



**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Walk while apparently asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Grit teeth while apparently asleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Wet the bed during sleep?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Wake up screaming or seemingly afraid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Have disturbing dreams?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Have unusual movements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Awake during the night with headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ times/week	_____ age started	_____
Have erections while asleep (males)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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**

- |                                      | <b>Yes</b>               | <b>No</b>                |
|--------------------------------------|--------------------------|--------------------------|
| Weight gain/loss                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty falling asleep            | <input type="checkbox"/> | <input type="checkbox"/> |
| Need to cut down alcohol consumption | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite                   | <input type="checkbox"/> | <input type="checkbox"/> |

**Skin**

- |                                   | <b>Yes</b>               | <b>No</b>                |
|-----------------------------------|--------------------------|--------------------------|
| Rash, sore, or excessive bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Lump or growth on skin            | <input type="checkbox"/> | <input type="checkbox"/> |

**Eyes**

- |                  | <b>Yes</b>               | <b>No</b>                |
|------------------|--------------------------|--------------------------|
| Wear glasses     | <input type="checkbox"/> | <input type="checkbox"/> |
| Decreased vision | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in eyes     | <input type="checkbox"/> | <input type="checkbox"/> |

**Ears, Nose, Throat, Mouth**

- |                                  | <b>Yes</b>               | <b>No</b>                |
|----------------------------------|--------------------------|--------------------------|
| Difficulty or changes in hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Earaches                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge from ears              | <input type="checkbox"/> | <input type="checkbox"/> |
| Buzzing or ringing in ears       | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent sneezing                | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose stuffiness or running       | <input type="checkbox"/> | <input type="checkbox"/> |
| Recurrent sore throat            | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent hoarseness            | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental problems                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Lymph glands or nodes            | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nose bleeds             | <input type="checkbox"/> | <input type="checkbox"/> |

**Genitourinary**

- |                             | <b>Yes</b>               | <b>No</b>                |
|-----------------------------|--------------------------|--------------------------|
| Painful urination           | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent urination          | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in urine              | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty emptying bladder | <input type="checkbox"/> | <input type="checkbox"/> |

**Musculoskeletal**

- |                         | <b>Yes</b>               | <b>No</b>                |
|-------------------------|--------------------------|--------------------------|
| Painful joints          | <input type="checkbox"/> | <input type="checkbox"/> |
| Sore muscles            | <input type="checkbox"/> | <input type="checkbox"/> |
| Back pain               | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain in calves of legs  | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness in extremities | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness in extremities | <input type="checkbox"/> | <input type="checkbox"/> |

**Neuropsychiatric**

- |                                  | <b>Yes</b>               | <b>No</b>                |
|----------------------------------|--------------------------|--------------------------|
| Anxiety                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent or severe headaches     | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness or faintness           | <input type="checkbox"/> | <input type="checkbox"/> |
| More nervous than average person | <input type="checkbox"/> | <input type="checkbox"/> |

**Cardiovascular**

- |                                | <b>Yes</b>               | <b>No</b>                |
|--------------------------------|--------------------------|--------------------------|
| Chest pain                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath            | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal swelling in legs/feet | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue or tire easily         | <input type="checkbox"/> | <input type="checkbox"/> |

**Respiratory**

- |                 | <b>Yes</b>               | <b>No</b>                |
|-----------------|--------------------------|--------------------------|
| Cough           | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in sputum | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing        | <input type="checkbox"/> | <input type="checkbox"/> |

**Endocrine**

- |                                    | <b>Yes</b>               | <b>No</b>                |
|------------------------------------|--------------------------|--------------------------|
| Excessive thirst or urination      | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in sexual drive/performance | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in heat or cold tolerance   | <input type="checkbox"/> | <input type="checkbox"/> |

**Gastrointestinal**

- |                                | <b>Yes</b>               | <b>No</b>                |
|--------------------------------|--------------------------|--------------------------|
| Frequent heartburn/indigestion | <input type="checkbox"/> | <input type="checkbox"/> |
| Nauseas or vomiting            | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood in stool                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers                         | <input type="checkbox"/> | <input type="checkbox"/> |

**For Women Only**

- |                                 | <b>Yes</b>               | <b>No</b>                |
|---------------------------------|--------------------------|--------------------------|
| Irregular periods               | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding between periods        | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant                | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of last menstrual period   | ____/____/____           | ____/____/____           |
| Ever have an abnormal Pap smear | <input type="checkbox"/> | <input type="checkbox"/> |
| Lump or growth on breast        | <input type="checkbox"/> | <input type="checkbox"/> |

**Allergic/Immunologic**

- |                  | <b>Yes</b>               | <b>No</b>                |
|------------------|--------------------------|--------------------------|
| Hayfever         | <input type="checkbox"/> | <input type="checkbox"/> |
| Hives            | <input type="checkbox"/> | <input type="checkbox"/> |
| Immunodeficiency | <input type="checkbox"/> | <input type="checkbox"/> |

**Hematologic/Lymphatic**

- |                                | <b>Yes</b>               | <b>No</b>                |
|--------------------------------|--------------------------|--------------------------|
| Anemia                         | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive bleeding or bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Transfusion              | <input type="checkbox"/> | <input type="checkbox"/> |

Reviewed by:

\_\_\_\_\_ MD \_\_\_\_\_ Date  
 \_\_\_\_\_ RN \_\_\_\_\_ Date



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: \_\_\_\_\_





### 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* doze
- 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: \_\_\_\_\_  
\_\_\_\_\_