UP HEALTH SYSTEM
SLEEP DISORDERS CENTER

AASM ACCREDITED Facility Member™

SLEEP DISORDERS QUESTIONNAIRE

Questionnaire must be completed in its entirety prior to Dr. Saari's review.
Please return to 890 Campus Drive, Suite B., Hancock, MI or fax to (906)-483-1960.

Patient Name: ______________________________________ **Date:** ____

Date of Birth: ________________________ **Age:** _________ **Marital Status:** _______________________________

Occupation: ____________________________ **Employer:** ____

Height: ________________ **Weight:** ________________ **Neck Size:** _____________________________________

Primary Care Physician: __________________________ **Referring Physician:** ____________________________________

Additional Physician(s) to receive sleep study report: ____

PRESENT CONDITION AND/OR REASON FOR THIS VISIT:

Why are you being referred for a sleep study? ____

____

How long have you had this problem? ____

Have you seen another doctor for this problem? ____

Have you ever had a Sleep Study before? ☐ Yes ☐ No If yes, where and when? ______________________________________

Do you have a Commercial Driver's License (CDL)? ☐ Yes ☐ No

SLEEP HISTORY:

Do you or has anyone noticed that you have the following symptoms? (check all that apply)

☐ Snore
☐ Snort
☐ Acting our your dreams
☐ Have vivid dreams
☐ Sleepy when you awaken
☐ Sleepy during the day
☐ Nap when not working
☐ Stop breathing while sleeping
☐ Have restless sleep
☐ Problems falling asleep
☐ Talk in sleep
☐ Have leg jerks
☐ Walk in sleep
☐ Other: ____
☐ Wake up gasping or choking
☐ Have morning headaches
☐ Take medicine for sleep
☐ Fall asleep when you do not mean to
☐ Feel like you have to move your legs
☐ Use the bathroom at night

What time do you usually go to bed? Weekdays _______ AM/PM Weekends _______ AM/PM

What time do you usually get out of bed? Weekdays _______ AM/PM Weekends _______ AM/PM

Have you ever had a motor vehicle accident or nearly had one due to sleepiness? ☐ Yes ☐ No

Please list any surgeries which would affect your brain, throat, facial bones, lungs or heart: ________________________________

____

Have you ever had your tonsils/adenoids surgically removed or other throat/nasal/facial surgery? Yes ☐ No ☐ If yes, what age?

____

Have you had major dental work done? Yes ☐ No ☐ If yes, please indicate status (bridges, plates, extractions, braces): ____

CHECK BOX(ES) IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

☐ Stroke or TIA
☐ Seizures
☐ Kidney disease
☐ Nasal or sinus problems
☐ High blood pressure
☐ Drug or alcohol addiction
☐ Lung disease
☐ Depression
☐ Diabetes
☐ Heart disease
☐ Thyroid problems
☐ Neurological disease

REVIEW OF SYSTEMS:

General:
☐ Fever or sweats
☐ Weight gain or loss ___ lbs.

Neurologic:
☐ Passing out
☐ Numbness or tingling
☐ Headache

Psychiatric:
☐ Depression
☐ Anxiety
☐ Stressful life event(s)

Ear, Nose, Throat:
☐ Sinus Congestion

Respiratory:
☐ Trouble breathing
☐ Coughing or wheezing

Musculoskeletal:
☐ Back pain
☐ Muscle aches or cramps
☐ Joint pain

Genitourinary:
☐ Frequent urination

Cardiovascular:
☐ Chest discomfort
☐ Rapid or skipped heartbeats

Endocrine:
☐ Heat or cold intolerance
☐ Menopausal symptoms
☐ Thyroid problems

Gastrointestinal:
☐ Nausea or vomiting
☐ Heartburn

SOCIAL HISTORY:

Do you currently smoke? ☐ Yes ☐ No

Former smoker? ☐ Yes ☐ No If yes, when did you quit? ______________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per week? ______________________

Do you currently use recreational drugs? ☐ Yes ☐ No

Do you drink caffeine: coffee/energy drink, soda or tea? ☐ Yes ☐ No If yes, how many cups per day? ___________

FAMILY HISTORY:

Is there anyone in your family with any of the following conditions?

☐ Seizures
☐ Dementia
☐ Insomnia
☐ Sleep Apnea
☐ Parkinson's Disease
☐ Excessive Sleepiness
☐ High blood pressure
☐ Coronary Artery Disease
☐ Diabetes
☐ Narcolepsy

ALLERGIES: ____

____

MEDICATIONS or include medication list.

Name	Dose	Frequency

EPWORTH SLEEPINESS SCALE (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would dose off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3 with 0 meaning you would never doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:

0 = would never doze
2 = Moderate chance of dozing

1 = Slight chance of dozing
3 = High chance of dozing

It is important that you circle a number for each of the questions.

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 – for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	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 (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3

Total Score: __________

Scoring your results

Now that you have completed the questionnaire, it is time to score your results and evaluate you own level of daytime sleepiness. It's simple. Just add up the numbers you put in each box to get you total score.

The Epworth Sleepiness Scale key

A total score of less than 10 suggests that you may not be suffering from excessive daytime sleepiness. A total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive daytime sleepiness and whether you have an underlying sleep disorder.

Your next steps

This scale should not be used to make your own diagnosis. It is intended as a tool to help you identify your own level of daytime sleepiness, which is a symptom of many sleep disorders.

If your score is 10 or more, please share this information with your physician. Be sure to describe all you symptoms, as clearly as possible, to aid in your diagnosis and treatment.

It is important to remember that the true excessive sleepiness is almost always caused by an underlying medical condition that can easily be diagnosed and effectively treated.