Coastal Neurology Services

Name____________________________**DOB**______________**Age**________ **Today's Date**__________________

General Information

Marital Status:_______ Height:_________ Weight:________ Sex:________ Neck Size:______

Occupation:________________________________ Years in this job:_______ Are you a shift worker? Y N

Usual work hours/days:_________________________________ Employer:_________________________________

PCP:____ Referring Provider:_______________________________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 indicate how you feel 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	**Chance of dozing**
Sitting and reading	__________
Watching TV	__________
Sitting, inactive in a public place (theatre, meeting, etc.)	__________
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	__________
Total…………………………………………………………………………	__________

(From John MW: A New method for measuring daytime sleepiness: The Epworth Sleepiness Scale: Sleep 14:540-545, 1991)

Questions about Your Sleep & Wake

How much do you smoke in a 24-hour period? ______ Cigarettes ______ Cigars ______ Pipes (bowls)
How often do you smoke within 2 hours of bedtime?____

How many cups a day do you drink of:	**How often within 2 hours of bedtime?**		
Caffeinated Coffee/Tea?_________	☐ Never	☐ Sometimes	☐ Often
Caffeinated Soft Drinks?_________	☐ Never	☐ Sometimes	☐ Often
Energy Drinks? _________	☐ Never	☐ Sometimes	☐ Often
Beer/Liquor/Wine? _________	☐ Never	☐ Sometimes	☐ Often

How often do you use:			
Marijuana	☐ Never	☐ Sometimes	☐ Often
Cocaine	☐ Never	☐ Sometimes	☐ Often
Hallucinogins	☐ Never	☐ Sometimes	☐ Often
Stimulants (uppers)	☐ Never	☐ Sometimes	☐ Often
Depressants (downers)	☐ Never	☐ Sometimes	☐ Often
Narcotics (heroin, morphine, opium, etc)	☐ Never	☐ Sometimes	☐ Often

Name:______________________________ Date of birth:______________________

Questions about Your Sleep & Wake

Do you exercise?__________ How often?____________ What type?______________
What medications do you use now to help you fall asleep?______________________________
What medications do you use now to help you stay awake?______________________________

Falling Asleep

What time do you usually go to bed? Workdays________ Weekends________
How many hours of sleep do you get on an average night? Workdays________ Weekends________
How long does it take you to fall asleep? ______________________________

When falling asleep, how often do you:

Have thoughts racing through your mind?	☐ Never	☐ Sometimes	☐ Often
Feel sad or depressed?	☐ Never	☐ Sometimes	☐ Often
Have anxiety or worry about things?	☐ Never	☐ Sometimes	☐ Often
Feel muscular tension?	☐ Never	☐ Sometimes	☐ Often
Feel unable to move (paralyzed)?	☐ Never	☐ Sometimes	☐ Often
Notice that parts of your body startle or jerk?	☐ Never	☐ Sometimes	☐ Often
Experience an irresistible urge to move your legs?	☐ Never	☐ Sometimes	☐ Often
Feel creeping, crawling, aching or twitching feelings in legs?	☐ Never	☐ Sometimes	☐ Often
Have vivid dream-like scenes even though you know you're awake?	☐ Never	☐ Sometimes	☐ Often
Experience pain or discomfort?	☐ Never	☐ Sometimes	☐ Often
Suddenly become awake or alert?	☐ Never	☐ Sometimes	☐ Often

Asleep

How many times do you usually awaken each night? ______________
If you awaken during the night, when does it usually occur? ☐ First half of sleep period ☐ Second half of sleep
How long does it take you to get back to sleep after you awaken?______________

My sleep is frequently disturbed by: ☐ Heat ☐ Cold ☐ Choking ☐ Bed Partner ☐ Hunger ☐ Asthma ☐ Pets ☐ Thirst ☐ Indigestion ☐ Cough ☐ Chest pain ☐ Shortness of breath ☐ Need to urinate ☐ Nightmares ☐ Noise

Are there pets in the room?__________ If yes, do they sleep with you?__________

How often do you:

Have restless/disturbed sleep?	☐ Never	☐ Sometimes	☐ Often
Sleep with someone else in your bed?	☐ Never	☐ Sometimes	☐ Often
Sleep with someone else in your room?	☐ Never	☐ Sometimes	☐ Often
Get up at night to attend to your children or someone else?	☐ Never	☐ Sometimes	☐ Often
Fear you won't return to sleep after waking?	☐ Never	☐ Sometimes	☐ Often
Snore loudly?	☐ Never	☐ Sometimes	☐ Often
Feel your heart pounding?	☐ Never	☐ Sometimes	☐ Often
Sweat a lot during the night?	☐ Never	☐ Sometimes	☐ Often
Walk in your sleep?	☐ Never	☐ Sometimes	☐ Often
Fall out of bed while asleep?	☐ Never	☐ Sometimes	☐ Often
Wake up screaming, violent or confused?	☐ Never	☐ Sometimes	☐ Often
Have unusual movements while asleep?	☐ Never	☐ Sometimes	☐ Often
Wet the bed?	☐ Never	☐ Sometimes	☐ Often
Dream?	☐ Never	☐ Sometimes	☐ Often
Grind your teeth at night?	☐ Never	☐ Sometimes	☐ Often

Name:________________________________ Date of birth:____________________

Waking Up

What time do you usually have your final awakening? Weekday________am/pm Weekend________am/pm

How often do you:

Depend on an alarm clock to wake up?	☐ Never	☐ Sometimes	☐ Often
"Sleep-in" in the morning (1hour past usual wake up time)?	☐ Never	☐ Sometimes	☐ Often
Have a very hard time waking up?	☐ Never	☐ Sometimes	☐ Often
Feel unable to move when waking up?	☐ Never	☐ Sometimes	☐ Often
Have dream-like images when waking up even though you're not asleep?	☐ Never	☐ Sometimes	☐ Often
Wake up confused/disoriented?	☐ Never	☐ Sometimes	☐ Often
Wake up with a headache?	☐ Never	☐ Sometimes	☐ Often
Wake up nauseous (sick to your stomach)?	☐ Never	☐ Sometimes	☐ Often
Wake up with a dry mouth?	☐ Never	☐ Sometimes	☐ Often
Wake up 1-2 hours before you have to?	☐ Never	☐ Sometimes	☐ Often

Bed Partner Questionnaire

Name of Patient:____________________ Date of birth:__________ Today's Date:__________

Name of person completing this portion of the questionnaire:______________________________

I have observed this person's sleep: ☐ Never ☐ Once or twice ☐ Often ☐ Every Night

Check any of the following behaviors you have observed this person doing **while asleep**:

☐ Light snoring ☐ Loud snoring ☐ Occasional loud snorts ☐ Choking
☐ Pauses in breathing ☐ Grinding teeth ☐ Sleepwalking ☐ Bed wetting
☐ Biting tongue ☐ Crying out ☐ Awakening in pain ☐ Head rocking/banging
☐ Becoming very rigid or shaking ☐ Sitting up in bed when not awake
☐ Twitching/kicking of legs during sleep ☐ Twitching/jerking of arms during sleep
☐ Getting out of bed when not awake ☐ Apparently sleeping even if he/she behaves otherwise
☐ Other: ____
____
____

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

____
____
____
____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? If yes, please explain.

____
____
____