ELECTRA MEMORIAL HOSPITAL

CARDIOPULMONARY

SLEEP QUESTIONAIRE

Name:_______________________________ Date:___________________________

Home Phone:(   )________________ Work Phone:(   )______________

SSN: _______________________________ DOB:___________________________

Gender:_____ Race:_________ Age:_____

Height:______ Weight:_______

Primary Physician:____

Referring Physician:____

Insurance Name:___________________________ ID# :___________________________

Briefly describe your sleep problem:

Current medications, include over-the-counter medicines and the dosage information:

Have you ever had a Sleep Study done before? YES NO

Have you ever been diagnosed with Sleep Apnea? YES NO

If YES, prescribed or attempted treatments:

Do you snore? YES NO

Do you awaken with dry mouth or sore throat? YES NO

Do you awaken gasping for air or short of breath? YES NO

Has anyone ever witnessed you stop breathing at night? YES NO

Do you awaken with morning headaches? YES NO

Do you feel rested in the morning? YES NO

Do you feel tired during the day? YES NO

Do you take naps during the day? YES NO

Have you ever been diagnosed with Emphysema or COPD? YES NO

Do you have a history of Heart Failure or Heart Attack? YES NO

Do you have a history of high blood pressure? YES NO

Have you been diagnosed with any muscular weakness disorder? YES NO

Do you get achy or "creeping" sensations in your legs at night? YES NO

When angry, surprised, or laughing, have you felt like you were going to faint, blackout or fall down? YES NO

Have you had difficulty staying awake during the day since you were a teenager? YES NO

Do you experience vivid, life-like scenes (dream like) when you are very tired, or prior to falling asleep? YES NO

Have you ever awakened from sleep and been unable to move? YES NO

Have you ever been told you grind your teeth while asleep? YES NO

Do you smoke? YES NO

What is your normal bedtime? _______________

What is your normal wake time?_____________

What is your average hours of sleep each night?____________

If needed, do you give the cardiopulmonary department permission to discuss with a family member the scheduling of your appointment? YES NO

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EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep/doze during the following?

0 = No chance 1= Slight chance 2= Moderate chance 3 = High chance

_____ Sitting and Reading

_____ Watching TV

_____ Sitting inactive in a public place (Theatre 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 with someone

_____ Sitting quietly after lunch, without alcohol

_____ Driving a car or while stopped in traffic

_____ **Total Score**

< 8 = Normal sleep function

8 – 10 = Mild sleepiness

11-15 = moderate sleepiness

16-20 = Severe sleepiness

21-24 = Excessive sleepiness