EASTERN IOWA
SLEEP CENTER

Name: _____

DOB: _____ Gender: M F

Height: _____ ft _____in Weight: _____ lbs

Study Date: _____

SLEEP QUESTIONNAIRE

F-03

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

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**

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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

Situation	Chance of Dozing
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest 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	_____

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	☐ Deviated nasal septum	☐ Gastric reflux or hiatal hernia
☐ Seizures	☐ Tonsillectomy	☐ Kidney disease
☐ Other neurological disease	☐ Lung disease	☐ Diabetes Mellitus
☐ Back or joint problems	☐ High blood pressure	☐ Depression
☐ Chronic pain syndrome	☐ Heart disease	☐ Anxiety
	☐ Thyroid disease	☐ 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?_____