	☐ Nightmares
☐ Waking up at night; having trouble falling back asleep	☐ Loss of muscle tone or paralysis going into sleep or upon awakening	☐ Fall asleep at unpredictable times
☐ Restless sleep	☐ Fatigue/tiredness	☐ Sleep talking
☐ Clock watching	☐ Frequent refreshing naps	☐ Screaming at night during sleep
☐ Frequent awakenings	☐ Frequent un-refreshing naps	☐ Night terrors
☐ Waking up too early on most mornings	☐ Sleep problems interfere with my life (work, social)	☐ Weight change? Y or N ☐ __ Gain or __Loss

Past Medical History (PMS):

☐ Hypertension	☐ Diabetes	☐ OSA ☐On CPAP	☐ Seizure	☐ Headaches
☐ Depression	☐ Anxiety	☐ PTSD	☐ Claustrophobia	☐ Anemia
☐ Asthma	☐ COPD	☐ GERD	☐ Migraines	☐ Stroke
☐ Atrial Fibrillation	☐ Congestive Heart Failure	☐ Cardiac Artery Disease	☐ TIA (transient ischemic attack)	☐ Parkinson's Disease
☐ Restless Leg Syndrome	☐ Dementia	☐ Fibromyalgia	☐ Using Oxygen	☐ Low testosterone
☐ Rhinitis	☐ Enlarged Tonsils	☐ Thyroid Disease	☐ Kidney Disease	☐ Other: _____________

Medications:
Please list all medications (prescribed, over the counter and vitamins):

Medications	Dose	Frequency

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Routine Sleeping Habits:

My bedtime: From________ am/pm to ________ am/pm;
Weekends: From ______ am/pm to _____am/pm
How long does it take you to fall asleep? ____________min/hours
Does your partner snore? Yes No
Is your bedroom environment? Dark: Yes No Quiet: Yes No Comfortable temperature: Yes No
Do you frequently have children or pets in the bed? Yes No
When do you sleep better (Check which one best applies to you): Weekdays Weekends Vacation
Do you do any of the following in bed:
Watch Television: Yes No Video Games: Yes No Computer: Yes No Cell Phone/Text: Yes No

Restless Legs Symptoms:
Do you have an urge to move your legs when you are sitting or lying? Yes No
If yes, are they worse during evening/ night? Yes No
Are they relieved by movement (stretching, getting-up)? Yes No
Does a bed partner report kicking/sheets in disarray? Yes No

EPWORTH SLEEPINESS SCALE:
This scale refers to your usual way of life in recent times. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? 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.

SCALE:
0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Sitting and reading Situation/Activity Chance of Dozing:	**Scale**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place such as a theater or meeting	
As a passenger in a car for an hour without a break	
Lying down resting in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total score (add all responses)	