USF UNIVERSITY OF SOUTH FLORIDA

DEPARTMENT OF OTOLARYNGOLOGY – HNS
SLEEP DISORDERS & DIAGNOSTIC CLINIC

Patient Name: _____ Medical Record # _____
Last First MI

Age: _____ Date of Birth: _____ Sex: M F (circle)

PHYSICIAN INFORMATION

Primary Care Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Referring Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

Name of Person Referring You to the Sleep Center: _____

Would you like your records to go to any other physician? ☐ Yes ☐ No

Other Physician: _____ Specialty: _____

Address: _____

Phone: _____ Fax: _____

1. **Briefly describe your sleep problem**: _____

_____

_____

At what age did this problem begin? _____

How does this affect your life and daily activities? _____

_____

How serious a problem is this for you on a scale of 1 to 10? (1 is not serious and 10 is very serious) _____

2. **Have you had any previous evaluations (exam or sleep study)?** ☐ Yes ☐ No

When: _____ Where: _____ Results _____

3. **Have you had any previous treatment?** ☐ Yes ☐ No

When: _____ Where: _____ What type: (i.e., CPAP) _____

4. **Please list any medications (prescribed or otherwise) that you have used to help your sleep problem**:

DRUG	AMOUNT	FREQUENCY	HOW LONG?	HOW USEFUL?	PHYSICIAN

EAR, NOSE, & THROAT CENTER
USF Eye Institute
Physical: 13131 Magnolia Dr.
Mailing: 12901 Bruce B. Downs Blvd, MDC Box 73
Tampa, FL 33612
Phone: (813) 974-4683
Fax: (813) 974-7586

SLEEP HABITS

5. **If employed, what are your usual working hours?**

   Start: _____am / pm Stop: _____am / pm

6. **Do you ever change work shifts?** ☐ Never ☐ Infrequently ☐ Regularly

7. **Write in the time you usually go to bed and get up on weekdays.**

   Go to bed _____ am / pm Get up _____ am / pm

8. **Write in the time you usually go to bed and get up on weekends**.

   Go to bed _____ am / pm Get up _____ am / pm

9. **Do you have a regular sleep partner?** ☐ Yes ☐ No

10. **On the average, how long does it take you to fall asleep?**_____ minutes

11. **What do you ordinarily do just prior to going to sleep?** (e.g. reading, TV, bath, etc)

    ☐ Reading ☐ TV ☐ Bath ☐ Exercise ☐ Eat

    Other: _____

12. **On the average, how often do you wake up during the night?** _____ times

13. **Do you ever wake up too early in the morning and then are unable to return to sleep?** ☐ Yes ☐ No

14. **On the average, how long are you actually asleep at night?** _____ hours _____ minutes

15. **How do you ordinarily awaken?** ☐ Spontaneously ☐ Alarm Clock ☐ Other

16. **How difficult is it for you to awaken and get out of bed after sleeping?**

    ☐ Very Difficult ☐ Difficult ☐ Sometimes Difficult ☐ No Problem

17. **How long does it take for you to be alert and functioning after sleeping?** _____ hours _____ minutes

18. **Do you nap or return to bed after arising?** ☐ Yes ☐ No ☐ Sometimes

    If yes, how many times per day? _____ Average length of nap: _____ hours _____ minutes

19. **Are you bothered by sleepiness during the day?** ☐ Yes ☐ No

20. **Do you feel you get too much sleep at night?** ☐ Yes ☐ No

21. **Do you feel you get too little sleep at night?** ☐ Yes ☐ No

22. **Do you usually feel tired during the day?** ☐ Yes ☐ No

    If yes, what do you attribute this to? _____

    _____

23. **Do you find yourself falling asleep when you don't mean to?** ☐ Yes ☐ No

    If yes, describe: _____

    _____

    How long does the sleep episode last? _____ Hours _____ Minutes

    Do you feel rested or refreshed after the sleep episode? ☐ Yes ☐ No

24. **Have you ever suddenly fallen?** ☐ Yes ☐ No

25. **Have you ever experienced sudden bodily weakness (jaw, head, shoulders, arms, legs)?** ☐ Yes ☐ No

If you have suddenly fallen or experienced weakness, were you aware of things around you? ☐ Yes ☐ No

Was the fall or weakness brought on by any particular event or feeling (laughter, fear, sadness, etc.)? ☐ Yes ☐ No

If so, briefly describe: _____

_____

_____

26. **Have you ever experienced muscle weakness or paralysis upon:**

Going to sleep? ☐ Yes ☐ No

Awakening from sleep? ☐ Yes ☐ No

How often does this occur? _____ Times/Week

27. **Have you experienced seeing things or hearing voices that weren't real?**

On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

28. **Have you experienced a feeling like falling or the bed moving?**

On going to sleep? ☐ Yes ☐ No

During the night? ☐ Yes ☐ No

On awakening from sleep? ☐ Yes ☐ No

During the day? ☐ Yes ☐ No

29. **Do you have difficulty breathing at night**? ☐ Yes ☐ No

If so, briefly describe: _____

_____

_____

How often? _____ Times/Night When did this first occur? _____ (Age)

30. **Have you been told you snore when you sleep?** ☐ Yes ☐ No

Does the snoring disturb:

A bed partner (or someone in the same bedroom)? ☐ Yes ☐ No

Someone in the next room? ☐ Yes ☐ No

31. **Have you been told you stop breathing when you sleep?** ☐ Yes ☐ No

32. **Have you ever experienced upon lying in bed before sleep or on awakening from sleep, a restlessness of legs, "nervous legs," a creeping crawling sensation of legs or twitching?** ☐ Yes ☐ No

How often does this occur? _____ times/week

How long does the sensation last? _____ minutes

Does anything relieve the sensation (e.g. getting out of bed, a massage, medication, etc)? _____

_____

When did you first experience this? _____ (age)

33. **Has anyone ever told you that your arms or legs jerk or twitch while you are asleep?** ☐ Yes ☐ No

If yes, how often during the night does this occur? _____ times/night

How many nights per week does this happen? _____ times/week

At what age did this come to your attention? _____

Does this seem to awaken you from sleep? ☐ Yes ☐ No

34. **Have you ever experienced doing something without being aware at the time of the action?** ☐ Yes ☐ No

If so, briefly describe: _____

_____

_____

How often does this occur? _____ times/week

35. **Do you know or do others tell you that you**:

				Treatment
Talk while apparently asleep?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Walk while apparently asleep?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Grit teeth while apparently asleep?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Wet the bed during sleep?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Wake up screaming or seemingly afraid?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Have disturbing dreams?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Have unusual movements?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Awake during the night with headaches?	☐ Yes ☐ No	_____ times/week	_____ age started	_____
Have erections while asleep (males)?	☐ Yes ☐ No	_____ times/week	_____ age started	_____

ALLERGIES *(Specify drug and reaction)*

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATIONS

Do you use any prescribed medications either regularly or occasionally? ☐ **Yes** ☐ **No**

If so, please list by name below (include over the counter medications, herbal products, supplements, and vitamins):

Name of Medication	Amount	How Often	Reason Used	How Long Used	Prescribing Physician

Give the year of your last physical examination _____

Results of this exam _____

Height: _____ inches Weight: _____ pounds Neck Size: _____inches

Have you now or ever in the past experienced any health problems or had surgery associated with the below listed areas?

	Yes	**Type of Problem**	**Dates**	**Physician, Clinic or Hospital**
A – mental health				
B – head or nervous system				
C – eyes, ears, nose, mouth, throat				
D – heart, circulation				
E – breathing (lungs)				
F – stomach, digestive				
G – urine, kidney				
H – sexual				
I – bones, joints, arms, legs				
J – diabetes, glands				
K – blood pressure				
L – weight problems				
M - other				

SOCIAL HISTORY (tobacco, caffeine, alcohol, drug use)

Do you currently smoke cigarettes? ☐ **Yes** ☐ **No** How many years? _____ # packs per day _____

Have you used tobacco products like cigars, pipes, or smokeless tobacco? ☐ **Yes** ☐ **No**

How many years? _____ # per day _____

Do you currently consume alcohol? ☐ **Yes** ☐ **No**

How many years? _____ What type? _____ Amount per day _____

On the average, how many alcoholic beverages do you drink on weekdays? _____ drinks/day

On the average, how many alcoholic beverages to you drink on weekends? _____ drinks/day

Have you received treatment for substance abuse? ☐ **Yes** ☐ **No**

On average, how much do you drink of the following beverages?

Coffee _____ cups/day

Tea _____ cups/day

Carbonated or other soft drinks _____ bottles/day

OCCUPATIONAL HISTORY

Current job _____ Year started _____

Previous positions _____

FAMILY HISTORY

Marital Status _____ Number of Children _____ Ages _____

Family Member	Age	Living	Deceased	Illnesses*	Cause of Death	List Sleep Problems
Father						
Mother						
Brothers						
Sisters						
Children (indicate sex)						

Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses.

REVIEW OF SYSTEMS *Check all responses that apply.*

General	**Yes**	**No**
Weight gain/loss	☐	☐
Difficulty falling asleep	☐	☐
Need to cut down alcohol consumption	☐	☐
Fever	☐	☐
Change in appetite	☐	☐

Skin	**Yes**	**No**
Rash, sore, or excessive bruising	☐	☐
Lump or growth on skin	☐	☐

Eyes	**Yes**	**No**
Wear glasses	☐	☐
Decreased vision	☐	☐
Pain in eyes	☐	☐

Ears, Nose, Throat, Mouth	**Yes**	**No**
Difficulty or changes in hearing	☐	☐
Earaches	☐	☐
Discharge from ears	☐	☐
Buzzing or ringing in ears	☐	☐
Frequent sneezing	☐	☐
Nose stuffiness or running	☐	☐
Recurrent sore throat	☐	☐
Persistent hoarseness	☐	☐
Dental problems	☐	☐
Sinus problems	☐	☐
Lymph glands or nodes	☐	☐
Frequent nose bleeds	☐	☐

Genitourinary	**Yes**	**No**
Painful urination	☐	☐
Frequent urination	☐	☐
Blood in urine	☐	☐
Difficulty emptying bladder	☐	☐

Musculoskeletal	**Yes**	**No**
Painful joints	☐	☐
Sore muscles	☐	☐
Back pain	☐	☐
Pain in calves of legs	☐	☐
Weakness in extremities	☐	☐
Numbness in extremities	☐	☐

Neuropsychiatric	**Yes**	**No**
Anxiety	☐	☐
Depression	☐	☐
Frequent or severe headaches	☐	☐
Dizziness or faintness	☐	☐
More nervous than average person	☐	☐

Cardiovascular	**Yes**	**No**
Chest pain	☐	☐
Shortness of breath	☐	☐
Abnormal swelling in legs/feet	☐	☐
Fatigue or tire easily	☐	☐

Respiratory	**Yes**	**No**
Cough	☐	☐
Blood in sputum	☐	☐
Wheezing	☐	☐

Endocrine	**Yes**	**No**
Excessive thirst or urination	☐	☐
Change in sexual drive/performance	☐	☐
Change in heat or cold tolerance	☐	☐

Gastrointestinal	**Yes**	**No**
Frequent heartburn/indigestion	☐	☐
Nauseas or vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Ulcers	☐	☐

For Women Only	**Yes**	**No**
Irregular periods	☐	☐
Bleeding between periods	☐	☐
Are you pregnant	☐	☐
Date of last menstrual period	___/___/___	
Ever have an abnormal Pap smear	☐	☐
Lump or growth on breast	☐	☐

Allergic/Immunologic	**Yes**	**No**
Hayfever	☐	☐
Hives	☐	☐
Immunodeficiency	☐	☐

Hematologic/Lymphatic	**Yes**	**No**
Anemia	☐	☐
Excessive bleeding or bruising	☐	☐
Blood Transfusion	☐	☐

Reviewed by:

_____MD _____ Date

_____RN _____ Date

USF
UNIVERSITY OF
SOUTH FLORIDA

HOSPITAL ANXIETY AND DEPRESSION SCALE

This questionnaire is designed to help your doctor know how you feel. Ignore the numbers printed on the left of the questionnaire. Read each item and underline the reply that comes closest to how you have been feeling in the last week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than an exhaustively considered response.

A **I feel tense or "wound up"**
- 3 All of the time
- 2 A lot of the time
- 1 From time to time, occasionally
- 0 Not at all

D **I still enjoy things I used to enjoy**
- 0 Definitely as much
- 1 Not quite so much
- 2 Only a little
- 3 Hardly at all

A **I get a sort of frightened feeling as if something awful is about to happen**
- 3 Very definitely and quite badly
- 2 Yes, but not too badly
- 1 A little, but it doesn't worry me
- 0 Not at all

D **I can laugh and see the funny side of things**
- 0 As much as I always could
- 1 Not quite so much now
- 2 Definitely not so much now
- 3 Not at all

A **Worrying thoughts go through my mind**
- 3 A great deal of the time
- 2 A lot of the time
- 1 From time to time, but not too often
- 0 Only occasionally

D **I feel cheerful**
- 3 Not at all
- 2 Not often
- 1 Sometimes
- 0 Most of the time

A **I can sit at ease and feel relaxed**
- 0 Definitely
- 1 Usually
- 2 Not often
- 3 Not at all

D **I feel as if I am slowed down**
- 3 Nearly all of the time
- 2 Very often
- 1 Sometimes
- 0 Not at all

A **I get a sort of frightened feeling, like "butterflies in the stomach"**
- 0 Not at all
- 1 Occasionally
- 2 Quite often
- 3 Very often

D **I have lost interest in my appearance**
- 3 Definitely
- 2 I don't take as much care as I should
- 1 I may not take as much care
- 0 I take just as much care as ever

A **I feel restless, as though I have to be on the move**
- 3 Very much indeed
- 2 Quite a lot
- 1 Not very much
- 0 Not at all

D **I look forward with enjoyment to things**
- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

A **I get sudden feelings of panic**
- 3 Very often indeed
- 2 Quite often
- 1 Not very often
- 0 Not at all

D **I can enjoy a good book, radio or TV program**
- 0 Often
- 1 Sometimes
- 2 Not often
- **3** Very seldom

A Total: _____ D Total : _____

Name: _____ Date: _____

USF
UNIVERSITY OF
SOUTH FLORIDA

THE EPWORTH SLEEPINESS SCALE

Name: _____

Date: _____ Your Age: _____

Sex (male=M, female=F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 imagine how they would have affected you. Use the following scale to choose *the most appropriate number* for each situation.

0 = would ***never*** dose
1 = ***slight*** chance of dosing
2 = ***moderate*** chance of dosing
3 = ***high*** chance of dosing

Situation:	**Chance of Dosing:**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation. Total: _____

_____