MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

The following questions are about complaints and problems associated with sleep. Please fill out the questionnaire to the best of your ability. It is very helpful for the sleep medicine provider who will be evaluating you.

Name: _____

Occupation (currently or prior to retirement): _____

Who lives with you: _____

Why have you come to see the sleep specialist? What sleep problem are you having? How long have you had this problem?

_____

_____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? This refers to your usual way of life recently. Even if you have not done some of these things recently, try to answer how they would affect 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	**NUMBER 0-3**
Sitting and reading	
Watching television	
Sitting inactive in a public place (ex: meeting or church)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after a meal (when you have not had alcohol)	
In a car, while stopped for traffic	
TOTAL	

Have you ever had a sleep study? ○ Yes / No ○ If yes: When and where?_____

Comments:

_____

Medical History: Do you have any of the following?:

Seizures: Yes ○ No ○ Congestive Heart Failure (CHF): Yes ○ No ○
COPD: Yes ○ No ○ Other: Yes ○ No ○ If Yes, explain:

MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

Psych History:
PTSD : Yes ◯ No ◯ Depression : Yes ◯ No ◯
Anxiety: Yes ◯ No ◯ Chronic Pain: Yes ◯ No ◯

Childhood: Did you have childhood sleep problems of any type? ◯Yes / ◯No
If yes please describe: _
_____

Sleep Environment and Schedule:
Do you have a comfortable bedroom or sleep environment? ◯Yes / ◯No If no, why not?
_____
Pre-bedtime rituals: TV / Reading /
Computer_____
What medications/herbals do you take before bedtime?
_____
Do you take any pain medication? If yes what pain med _____
Do you take any nasal decongestant pills daily or nightly (for example, pseudoephedrine/Sudafed)?
◯Yes or◯no?

Sleep Schedule:

	Weekday	**Weekend**
Time you are in bed?	_____AM/PM	_____AM/PM
Time it takes to fall asleep?	_____minutes or hours	
Time you get up?	_____AM/PM	_____AM/PM

How many times do you wake during your sleep period? _____
What wakes you up? _____
How long does it take to fall back asleep after waking up? _____minutes or hours
How many hours do you actually sleep each night? _____ Average (hours)
How do you feel upon awakening after your sleep period? "_____"

Do you take naps? ◯Yes /◯No How many times per week?
On the average, how long are the naps? _____ hrs.
How do you feel after taking a nap? "_____"

Work schedule When does your usual work (shift) start? _____ AM or PM
When does your usual work shift end? _____ AM or PM
Do you do 3rd shift work (overnight)? Yes ◯ No ◯

Social History and Other Substances history

Caffeine: Regular coffee _____ cups/day Decaffeinated coffee _____ cups/day
Soft drinks with caffeine? Yes ◯ No ◯ If yes, how many? ____ per day
Do you drink tea with caffeine? Yes ◯ No ◯ If yes, how many cups/glasses ____ per day?
What time in the day do you have your last caffeinated beverage?_____

MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

Tobacco: Ever smoked? Yes ◯ No ◯ If yes, how long? _____; Highest # of packs per day: _____
Do you still smoke? Yes ◯; No ◯ If no, when did you quit? _____
Alcohol: Daily alcohol intake? If so when and how much?
_____
Do you take any other substances (e.g. cocaine, marijuana) **Yes** ◯ **No** ◯
If yes, what substance and how often? _____

Family History Do any member of your family have any of the following?
Insomnia _____
Narcolepsy _____
Snoring _____
Sleep Apnea _____
Restless leg syndrome_____
Sleep walking _____
Other – Describe
_____

Snoring

Has anyone told you that you snore loudly? Yes ◯ No ◯
Do you snore every night? Yes ◯ No ◯
Have you awakened with a dry mouth or dry mouth in the morning? Yes ◯ No ◯
Has anyone told you that you quit breathing or hold your breath at night? Yes ◯ No ◯
Have you ever awakened gasping for breath? Yes ◯ No ◯
Do you ever wake at night with coughing, choking, or respiratory discomfort? Yes ◯ No ◯
Do you have trouble breathing through your nose at night? Yes ◯ No ◯
Do you have morning headaches? Yes ◯ No ◯

Reflux
Do you often wake with a sour taste or burning sensation in your chest? Yes ◯ No ◯

Drowsiness/ Sleepiness / Consequences of sleepiness
Are you frequently fatigued or drowsy during the day? Yes ◯ No ◯
Have you had any accidents at work due to sleepiness? Yes ◯ No ◯
Have you had any near traffic accidents due to sleepiness? Yes ◯ No ◯

Insomnia
Do you have difficulty initiating sleep at night? Yes ◯ No ◯
Do you have difficulty staying asleep at night? Yes ◯ No ◯
Do you have pain that bothers you at night? Yes ◯ No ◯
Are you a night owl? Yes ◯ No ◯

Restless Legs Syndrome/ Periodic Limb Movement Disorder
Do you frequently kick and jerk your legs at night while trying to fall asleep? Yes ◯ No ◯

MD TRUCARE
823 IRA E WOODS AVENUE
SUITE: 200
GRAPEVINE, TX 76051

Do you have discomfort in your legs while trying to fall asleep? Yes ◯ No ◯ Does moving your legs give you relief of discomfort? Yes ◯ No ◯
Do you have tingly or discomfort in your legs during the day? Yes ◯ No ◯
Do you have discomfort in your legs when sitting for long periods? Yes ◯ No ◯

Excessive Daytime Somnolence/Narcolepsy

Do you have sudden episodes of sleep during the day? Yes ◯ No ◯
Have you ever had periods in which you feel paralyzed while going to sleep or waking up? Yes ◯ No ◯
Have you ever had visual hallucinations or dream-like mental images when falling asleep? Yes ◯ No ◯
Have you ever experienced sudden, uncontrollable muscle weakness during strong emotions? Yes ◯ No ◯
___ (such as your mouth dropping open or legs going limp during laughter or anger)
Do you experience muscle weakness when you laugh? Yes ◯ No ◯
If yes, during your episodes of muscle weakness, can you hear? Yes ◯ No ◯

Parasomnias Do you sleep walk? Yes ◯ No ◯
Do you wet the bed at night? Yes ◯ No ◯ Do you talk in your sleep? Yes ◯ No ◯
Do you ever wake up screaming? Yes ◯ No ◯
Do you have frequent nightmares or vivid dreams? Yes ◯ No ◯
Do you grind your teeth in your sleep? Yes ◯ No ◯
Do you act out in your dreams or have woken up with bruises in the morning? Yes ◯ No ◯

Exercise

Do you exercise regularly? Yes ◯ No ◯
Weight: Gained _____ lbs. or Lost _____lbs. over ____ months