Stony Brook Medicine
Stony Brook University Hospital
Sleep Disorders Center
240 Middle Country Road, Suite A
Smithtown, NY 11787

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…:
- 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
- Choking/gasping
- Full bladder
- Pain
- Hunger
- Bed partner/kids/pets
- Thirst
- 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
- Hallucinations
- Sudden extreme muscle weakness (cataplexy)

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 • No
Are you honked at red lights? • Yes • Sometimes • No
Have you had a motor vehicle accident related to sleepiness? • Yes • No
Do you have narcolepsy (overwhelming daytime drowsiness & sudden attacks of sleep) • Yes • No
Do 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	1	2	3
No chance of dozing	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

1. Sitting and reading ..... ____
2. Watching TV ..... ____
3. Sitting inactive in a public place (e.g. theater or a meeting) ..... ____
4. As a passenger in a car for an hour without a break ..... ____
5. Lying down to rest in the afternoon when circumstances permit ..... ____
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:*

1	2	3	4	5	6	7
Complety Disagree						Completely Agree

1. Exercise brings on my fatigue ..... _____
2. I am easily fatigued ..... _____
3. Fatigue interferes with my physical functioning ..... _____
4. Fatigue causes frequent problems for me ..... _____
5. My fatigue prevents sustained physical functioning ..... _____
6. Fatigue interferes with carrying out certain duties and responsibilities .. _____
7. Fatigue is my most disabling symptom ..... _____
8. Fatigue is among my 3 most disabling symptoms ..... _____
9. Fatigue interferes with my work, family or social life ..... _____
10. Fatigue makes other symptoms worse ..... _____

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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	2	3	4	5
Not at all	A little bit	Moderately	Quite a bit	Extremely

1. Startled easily ..... _____
2. Hands were shaky ..... _____
3. Was short of breath ..... _____
4. Felt faint ..... _____
5. Had hot or cold spells ..... _____
6. Hands were cold or sweaty ..... _____
7. Was trembling or shaking ..... _____
8. Had trouble swallowing ..... _____
9. Felt dizzy or lightheaded ..... _____
10. Had pain in my chest ..... _____
11. Felt like I was choking ..... _____
12. Muscles twitched or trembled ..... _____
13. Had a very dry mouth ..... _____
14. Was afraid I was going to die ..... _____
15. Felt heart racing, pounding or palpitations ..... _____
16. Felt numbness or tingling in my body ..... _____
17. Had to urinate frequently ..... _____

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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 failure
- Cardiac arrhythmia
- Depression
- Gastroesophageal reflux
- Irritable bowel syndrome
- Asthma
- COPD/Emphysema
- Rhinitis/sinusitis
- Anemia
- Fibromyalgia
- Attention deficit disorder
- Erectile dysfunction
- Stroke
- Seizures
- Diabetes
- Thyroid disease
- Chronic fatigue syndrome
- Migraine/tension headaches

Other: _____

SURGICAL HISTORY

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.		

ALLERGIES 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

Marriage status: _____ Occupation: _____
Work status: • Full-time employment • Self-employed • Unemployed
• Part-time employment • Student • Disabled
Do you have a job that requires you to work rotational shifts? • Yes • No

Tobacco use: • Never used. • Current smoker – smoking ___ packs per day, for ___ years.
• Former smoker – Quit date ____, smoked ___ packs per day, for ___ years.

Alcohol use: • Never • Once a month • Once a week • 1 drink a day • More than 1 drink a day

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? ___