Print Form

SLEEP HISTORY QUESTIONNAIRE

(TO BE COMPLETED BY PATIENT)

Name:_____ D.O.B._____ Date:

ATTENTION PATIENTS:

The physicians of Georgia Pulmonary Group specialize in both pulmonary medicine and sleep medicine. This questionnaire asks general questions relating to your sleep and will help us determine if you may have some kind of sleep disorder. The symptoms of some sleep disorders are obvious, like snoring, while others may be more subtle. We appreciate your assistance in helping us to provide you with the best and most complete care possible by filling out this form completely and honestly.

SYMPTOMS DURING SLEEP

Indicate by PLACING A CHECK MARK if you experience any of the following symptoms when sleeping or trying to sleep:

- ☐ Loud snoring
- ☐ Breathing or snoring stops in my sleep
- ☐ Awaken gasping for breath
- ☐ Become sleepy during the day
- ☐ Difficulty falling asleep
- ☐ Difficulty remaining asleep
- ☐ Fatigue
- ☐ Awaken with a dry mouth
- ☐ Morning headaches
- ☐ Irritability/Depression
- ☐ Memory impairment or Inability to concentrate
- ☐ Irresistible urge to move legs or arms
- ☐ Legs or arms jerking during sleep
- ☐ Frequent urination disrupting sleep
- ☐ Sleep talking or Sleep walking

Have you previously been diagnosed with a sleep disorder?_____

If yes, when and what disorder?_____

_____

_____

SLEEP HABITS

1) At what time do you usually get in the bed?____AM/PM
2) How long does it take you to fall asleep after you have turned out the lights_____minutes/hours.
3) How often do you awaken each night_____
4) Total time I spend awake in bed_____minutes/hours.
5) I usually wake up from sleep at____AM/PM
6) What time do you get out of bed from sleep____AM/PM
7) Indicate total length of naps daily_____
8) If you do rotating shift work, or have other work schedule changes and need more space to describe:

_____

EPWORTH SLEEPINESS SCALE

Always Tired? How Likely Are You To Fall Asleep In The Following Situations?

Even if you haven't experienced some of these situations recently, consider how you might be affected. Use the following scoring guide to rate your response - Be honest!

Your Score

0 = I would never fall asleep.
1 = Slight chance of falling asleep.
2 = Moderate chance of falling asleep.
3 = High chance of falling asleep.

☐	Sitting and reading
☐	Watching TV
☐	Sitting, Inactive in a public place (e.g. in a theatre or meeting)
☐	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 the traffic
☐	**Total Score**

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