

Emory Program in Sleep Medicine Sleep and Health Questionnaire

Demographics

Today's Date: ____ / ____ / ____

Name: _____ Date of Birth: ____ / ____ / ____

Address: _____ Sex: Male Female

City / State / Zip: _____

Preferred Contact Number: _____ Work Home Cell

Occupation: _____

Height: ____ ft ____ in Weight: ____ lbs Shirt Collar size: ____ inches

Name of Doctor who sent you here: _____

Doctor's Phone Number: _____

Address: _____

City / State / Zip: _____

Reason for Referral

What would you say is your primary sleep problem? (If none, why did your doctor refer you to the sleep clinic?)

Describe how and when this problem began and how often it is occurring:

Have you ever had a sleep study? Yes No

If Yes, When and Where: _____

Describe any other treatments you have received for your problem:

Your Sleep Habits	
How many hours of sleep do you usually get per night?	
What time do you usually go to bed?	
What time do you usually wake up?	
How long does it take for you to fall asleep?	
How many times do you typically wake up at night?	
What awakens you?	
If you wake up, on average, do you have trouble going back to sleep?	
What hours do you work?	
Do you ever rotate shifts?	

Symptoms During Sleep	Yes	No
Do you feel refreshed after a typical night's sleep?		
Do you feel sleepy during the day even when you have slept all night?		
Do you nap at least once per week?		
Do you feel refreshed after a short nap?		
Do you sleep better in a recliner or a chair than you do in bed?		
Do you ever experience vivid dream-like scenes upon awakening or falling asleep?		
When you are angry or laugh, do you ever feel weak in any part of your body?		
Are you ever unable to move or speak for a short period of time as you are falling asleep or awakening?		
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?		
Do you snore?		
Is your bed partner disturbed by your snoring?		
Has anyone every told you that your breathing stops for brief periods during the night?		
Do you have a bitter taste in the back of your throat when you wake up?		
Do you walk or talk in your sleep?		
Do you grind or clench your teeth during your sleep?		
Are you a restless sleeper, tossing and turning at night?		
Do you feel drowsy while driving your car?		
Have you ever fallen asleep while driving?		

Indicate, on average, how often you experience the following symptoms when sleeping or trying to sleep.

Symptom	Times Per Week			
	Daily	4-6	1-3	Never
My mind races with many thoughts when I try to fall asleep				
I often worry whether or not I will be able to fall asleep				
Fatigue				
Awaken with a dry mouth				
Morning headaches				
Irritability / Depression				
Memory impairment / Inability to concentrate				
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep				
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep				
Pain which delays, prevents, or awakens me from sleep				
Irresistible urges to move my legs or arms while in bed				
Creeping or crawling sensations in your legs before falling asleep				
Legs or arms jerking during sleep				
Frequent urination disrupting sleep				
Sleep talking or Sleep walking				
Snoring				

Epworth Sleepiness Scale

This refers to your usual way of life in recent times. Even if you haven't 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:

- 0 = Would **never** doze
- 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 (eg, a theatre or a meeting place)	
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 the traffic	

Medical History: Please check all previously diagnosed medical conditions:

- | | | |
|--|---|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Reflux / Heartburn |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Atrial fibrillation (A Fib) | <input type="checkbox"/> Congestive heart failure / Heart failure | |
| <input type="checkbox"/> Depression | | |

Please list any other significant medical problems and any surgeries you have had:

_____	_____
_____	_____
_____	_____

Current Medications, prescription and otherwise (with doses, if known)

_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications? If so, what are they? What kind of reaction did you have?

Family Medical History

	Age	Medical Problems, (if deceased, list cause of death)
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

Social History

Do you currently smoke? Yes No

Packs per day: _____ How many years have you smoked: _____

If not currently smoking, have you smoked in the past? Yes No

When was your last cigarette? _____

Number of alcoholic beverages per day _____ / per week _____ / per month _____

How much caffeinated coffee do you drink per day? _____ cups

How much caffeinated tea (hot or iced) do you drink per day? _____ cups / _____ glasses

How much caffeinated soda do you drink per day? _____ cans

Review of Systems (please answer all questions, checking yes or no)

Yes	No	General	Comment
		Weakness	
		Fatigue	
		Decreased appetite	
		Increased appetite	
		Weight loss	
		Weight gain	
		Chills	
		Fever	
		Night sweats	

Yes	No	Eyes, Ears, Nose Throat	Comment
		Decreased ability to see	
		Blurred vision	
		Spots before eyes	
		Difficulty hearing	
		Ringing in ears	
		Pain in ears	
		Discharge from ear	
		Nosebleeds	
		Nasal congestion	
		Post-nasal drip	
		Sinus trouble	
		Sore throat	
		Hoarseness	
		Pain in neck	
		Dental trouble	
		Bleeding gums	

Yes	No	Respirator	Comment
		Cough	
		Coughing up phlegm	
		Coughing up blood	
		Wheezing	
		Asthma	
		COPD	
		Shortness of breath	
		Chest pain with cough or deep breathing	

Yes	No	Cardiovascular	Comment
		Chest discomfort	
		Shortness of breath when lying down	
		Sitting up to breathe	
		Heart racing	
		Swelling of legs	
		Varicose veins	
		Leg pain with exertion	
		Blue/purple color of hands/feet	

Yes	No	Gastrointestinal	Comment
		Nausea	
		Vomiting	
		Diarrhea	
		Constipation	
		Heartburn	
		Abdominal pain	
		Bright red blood in stools	
		Black stools	
		Change in bowel habits	
		Hemorrhoids	

Yes	No	Musculoskeletal	Comment
		Painful joints	
		Swelling of joints	
		Redness of joints	
		Stiffness of joints	
		Deformities of joints or extremities	
		Muscle pain	
		Back pain	
		Pain running down the back of your legs	

Yes	No	Endocrine	Comment
		Goiter	
		Heat intolerance	
		Cold intolerance	
		Tremulous hands	
		Change in pitch of voice	
		Increased body hair (face, under arms, or pubic)	
		Decreased body hair	
		Loss of periods	
		Increased thirst	
		Increased urination	

Yes	No	Neurologic/Psychiatric	Comment
		Nervousness/Anxiety	
		Depression	
		Difficulty with memory for past events	
		Difficulty with memory for recent events	
		Difficulty with thinking or problem solving	
		Headaches	
		Blackouts	
		Dizziness	
		Double vision	
		Paralysis or weakness of limb(s)	
		Loss of sensation	
		Loss of balance	
		Loss of coordination	
		Difficulty in speaking	
		Seizures or spells	

Yes	No	Hematologic/Allergy	Comment
		Anemia	
		Blood Disorder	
		Immunocompromised	
		Seasonal allergies	
		Drug allergies	

Yes	No	Skin	Comment
		Itching	
		Rash or Ulcers	
		Change in color	
		Change in texture of hair or hair loss	
		Nail changes	