University Health Care
Sleep~Wake Center

Date____ / ____ / ____

Name________________________, ______________________, _________
Last First MI

DOB________________ Age_______ Current Occupation________________________

Home Phone______________ Work phone____________ Cell Phone________________

Ethnicity : ☐ White ☐ Hispanic ☐ Asian ☐ African American ☐ American Indian
☐ Pacific Islander ☐ Other_____________________________________
What is your primary language?_____________________________

Have you ever had: (please check any of the following that apply)
Previous evaluation for your sleep disturbance? ☐ no ☐ yes, from whom______________

A measurement of your nighttime oxygen levels? (overnight oximetry)
☐ no ☐ yes: ☐ normal ☐ abnormal ☐ don't know

A sleep study performed in a sleep lab?
☐ no ☐ yes: ☐ normal ☐ abnormal ☐ don't know

I am currently using ☐ CPAP ☐ BiLevel ☐ Oxygen

☐ I have tried to use CPAP/BiLevel/Oxygen, but was unable to wear it.

For the next four questions, try to pick the single best answer that applies to you.

1) The main reason that I am here is:
- ☐ I think I have a sleep problem
- ☐ My bed partner or someone who saw me sleeping thinks I have a sleep problem
- ☐ My doctor or another health care provider thinks I have a sleep problem
- ☐ I need a sleep evaluation to maintain/reinstate a professional license
- ☐ I am not sure why I am here

2) The most worrisome concern I have about my sleep problem is:
- ☐ My sleep problem is impacting my quality of life (for example: I am often very tired)
- ☐ My sleep problem may be causing or contributing to another medical problem
- ☐ I am worried my sleep problem my damage my health
- ☐ I am worried about my safety, or the safety of others
- ☐ My sleep problem causes someone else not to sleep well
- ☐ I am concerned that my sleep problem may impact my professional license
- ☐ I do not really have any specific concerns, but it was recommended I make this appointment

3) The most important thing I need from this clinic visit is:

- ☐ To determine if I have a sleep problem
- ☐ To treat the sleep problem that I have
- ☐ To feel better
- ☐ To satisfy the person who referred me
- ☐ Clearance for professional activities
- ☐ Unsure

4) The worst symptom I have related to my sleep problem is:

- ☐ Tiredness
- ☐ Fatigue
- ☐ Can't go to sleep when I want to
- ☐ Can't stay asleep
- ☐ Snoring or irregular breathing that bothers someone else
- ☐ Movements or behaviors that bother someone else
- ☐ I don't have any of these things

TYPICAL **WEEKDAY** SLEEP SCHEDULE

I first get into bed at approximately ____________ ☐ p.m. ☐ a.m.

I turn out the lights at approximately _____________ ☐ p.m. ☐ a.m.

It takes approximately _________ minutes to fall asleep.

I wake up approximately _________ times per night.

I have difficulty getting back to sleep: USUALLY ☐ RARELY ☐

My final awakening is approximately: ______ to ______ ☐ p.m. ☐ a.m.

After my final awakening, I usually get out of bed:

IMMEDIATELY ☐ AFTER MORE THAN 30 MINUTES ☐

TYPICAL **WEEKEND** SLEEP SCHEDULE

I first get into bed at approximately ____________ ☐ p.m. ☐ a.m.

I turn out the lights at approximately _____________ ☐ p.m. ☐ a.m.

It takes approximately _________ minutes to fall asleep.

I wake up approximately _________ times per night.

I have difficulty getting back to sleep: USUALLY ☐ RARELY ☐

My final awakening is approximately: ______ to ______ ☐ p.m. ☐ a.m.

After my final awakening, I usually get out of bed:

IMMEDIATELY ☐ AFTER MORE THAN 30 MINUTES ☐

Please check all that apply to you.

- ☐ I have snoring that bothers other people
- ☐ I only snore when I am lying flat on my back
- ☐ I have been told that I stop breathing in my sleep
- ☐ I have awakened feeling short of breath or choking
- ☐ No matter how hard I try to stay awake during the day, I often fall asleep, even if I've had a full night's sleep
- ☐ Sleepiness is a problem during work or at school.
- ☐ I feel drowsy when driving, even if I've had a full night's sleep.
- ☐ At night, I am usually quite concerned about whether I will be able to **fall** asleep
- ☐ At night, I am usually quite concerned about whether I will be able to **stay** asleep
- ☐ I have relied on sleeping pills/aides (list)________________________________
- ☐ I do not look forward to bedtime because I always have trouble sleeping
- ☐ Thoughts flood my mind and prevent me from sleeping.
- ☐ I frequently wake up in the middle of the night and can't go back to sleep.
- ☐ I wake up too early in the morning.
- ☐ I worry and have trouble relaxing.
- ☐ I lie awake for at least 30 minutes or more before I can fall asleep.
- ☐ There are things in my sleep environment that keep me awake or wake me up (example: pets)
- ☐ I leave the TV/radio on when I go to sleep
- ☐ I read in bed
- ☐ I have a strong tendency to got to bed late and wake up late
- ☐ I have a strong tendency to go to bed early and wake early
- ☐ My sleep pattern is quite variable
- ☐ I have a shift work schedule (specify work hours __________________)

  I feel I get enough sleep ☐ often ☐ sometimes ☐ rarely
- ☐ I sleep walk
- ☐ I sleep talk
- ☐ I have very scary dreams/nightmares
- ☐ I eat in my sleep
- ☐ I grind my teeth
- ☐ My legs bother me at night
- ☐ I have "Charlie Horses"/ muscle cramps in my legs at night
- ☐ Although I can sleep through the night or during the day, I feel muscle tension, crawling sensations, or my legs ache
- ☐ My legs bother me at night and feel better when I move them
- ☐ Strange things happen to me as I am falling asleep

☐ I have a weakness and or loss of strength if I experience a sudden, strong emotion
☐ While falling asleep or shortly afterwards, I experience vivid, dreamlike scenes
☐ I often feel paralyzed for brief periods while falling asleep or just after waking up

Please check all that apply

I have a family history of:
☐ Insomnia ☐ Narcolepsy ☐ Sleep Apnea ☐ Restless legs
☐ Excessive sleepiness ☐ Snoring

I have had surgery on, or for: ☐ vocal cords ☐ nose ☐ palate ☐ airway ☐ sinuses
☐ jaw ☐ brain ☐ thyroid ☐ acid reflux ☐ gastric bypass/banding

Please list any other surgeries not listed above ____

I need assistance with ☐ walking ☐ dressing ☐ bathing/toileting

I am ☐ Single ☐ Married ☐ Divorced ☐ Widowed

I live ☐ alone with ☐ spouse/partner ☐ child/children ☐ other ___________________

I sleep ☐ alone with ☐ spouse/ partner ☐ child/children ☐ pets

I live in ☐ an apartment/condo ☐ a house ☐ an assisted living facility/group home

Highest level of education:
☐ Grade school ☐ High school/GED ☐ Some College ☐ Bachelors degree
☐ Graduate degree

☐ I drink caffeinated beverages. How many per day_________________________________

☐ I drink alcohol. How many drinks per day____

☐ I smoke or have smoked in the past. List number of packs per day_______, for how many years? ___________ ☐ I have quit smoking. How long ago did you quit? ________

☐ I exercise regularly (at least 3 times/week for 30 minutes)

☐ I use recreational drugs. Specify___________________________

In general, I am able to, or find it easy to follow through with treatments that are prescribed to me: ☐ highly likely ☐ somewhat likely ☐ not very likely ☐ not at all ☐ unsure

I usually feel as though I'm a participant in my health care
☐ strongly agree ☐ agree ☐ disagree ☐ strongly disagree ☐ unsure

Please check all that apply to you

- ☐ Asthma
- ☐ COPD
- ☐ Other lung disorder ___________________
- ☐ Pulmonary hypertension
- ☐ Airway abnormality (vocal cord dysfunction or paralysis, laryngomalacia)
- ☐ Hay fever/Allergies
- ☐ Gastro esophageal Reflux / acid stomach
- ☐ Peptic Ulcer
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Adrenal disease
- ☐ Seizures
- ☐ Neurological disorder __________________
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Hypertension
- ☐ Coronary disease / heart attack
- ☐ Heart failure
- ☐ Atrial Fibrillation / irregular heart rate
- ☐ Chronic Fatigue / Fibromyalgia
- ☐ Developmental Delay / Mental Retardation
- ☐ Depression
- ☐ BiPolar disorder / Schizophrenia
- ☐ other Psychiatric disorder ______________
- ☐ Chemical dependency
- ☐ Cancer ______________________________
- ☐ Dentures (Do you wear them? Yes No)

Please check all that apply to you

- ☐ persistent cough
- ☐ wheezing, coughing, or shortness of breath with exercise
- ☐ post nasal drip
- ☐ sinus congestion
- ☐ trouble swallowing or hoarseness
- ☐ problems breathing through my nose at night
- ☐ frequent sore throats
- ☐ heartburn
- ☐ frequent use of antacids (Rolaids, Tums, etc.)
- ☐ weight gain
- ☐ weight loss
- ☐ headaches
- ☐ memory loss
- ☐ chest pain at rest or with exercise
- ☐ high blood pressure
- ☐ swelling in ankles
- ☐ feeling sad, down or depressed
- ☐ feelings of anxiety or panic
- ☐ frequent nighttime urination
- ☐ impotence
- ☐ losing my sex drive
- ☐ jaw/face pain
- ☐ pain (specify where __________ how often_________________)
- ☐ night sweats
- ☐ rash/itch
- ☐ other diagnosis or symptoms not listed ________________________

MEDICATIONS I AM CURRENTLY TAKING

(include herbal supplements & over the counter medications)

Name of medication Dosage How often do you take Prescribing Provider

1)____

2) ____

3) ____

4) ____

5)____

6)____

7)____

8)____

9)____

10)____

11)____

12)____

13)____

14) ____

ALLERGIES I HAVE

Medication allergies:__________________________________

____

Latex allergies: Y or N Food allergies: ____________________________

Other:____

Who is your Primary Care Physician?____

Name of Physician/Health Care provider who referred you to the Sleep-Wake Center?

____

Are there other Physicians/Health Care providers with which you would like us to share information? If so, name and address:

____

Epworth Scale

Under normal circumstances, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number for each situation:

(0) would *never* doze or sleep.

(1) *slight* chance of dozing or sleeping

(2) *moderate* chance of dozing or sleeping

(3) *high* chance of dozing or sleeping

Please circle your answer

Sitting and reading: 0 1 2 3

Watching TV: 0 1 2 3

Sitting inactive in a public place: 0 1 2 3

Lying down in the afternoon: 0 1 2 3

Sitting and talking to someone: 0 1 2 3

Sitting quietly after lunch (no alcohol): 0 1 2 3

Riding as a passenger in a motor vehicle for an hour or more: 0 1 2 3

Stopped for a few minutes in traffic when you are driving: 0 1 2 3

Epworth total______________________/24

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE
(FOSQ)

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty performing certain activities because you are too sleepy or tired. In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, you want to "nod off", or you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

DIRECTIONS: Please put an (X) in the box for your answer to each question. Select only **one** answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

	(0) I don't do this activity for other reasons	**(4) No difficulty**	**(3) Yes, a little difficulty**	**(2) Yes, moderate difficulty**	**(1) Yes, extreme difficulty**
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?					
2. Do you generally have difficulty remembering things, because you are sleepy or tired?					
3. Do you have difficulty operating motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?					
4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?					
5. Do you have difficulty visiting with your family or friends in their home because you become sleepy or tired?					
6. Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?					
7. Do you have difficulty watching a movie or videotape because you become sleepy or tired?					
8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?					
9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?					
10. Has your desire for intimacy or sex been affected because you are sleepy or tired?					