

TEL: 631.444.2500 FAX: 631.444.2580

Why are you being seen in the sleep clinic?

Have you had a sleep evaluation in the past? (if yes, when/where and which CPAP machine did you receive?) \_\_\_\_\_

## SLEEP HABITS

## WHILE FALLING ASLEEP:

What time do you usually go to bed on weeldays/workdays? \_ : \_ am/pm How long does it take you to fall asleep? \_\_\_\_\_ minutes

What time do you usually go to bed on weekends/days off? : am/pm How long does it take you to fall asleep? \_\_\_\_ minutes

#### As you are falling sleep, do you experience:

 Restless leg syndrome (Urge to move your legs, or a crawling, creeping, pulling, or itching sensation relieved by moving your legs)

- · Visual, tactile, or auditory hallucinations
- Often experiencing an inability to relax
- Intense thoughts

## WHILE ASLEEP, DO YOU ...:

٠	Snores heavily.	If yes, how many times per week:
•	Stop breathing.	If yes, how many times per week:
•	Awaken choking or gasping.	If yes, how many times per week:
•	Teeth grinding.	If yes, how many times per week:
•	Act out your dreams.	If yes, how many times per week:
•	Have nightmares.	If yes, how many times per week:
•	Sleep walk.	If yes, how many times per week:
•	Sleep talk.	If yes, how many times per week:
•	Eat while you are asleep.	If yes, how many times per week:

How many times do you wake up in a typical night? \_\_\_\_

How long does it usually takes you to fall back to sleep? \_\_\_\_ minutes. What causes you to wake up (check all that apply)?

- Snoring
  Pain
  Choking/gasping
  Full bladder
  Bed partner/

  - Bed partner/kids/pets

- Pain Thirst
- Hunger Worries

Bedroom noise

## WAKING UP:

What time do you usually awaken on weekdays/workdays? \_\_: \_\_ am/pm



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To an alarm clock • Spontaneously
How many hours do you sleep per weeknight/worknight? \_\_\_\_ hours.
How many hours do you spend in bed per weeknight? \_\_\_\_ hours.
Is it refreshing: • Never/Rarely • Sometimes • Often/Always

What time do you usually awaken on weekends/days off? \_ : \_ am/pm

To an alarm clock • Spontaneously How many hours do you sleep on those nights? \_\_\_\_ hours. How many hours do you spend in bed on those nights? \_\_\_\_ hours. Is it refreshing: • Never/Rarely • Sometimes • Often/Always

Upon awakening, do you experience:

- Congested nose
- Dry mouth
   Sore throat
- Morning headache
- Bed in disarray
  Paralysis
  Sudden extreme muscle weakness (cataplexy)
- Hallucinations
   Sudden ex

# DURING THE DAY:

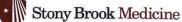
How many naps do you take daily? \_\_\_\_ How many minutes is each nap? \_\_\_\_ Do you feel refreshed after the nap(s)? • Yes • Sometimes • No

Are you sleepy while driving?• Yes • Sometimes • NoAre you honked at red lights?• Yes • Sometimes • NoHave you had a motor vehicle accident related to sleepiness? • Yes • NoDo you have narcolepsy (overwhelming daytime drowsiness & sudden attacks of sleep) • Yes • NoDo you have cataplexy (sudden loss of muscle tone) • Yes • No

Do you have the following (central sensitization syndromes) somatic symptom disorders?

- Chronic Fatigue Syndrome
- Chronic migraine or tension-type headaches
- Temporomandibular joint (TMJ) syndrome
- Fibromyalgia
- Joint hypermobility Syndrome
- Mitral valve prolapse syndrome
- Irritable Bowel Syndrome (IBS)
- Erectile Dysfunction

\*Include Epworth Sleepiness Scale, Fatigue Severity Scale, & Body Sensation Questionnaire here, in a fillable form, that auto-calculates score and interpretation afterwards\*



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## **Epworth Sleepiness Scale**

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	service "to bas he at	2	3	
No chance	Slight chance	Moderate chance	High chance	
of dozing	of dozing	of dozing	of dozing	

	Sitting and reading	
2.	Watching TV	
3.	Sitting inactive in a public place (e.g. theater or a meeting)	
4.	Fatigure nearest with a second because and a As a passenger in a car for an hour without a break	
5.	Lying down to rest in the afternoon when circumstances permit	c
6.	Sitting and talking to someone	
7.	Sitting quietly after a lunch without alcohol	
8.	In a car, while stopped for a few minutes in the traffic	
	SUM	



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## **Fatigue Severity Scale**

Below are a series of statements regarding fatigue. By fatigue we mean a sense of tiredness, lack of energy or total body give-out. Please read each statement and choose a number from 1 to 7, where number 1 indicates that you completely disagree with the statement and number 7 means you completely agree. Please answers this questions a they apply to the last two weeks:

questions a	they appl	y to the <u>last</u>	<u>two weeks</u> :			
1	2	3	<b>4</b> ·	5	6	7 Completely
Complety						Agree
Disagree						Agree
1. Exercis	e brings o	on my fatigue	э			
2. I am ea	asily fatigu	ed		·		
3. Fatigue	e interfere	s with my ph	ysical functio	oning	•••••	
4. Fatigue	e causes f	requent prot	olems for me			
5. My fati	gue preve	nts sustaine	d physical fu	nctioning		
6. Fatigue	e interfere	s with carryi	ng out certair	n duties a	nd respons	ibilities
7. Fatigue	e is my mo	ost disabling	symptom			
8. Fatigue	e is among	g my 3 most	disabling syr	nptoms		

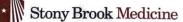
9. Fatigue interferes with my work, family or social life ......
 10. Fatigue makes other symptoms worse ......

SUM

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## **Body Sensations Questionnaire**

Below is a list of feelings, sensations, problems, and experiences that people sometimes have. Read each item and use the 1 to 5 scale below to select a rating that best describes **how much** you have felt or experienced things this way **during the past week, including today**. Use this scale when answering and select just one number for each item:

1 Not at all	2, A 1941 - 194 -	3	4	5
NUL AL AII	A little bit	Moderately	Quite a bit	Extremely
1. Startled	easily			
2. Hands v	vere shaky			
				10
			·····	

SUM

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### **REVIEW OF SYSTEMS**

Check all boxes that apply to you:

GENERAL	ENDOCRINE	GASTROINTESTINAL
Fever or chills	Heat/cold intolerance	Heartburn
Loss of appetite	Excessive thirst	Nausea or vomiting
EYES	BLOOD	Constipation
Visual changes	Anemia	Diarrhea
Eye dryness/ tearing	Easy bruising/bleeding	Abdominal pain
EARS/NOSE/THROAT	URINARY	Abdominal bloating
Hearing loss	Urinate frequently	NEUROLOGICAL
Bad breath	Urinary incontinence	Headaches
CARDIOVASCULAR	MUSKULOSKELETAL	Tremors
Chest pain	Joint pain	Numbness/Tingling
Palpitations	Muscle pain	Seizures
Swelling of feet	Cramps	Dizziness/Fainting
RESPIRATORY	SKIN	PSYCHIATRIC
Shortness of breath	Rashes	Anxiety/Nervousness
Cough	Dryness	Depression
Wheezing		Memory Loss

PAST MEDICAL HISTORY Do you have any of the following medical conditions?

- High blood pressure
- Heart attack
- Heart failureCardiac arrhythmia

Depression

- COPD/EmphysemaRhinitis/sinusitis
- Anemia

Asthma

- Fibromyalgia
- Gastroesophageal reflux
   Attention deficit disorder
  - Erectile dysfunction
- Stroke
- Seizures
- Diabetes
- Thyroid disease
- Chronic fatigue syndrome
- Migraine/tension headaches Other:

SURGICAL HISTORY

• Irritable bowel syndrome

Have you had a tonsillectomy: • Yes • No Have you had any complications related to anesthesia? • Yes • No List all other surgical procedures that you have had: \_\_\_\_\_



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MEDICATIONS (Please list all the medications that you currently take.)

Medication name	Dose	Times per day	Medication name	Dose	Times per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

# <u>ALLERGIES</u> Are you allergic to any medication? • Yes • No If yes, please list the medication and your reaction to it.

Medication name	Reaction	Medication name	Reaction

## SOCIAL HISTORY

How many caffeine-containing beverages do you consume on a typical day? \_\_\_\_Coffee(s) \_\_\_\_Tea(s) \_\_\_\_Soda(s)

FAMILY HISTORY Does anyone in your immediate family have the following medical conditions?



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	Father	Mother	Brother/Sister	Children
High blood pressure				
Heart attacks				
Asthma				
COPD/Emphysema				
Diabetes				
Depression				
Obesity				
Snoring				
Sleep apnea				
Narcolepsy				
Thyroid gland disease				
ADHD				
Parkinson's Disease				
Dementia				
Strokes				

What is your current: weight? \_\_\_ lbs. Height? \_\_\_ inches. Collar size? \_\_\_\_