SLEEP QUESTIONNAIRE

Referring Provider: ____________________________  Primary Care Provider: ____________________________

Have you seen our:  □ EISC website (www.eisleep.com)  □ Billboard  □ other: ____________________________

What is your primary problem with sleep? ____________________________

How long have you had this problem? ____________ ____________

Do you have or has anyone noticed that you have the following symptoms?

□ Snore  □ Have morning headaches  □ Have heartburn or gastric reflux at night
□ Awakened by your own snoring  □ Episodes of confusion  □ Have restless sleep
□ Wake up gasping for air  □ Have vivid dreams  □ Have limb jerks while asleep
□ Stop breathing while asleep  □ Talk while asleep  □ Have an urge to move your legs
□ Wake up with a dry mouth  □ Walk while asleep  □ Have a creepy, crawly feeling in your legs
□ Have nighttime wheezing  □ Shift work

What is your typical sleep schedule on work days? Bedtime: _______ am/pm; Rise Time: _______ am/pm

What is your typical sleep schedule on off days?  Bedtime: _______ am/pm; Rise Time: _______ am/pm

How long does it take you to fall asleep on work days? ____________ On off days? ____________

How many times do you wake up during the night? ______ How many of those for restroom visits? ______

How long does it usually take you to fall back asleep? ____________________________

If you have difficulty falling asleep, what activities do you do in bed to help you fall asleep?

□ Watch TV  □ Read  □ Toss & Turn  □ Worry  □ Other ____________________________

How many hours do you usually sleep on work days? ______ On off days? ______

Do you feel excessively sleepy in the daytime? □ No  □ Yes

Do you nap during the day? □ No  □ Yes  If yes, how often and for how long? ____________________________

Are you refreshed by a typical night’s sleep? □ No  □ Yes  Are your naps refreshing? □ No  □ Yes

Have you ever felt weak in your muscles when laughing, angry or with other emotions? □ No  □ Yes

Have you ever seen or heard things that aren’t there while falling asleep or while waking up? □ No  □ Yes

Have you ever felt like you couldn’t move while falling asleep or waking up? □ No  □ Yes

Do you usually dream during your naps? □ No  □ Yes

COMPLETE THE 2ND PAGE
# Epworth Sleepiness Scale

Please estimate your risk of falling asleep in the following situations, using the scale below.

0 = No chance of dozing, 1 = Slight chance of dozing, 2 = Moderate chance of dozing, 3 = High chance of dozing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Chance of Dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
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<tr>
<td>Sitting inactive in a public place (theater or meeting)</td>
<td></td>
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<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
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<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
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<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td></td>
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<tr>
<td>In a car, while stopped for a few minutes in traffic</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Have you had a sleeping problem diagnosed in the past? □ No □ Yes

If yes, what was the problem and what treatment(s) was/were recommended? ______________________________

Did the treatment(s) help? □ No □ Yes  Where was the diagnosis made? ______________________________

Please check the appropriate box if you have a history of:

- □ Stroke or TIA
- □ Seizures
- □ Other neurological disease
- □ Back or joint problems
- □ Chronic pain syndrome
- □ Deviated nasal septum
- □ Tonsillectomy
- □ Lung disease
- □ High blood pressure
- □ Heart disease
- □ Thyroid disease
- □ Gastric reflux or hiatal hernia
- □ Kidney disease
- □ Diabetes Mellitus
- □ Depression
- □ Anxiety
- □ Drug/Alcohol addiction

Please list any other current or past medical problems, including past surgeries: ______________________________

Are you allergic to latex? □ No □ Yes

Please list any allergies to medicines: ______________________________

Please list all your current medications (including over-the-counter medicines and herbal remedies), along with the dosage amount and frequency.

□ I have provided a list of my medications.

Marital Status: ______________________________  Occupation: ______________________________

Do you use tobacco? □ No □ Yes  If so, how much? ______________________________

Do you drink alcohol? □ No □ Yes  If so, how much? ______________________________

Do you drink caffeinated beverages? □ No □ Yes  If so, how much? ______________________________