WhidbeyHealth
Sleep Care

WhidbeyHealth Sleep Care
1300 N.E. Goldie Street, Oak Harbor, WA 98277
(360)240-4080 FAX (360)240-4081
www.whidbeyhealth.org

Please complete this questionnaire
and bring it to your first appointment.
You are welcome to bring someone with you who is familiar with your sleep patterns.

NAME:____DATE:___________

1. **The reason why you are here today:** (Insomnia, snoring, observed pauses in breathing, frequent awakenings at night, un-refreshed sleep, excessive daytime sleepiness, fatigue, etc.)____
2. How long have you had these symptoms? ______________________________
3. What is your usual bedtime?______________________________________
4. How long do you normally take to fall asleep?___________________________
5. Do you snore?____
6. Has anyone ever noticed you quit breathing while you are asleep? [ ]Yes [ ]No
7. Does your spouse/partner sleep separately from you due to snoring? [ ]Yes [ ]No
8. How many times do you usually wake up at night?________________________
9. Why do you wake up at night? Choking? Snoring? Gasping for Air? Pain? Bathroom?____
10. Do you toss and turn or twitch in your sleep? [ ]Yes [ ]No
11. Do you talk or walk in your sleep? [ ]Yes [ ]No
12. Do you recall having dreams at night? [ ]Yes [ ]No
13. What time do you usually get out of bed in the morning? ___________________
14. Do you feel refreshed when you wake in the morning? [ ] Yes [ ] No
15. Do you have a morning headache? [ ]Yes [ ]No
16. Do you feel sleepy or fatigued during the day? [ ] Yes [ ] No

EPWORTH SLEEPINESS SCALE

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

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

SITUATION	**Chance of dozing 0-3**
SITTING AND READING	0 1 2 3
WATCHING TELEVISION	0 1 2 3
SITTING INACTIVE IN A PUBLIC PLACE, i.e. a theater or meeting	0 1 2 3
AS A PASSENGER IN A CAR	0 1 2 3
LYING DOWN TO REST IN THE AFTERNOON	0 1 2 3
SITTING AND TALKING TO SOMEONE	0 1 2 3
SITTING QUIETLY AFTER LUNCH (WITHOUT ALCOHOL)	0 1 2 3
IN A CAR AS A DRIVER, WHILE DRIVING OR AT A STOP LIGHT IN TRAFFIC	0 1 2 3

Patient signature_____________________________

17. Have you ever fallen asleep while driving? [ ]Yes [ ]No
18. Do you take naps during the day? [ ]Yes [ ]No
19. If you fall asleep during the day do you dream? [ ]Yes [ ]No
20. Have you ever had sleep paralysis as you wake from sleep (can't move?) [ ]Yes [ ]No
21. Have you ever felt weak in the knees when startled or emotional? [ ]Yes [ ]No
22. Are you bothered by creepy, crawly, restless sensations in your legs when you are still? [ ]Yes [ ]No
23. Do you have a problem with memory or concentration? [ ]Yes [ ]No

Please circle if you have the following medical problems: (hypertension, congestive heart failure, coronary heart disease, arrhythmia, anemia, asthma, emphysema, gastroesophageal reflux disease, dysphagia, diabetes, insulin resistance, hypothyroidism, anxiety, depression, mood disorder, attention deficit, claustrophobia, arthritis, gout, fibromyalgia, impotence. etc.) Please list any other medical conditions that you are being treated for.

____
____
____

List all your current medications: (include non-prescription drugs)

____
____
____
____

Allergies to medications? Yes [ ] No [ ] Please list ______________________
What is your occupation?______________________
Do you or did you smoke cigarettes? [ ]Yes [ ]No How much?______ (pack per day)
How many years?______________ When did you quit?______________________
Do you drink alcohol? [ ]Yes [ ]No How much?________ How often?______________________
Do you drink caffeinated beverages? [ ]Yes [ ]No How much?______________________
Do you have family members with sleep disorders such as sleep apnea or snoring? [ ]Yes [ ]No
Who?______________________

Constitutional:
In the past 5 years has your weight changed? Pounds gained? _________ Pounds lost? _________
Do you have problems with any of the following? Check all that apply.

Heart
[ ] high blood pressure
[ ] palpitations
[ ] chest pain
[ ] irregular heart rate/pulse
[ ] leg or foot swelling
[ ] have to sleep sitting up
Others? __________________

Respiratory
[ ] shortness of Breath
[ ] wheeze
[ ] sputum production
[ ] chronic cough
Others? _______________

Gastrointestinal
[ ] heartburn
[ ] difficulty Swallowing
[ ] nausea
[ ] vomiting
[ ] diarrhea
[ ] abdominal pain
Others?________________________

Urinary
[ ] incontinence
[ ] frequency
[ ] urgency
[ ] impotence
Others?___________________

Neurological
[ ] headaches
[ ] seizure
[ ] head trauma
[ ] disorientation
[ ] speech dysfunction
[ ] gait or balance problems
[ ] fainting or unconsciousness
Others?___________________

Psychiatric
[ ] Attention Deficit Hyperactivity
[ ] anxiety
[ ] depression
[ ] mood disorder
[ ] claustrophobia
Others?_______________________

Patient signature___________________________________

Ears/Nose/Throat
[ ] nasal congestion
[ ] sinus problems
[ ] nose bleeds
[ ] dry mouth/throat
[ ] hoarseness
[ ] injury to nose
[ ] tonsillectomy
[ ] wisdom teeth removed

Endocrine
[ ] thyroid disease
[ ] history of goiter
[ ] tired /sluggish
[ ] too hot or cold
[ ] excessive thirst
[ ] increased appetite
[ ] increased urination
[ ] unexplained weakness

Musculoskeletal
[ ] joint pain / stiffness
[ ] neck pain
[ ] back pain
[ ] joint swelling
[ ] muscle pain/cramping
[ ] mobility problems

Allergic/Immunological
[ ] sneezing/runny nose
[ ] rash
[ ] itching
[ ] allergies to food or environment

Others?_________________ Others? _________________ Others? ______________________

Are there prior sleep studies? [ ]Yes [ ]No **If yes,** what year and where did you have your sleep study?____

Patient signature___________________________________