At Home Sleep Studies, LLC
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Name (First):_____ (MI)_____ (Last)_____

Age:_____ Weight:_____ Height:_____ Neck Size:_____inches Occupation:_____

EPWORTH SLEEPINESS SCALE (0 – 3)

0 = would never feel sleepy
1 = *slight* chance of being sleepy
2 = *moderate* chance of being sleepy
3 = *high* chance of being sleepy

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (meeting, theater)	_____
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 eating lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total Points	_____

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

MY MAIN SLEEP COMPLAINT(S)

- ❑ Trouble sleeping at night for how long months:_____ and years_____
- ❑ Being sleepy all day for how long months:_____ and years_____
- ❑ Snoring for how long months:_____ and years_____
- ❑ Unwanted behaviors during sleep for how long months:_____ and years_____
  Explain Behavior:_____
- ❑ Other, Explain:_____

SLEEP HABITS

- ❑ I usually watch TV or read in bed prior to sleep
- ❑ I often travel across 2 or more time zones
- ❑ I drink alcohol prior to bedtime
- ❑ I smoke prior to bedtime or when I awaken during the night
- ❑ I eat a snack at bedtime
- ❑ I eat if I wake up during the night
- ❑ I typically wake up from sleep to go to the bathroom
- ❑ I have trouble falling asleep
- ❑ I often wake up during the night
- ❑ I am unable to return to sleep easily if I wake up during the night
- ❑ I have thoughts that start racing through my mind when I try to fall asleep
- ❑ I wake up early in the morning, and I am still tired but unable to return to sleep
- ❑ I have nightmares as an adult
- ❑ I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep
- ❑ I sweat a great deal during sleep
- ❑ I cannot sleep on my back

BREATHING

- ❑ I have been told that I stop breathing while I sleep
- ❑ I wake up at night choking, smothering or gasping for air
- ❑ I have been told that I snore
- ❑ I have been told that I snore only when sleeping on my back
- ❑ I have been awakened by my own snoring

RESTLESSNESS

- ❑ I have uncomfortable feelings in my legs and/or arms during sleep
- ❑ I have to move my legs or walk to relieve the uncomfortable feelings in my legs
- ❑ I am a restless sleeper
- ❑ I have been told that I jerk my legs and/or arms during sleep
- ❑ I have a hard time falling asleep because of my leg movements
- ❑ I have talked in my sleep as an adult
- ❑ I have walked in my sleep as an adult
- ❑ I grind my teeth in my sleep

DAYTIME SLEEPINESS

- ❑ I take daytime naps
- ❑ I have a tendency to fall asleep during the day
- ❑ I have had "blackouts" or periods when I am unable to remember just happened
- ❑ I have fallen asleep while driving
- ❑ I have had auto accidents as a result of falling asleep while driving
- ❑ I fall asleep while watching TV
- ❑ I fall asleep during conversations
- ❑ I fall asleep in sedentary situations
- ❑ I performed poorly in school because of sleepiness
- ❑ I have had injuries as the result of sleepiness
- ❑ I have had sudden muscle weakness in response to emotions such as laughter, anger, or surprise
- ❑ I have had an inability to move while falling asleep or when waking up
- ❑ I have had hallucinations or dreamlike images or sounds when falling asleep or waking up

HABITS

Do you smoke? ❑ Yes ❑ No **IF YES: What Type and Amount Per Day For How Many Years**

❑ Cigarettes _____ pack(s) _____ years

❑ Cigars _____ cigars _____ years

❑ Tobacco _____ pipes _____ years

Do you drink alcohol? ❑ Yes ❑ No **IF YES: What Type and Frequency Amount Per Week**

❑Beer ❑Daily ❑Weekends ❑Rare _____ cans/week

❑Wine ❑Daily ❑Weekends ❑Rare _____ glasses/week

❑Liquor ❑Daily ❑Weekends ❑Rare _____ shots/week

PAST SLEEP EVALUATION AND TREATMENT

❑ I have had a previous sleep disorder evaluation or been previously treated for a sleep disorder

❑ I have had previous overnight sleep studies ❑ In-Lab ❑ Home Sleep Test ❑ Pulse Oximetry

❑ My last overnight sleep study was ❑ When:_____ ❑ Where:_____

❑ I have had daytime nap studies

❑ I currently use home Oxygen Your Oxygen Setting/LPM:_____

❑ I currently use PAP equipment for home use ❑ CPAP ❑ BiPAP ❑ ASV Your PAP Settings:_____

❑ I have had surgical treatment for a sleep disorder ❑ Year of Surgery:_____

❑ I have previously been prescribed medication for a sleep disorder

❑ I have taken Sleeping Aids for sleeping or helping stay awake. Did Sleeping Aid Work? ❑ Yes ❑ No

GENERAL

- ❑ I sleep with someone else in my bed/in my room
- ❑ I fall out of bed while asleep
- ❑ I wet my bed
- ❑ I walk in my sleep
- ❑ I grind my teeth
- ❑ I have dreams
- ❑ I feel afraid I won't return to sleep after awakening
- ❑ I have a very hard time waking up
- ❑ I wake up screaming, violent or confused
- ❑ I depend on an alarm clock to wake up
- ❑ I wake up with a headache
- ❑ I wake up nauseous (sick to my stomach)
- ❑ I wake up with a dry mouth
- ❑ I wake up 1 or 2 hours before I have to get up

MY SLEEP IS FREQUENTLY DISTURBED BY (CHECK ALL THAT ARE TRUE)

❑Asthma	❑Heat	❑Cold	❑Light	❑Noise	❑Noise or Movement of Bed Partner
❑Cough	❑Hunger	❑Thirst	❑Need To Urinate	❑Choking Indigestion, "Gas" or Heartburn	
❑Chest Pain	❑Frightening Dreams		❑Shortness of Breath	❑Creeping, Crawling, Or Aching Feeling	

HEALTH HISTORY

Has your weight changed recently? ❑Yes ❑No IF YES, explain:_____

Please check any condition or illness you have or had:

☐ Allergies	☐ Depression	☐ Hemophilia (Bleeder)	☐ MRSA
☐ Arthritis	☐ Diabetes	☐ Hepatitis	☐ Muscle Cramps
☐ Asthma	☐ Dizziness	☐ Hernia	☐ Pneumonia
☐ Atrial Fibrillation	☐ Eye Trouble	☐ High Blood Pressure	☐ Prostate Trouble
☐ Back Trouble	☐ Fainting	☐ HIV/AIDS	☐ Ringing of the Ears
☐ Black Outs	☐ Gout	☐ Impotence	☐ Seizures
☐ Bladder Trouble	☐ Headaches	☐ Insomnia	☐ Stroke
☐ Bronchitis	☐ Hearing Trouble	☐ Kidney Trouble	☐ Tuberculosis
☐ Cancer	☐ Heart Attack	☐ Low Blood Pressure	☐ Ulcers
☐ CHF	☐ Heart Disease	☐ Meningitis	☐ Venereal Disease
☐ COPD	☐ Heartburn/GERD	☐ Mental Problems	☐ Other:_____

SURGERIES AND HOSPITALIZATIONS

Please list any hospitalizations and/or surgeries you have had. PLACE THE LATEST FIRST: include where, what, why, and when.

_____

_____

_____

_____

_____

CHECK ONE BOX FOR EACH STATEMENT OF USAGE

		Never	Sometimes	Often
A.	Marijuana	❑	❑	❑
B.	Cocaine	❑	❑	❑
C.	Hallucinogens (LSD, Mescaline, Angel dust, etc.)	❑	❑	❑
D.	Stimulants (uppers)	❑	❑	❑
E.	Depressants (downers)	❑	❑	❑
F.	Narcotics (heroin, morphine, opium, etc.)	❑	❑	❑

Please list the name and dose (in mg) of all medications that you take **now** or **within the past 30 days**:

Medication	Dose	What for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the name of any pill for sleeping or to help you stay awake that you have taken in the past.

Name	Did it help?
_____	❑Yes ❑No
_____	❑Yes ❑No

BED PARTNER QUESTIONNAIRE

Name of Patient:_____

Name of person filling out this form: _____

I have observed this person's sleep: ❑ Never ❑ Once or Twice ❑ Often ❑ Every Night

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

❑ Light snoring	❑ Loud Snoring	❑ Occasional loud snorts
❑ Choking	❑ Pauses in breathing	❑ Twitching or kicking of the legs
❑ Bed Wetting	❑ Biting tongue	❑ Twitching or jerking of the arms
❑ Crying Out	❑ Head rocking or banging	❑ Sitting up in bed not awake
❑ Awakening with pain	❑ Getting out of bed but not awake	❑ Becoming very rigid and/or shaking even if s/he behaves otherwise

❑ Other:_____

Please describe the other 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?
❑ Yes ❑ No If yes, please explain:

_____