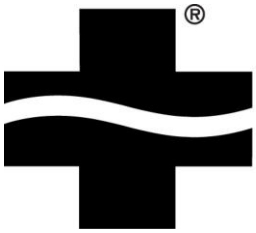

SLEEP DISORDERS CENTER OF THIBODAUX REGIONAL

604 NORTH ACADIA ROAD, Suite 210
THIBODAUX, LA 70301
985-493-4759

SLEEP HISTORY QUESTIONNAIRE

DATE: ____ / ____ / _____

NAME:_____ _____ AGE_____
(First) (Middle) (Last)
ADDRESS: _____
(Street) (City) (State) (Zip)
PHONE: Home( )_____Work:( )_____Cell ( ) _____

Date of Birth_____/_____/_____ Height_____ Weight_____Marital status___

E-mail address:_____

In Case of Emergency contact:_____

****

Social Security #_____Phone # of Insurance Co._____
Insurance Company_____Policy Number_____
Is Policy Private or Group?_____Subscriber_____
If Group, Name of Employer_____

****

Was this a Self Referral or Physician Referral?
If Physician Referral, Physician Name:_____

****

How Did You First Hear About Our Sleep Disorders Center? (Circle only one)

A. Physician
B. Relative
C. Friend
D. Newspaper
E. TV/Radio
F. Seminar / Presentation
G. Other_____
_____

PAST MEDICAL HISTORY

Serious Medical Illness:_____

Surgical History:_____
_____

Trauma:_____

FAMILY HISTORY (LIST AGE AND HEALTH PROBLEMS OF IMMEDIATE FAMILY MEMBERS)

Father:_____
Mother:_____
Brothers:_____
Sisters:_____

SOCIAL HISTORY

Current Occupation:_____ # of years in current work:_____
Birthplace:_____ Marital Status: _____
# of years married:_____ # of times married_____
# of children, sex, and ages_____
Educational level: # of years in high school _____college _____other_____

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can.

THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE.

1. Describe your main problem (s) in your own words, including when and how this began and what treatment you have received for this in the past._____
_____
_____
_____
_____
_____

2. How often does this problem occur?

( ) almost every night
( ) for periods of at least one week
( ) irregularly
( ) other _____

3. How long has this problem bothered you?

( ) longer than 2 years
( ) 1 to 2 years
( ) several months
( ) within the last 3 months
( ) within the last month

4. On the scale below, please estimate the severity of your problem (s).

Mildly upsetting	Moderately severe	Very severe	Extremely severe	Totally incapacitating

5.. How do you describe your sleep problem? Check all that apply to you.

( ) difficult falling asleep
( ) wake up during the night
( ) wake up early in the morning
( ) excessive daytime sleepiness
( ) difficulty awakening

6. Do any other members of your family have sleep problems? Please explain:

7. Have you ever had a sleep study or sleep evaluation?

8. Please rate how often you:

	NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
Awaken from sleep short of breath	_____	_____	_____	_____	_____
Awaken at night with heartburn, belching or cough	_____	_____	_____	_____	_____
Snore	_____	_____	_____	_____	_____
Snore loudly enough that others complain	_____	_____	_____	_____	_____
Have trouble sleeping when you have a cold	_____	_____	_____	_____	_____
Suddenly wake up gasping for breath during the night	_____	_____	_____	_____	_____
Have breathing problems at night (observed by self or others)	_____	_____	_____	_____	_____
Sweat excessively at night	_____	_____	_____	_____	_____
Notice your heart pound-ing or beating irregularly during the night.	_____	_____	_____	_____	_____

	NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
Fall asleep during the day	_____	_____	_____	_____	_____
Fall asleep involuntarily	_____	_____	_____	_____	_____
Fall asleep while driving	_____	_____	_____	_____	_____
Fall asleep during physical effort	_____	_____	_____	_____	_____
Fall asleep when laughing or crying	_____	_____	_____	_____	_____
Experience loss of muscle tone when extremely emotional	_____	_____	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____	_____	_____
Experience vivid dream-like scenes upon awakening or falling asleep	_____	_____	_____	_____	_____
Feel afraid of going to sleep	_____	_____	_____	_____	_____
Have nightmares	_____	_____	_____	_____	_____
Remember your dreams	_____	_____	_____	_____	_____
Have thoughts racing through your mind	_____	_____	_____	_____	_____
Feel sad and depressed	_____	_____	_____	_____	_____

	NEVER	RARELY	SOMETIMES	FREQUENTLY	CONSTANTLY
Have anxiety (worry about things)	_____	_____	_____	_____	_____
Have muscular tension	_____	_____	_____	_____	_____
Notice parts of your body jerk	_____	_____	_____	_____	_____
Kick during the night	_____	_____	_____	_____	_____
Experience crawling and aching feelings in your legs	_____	_____	_____	_____	_____
Experience any type of leg pain during the night	_____	_____	_____	_____	_____
Have morning jaw pain	_____	_____	_____	_____	_____
Grind teeth during sleep	_____	_____	_____	_____	_____
Are bothered by pain during the day	_____	_____	_____	_____	_____
Are awakened by pain during the night	_____	_____	_____	_____	_____
Wake up feeling stiff in the mornings	_____	_____	_____	_____	_____
Wake up with sore or achy muscles	_____	_____	_____	_____	_____
Wake up with pain in neck, spine or joints	_____	_____	_____	_____	_____

9. Is your present social life satisfactory?

10. How many hours of sleep do you usually get per night? _____

11. What time do you usually go to bed on WEEKDAYS? _____
    WEEKENDS? _____
12. How long does it take for you to fall asleep? _____

13. How many times do you typically wake up at night? _____

14. If you wake up, on the average, how long do you stay awake? _____

15. What do you usually do when you awaken during the night? _____
_____

16. What time do you usually awaken in the morning on WEEKDAYS? _____
    WEEKENDS? _____

17. On the average, how long do you stay in bed after waking up in the morning? _____

18. Do you usually: (Check all that apply to you)

    ( ) sleep with someone else in your bed
    ( ) sleep with someone else in your room
    ( ) provide assistance to someone during the night (child, invalid, bed partner, animal)

19. Is your sleep often disturbed by :

    ( ) heat ( ) light
    ( ) cold ( ) bed partner
    ( ) noise ( ) not being in your usual bed
    ( ) other _____

20. Are your sleep habits on weekends different from the rest of the week?

    ( ) No
    ( ) Yes - please describe _____
    _____

21. With whom are you now living? (wife, husband, children, parents, etc., please list ages)
    _____
    _____

22. Do you work split shifts or rotating (variable) shifts? _____
23. Do you usually drink caffeinated beverages 6 hours before you go to bed?

    ( ) Yes
    ( ) No

24. Do you do physical exercise after 5:00 p.m.?

    ( ) Yes
    ( ) No

25. Do you read before falling asleep?

    ( ) Yes
    ( ) No

26. Do you watch TV in bed before falling asleep?

    ( ) Yes
    ( ) No

27. Do you take naps during the afternoon or evening? If so, what time and for how long?

    ( ) Yes
    ( ) No
    _____

28. Do you feel refreshed after a short (10-15 minute) nap?

    ( ) Yes
    ( ) No

29. How do you feel after an average night of sleep?

    ( ) usually drowsy and/or tired
        if so; for how long: ( ) 1 hour
        ( ) 2 hours
        ( ) 3 hours or longer
    ( ) most of the time good
    ( ) consistently good

30. Do you feel better during the
    ( ) morning
    ( ) afternoon
    ( ) evening

31. List prescription and over-the-counter medications taken daily.

NAME	AMOUNT	HOW OFTEN	REASON

32. List any herbal remedies taken daily.

_____

_____

_____

_____

33. List your consumption of the following per day:

coffee _____
tea_____
chocolate_____
nicotine _____
alcohol _____

colas _____
over the
counter drugs_____
other drugs_____

34. Please describe any other information pertinent to your sleep or wakefulness not previously described.

Thank you for your response. This information will be held in the strictest confidence.

THE EPWORTH SLEEPINESS SCALE

NAME: _____

TODAY'S DATE:_____YOUR AGE:_____

YOUR SEX_____

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 work out 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 dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation*	Chance of Dozing
Sitting and reading	_____
Watching T.V.	_____
Sitting inactive in a public place (e.g., a theater, or a 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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Thank you for your cooperation

****

* The numbers for the eight situations are added together to give a global score between 0 and 24.

(From Johns MW: A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 14:540-545, 1991)