

EMORY SLEEP CENTER
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 referred you: _____

Doctor's Phone Number: _____

Doctor's 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 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?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel sleepy during the day when you have slept all night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you nap at least once per week?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel refreshed after a short nap?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sleep better in a recliner or a chair than you do in bed?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever experience vivid dream-like scenes upon awakening or falling asleep?	<input type="checkbox"/>	<input type="checkbox"/>
When you are angry or laugh, do you ever feel weak in any part of your body?	<input type="checkbox"/>	<input type="checkbox"/>
Are you ever unable to move or speak for a short period of time as you are falling asleep or awakening?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you snore?	<input type="checkbox"/>	<input type="checkbox"/>
Is your bed partner disturbed by your snoring?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone every told you that your breathing stops for brief periods during the night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a bitter taste in the back of your throat when you wake up?	<input type="checkbox"/>	<input type="checkbox"/>
Do you walk or talk in your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Do you grind or clench your teeth during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a restless sleeper, tossing and turning at night?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel drowsy while driving your car?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever fallen asleep while driving?	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often worry whether or not I will be able to fall asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Awaken with a dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability / Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory impairment / Inability to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain which delays, prevents, or awakens me from sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irresistible urges to move my legs or arms while in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creeping or crawling sensations in your legs before falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs or arms jerking during sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent urination disrupting sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep talking or Sleep walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Epworth Sleepiness Scale

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
Sitting and reading	
Watching tv	
Sitting, inactive in a public place (eg, a theatre or 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 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, prescriptions and otherwise (with doses if known)

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
<input type="checkbox"/>	<input type="checkbox"/>	Weakness	
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	
<input type="checkbox"/>	<input type="checkbox"/>	Decreased appetite	
<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite	
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss	
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain	
<input type="checkbox"/>	<input type="checkbox"/>	Chills	
<input type="checkbox"/>	<input type="checkbox"/>	Fever	
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	

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

Yes	No	Respirator	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Cough	
<input type="checkbox"/>	<input type="checkbox"/>	Cough up phlegm	
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	
<input type="checkbox"/>	<input type="checkbox"/>	COPD	
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain with cough or deep breathing	

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

Yes	No	Gastrointestinal	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	
<input type="checkbox"/>	<input type="checkbox"/>	Bright red blood in stools	
<input type="checkbox"/>	<input type="checkbox"/>	Black stools	
<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits	
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	

Yes	No	Musculoskeletal	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Painful joints	
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of joints	
<input type="checkbox"/>	<input type="checkbox"/>	Redness of joints	
<input type="checkbox"/>	<input type="checkbox"/>	Stiffness of joints	
<input type="checkbox"/>	<input type="checkbox"/>	Deformities of joints or extremities	
<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	
<input type="checkbox"/>	<input type="checkbox"/>	Back pain	
<input type="checkbox"/>	<input type="checkbox"/>	Pain running down the back of your legs	

Yes	No	Endocrine	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Goiter	
<input type="checkbox"/>	<input type="checkbox"/>	Heat intolerance	
<input type="checkbox"/>	<input type="checkbox"/>	Cold intolerance	
<input type="checkbox"/>	<input type="checkbox"/>	Tremulous hands	
<input type="checkbox"/>	<input type="checkbox"/>	Change in pitch of voice	
<input type="checkbox"/>	<input type="checkbox"/>	Increased body hair (face, under arms or pubic)	
<input type="checkbox"/>	<input type="checkbox"/>	Decreased body hair	
<input type="checkbox"/>	<input type="checkbox"/>	Loss of periods	
<input type="checkbox"/>	<input type="checkbox"/>	Increased thirst	
<input type="checkbox"/>	<input type="checkbox"/>	Increased urination	

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

Yes	No	Hematologic/Allergy	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	
<input type="checkbox"/>	<input type="checkbox"/>	Immunocompromised	
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies	
<input type="checkbox"/>	<input type="checkbox"/>	Drug allergies	

Yes	No	Skin	Comment
<input type="checkbox"/>	<input type="checkbox"/>	Itching	
<input type="checkbox"/>	<input type="checkbox"/>	Rash or ulcers	
<input type="checkbox"/>	<input type="checkbox"/>	Change in color	
<input type="checkbox"/>	<input type="checkbox"/>	Change in texture of hair or hair loss	
<input type="checkbox"/>	<input type="checkbox"/>	Nail changes	