ADULT SLEEP CONSULT QUESTIONNAIRE

PLEASE FILL THIS FORM OUT COMPLETELY

Patient Name:_____ DOB:_____

Please briefly describe the current sleep problem or reason for sleep referral:

_____

_____

_____

Have you ever had a sleep study in the past? Yes or No

If so, when_____ and where_____

Please check any current sleep problems:

__ Snoring

__Pauses in breathing in sleep

__excessive daytime sleepiness

__dry throat/mouth upon awakening

__difficulty falling asleep

__difficulty staying asleep

__Sleep Paralysis

__frequent throat infections

__leg kicking in sleep

__restless sleep

__ headache upon awakening

__excessive urination at night

__acting out dreams

__Teeth Grinding

__nightmares

__nasal congestion

How long does it take you to fall asleep?_____ **Do you feel refreshed upon awakening? Yes or No**

Usual weekend/holiday bedtime:_____ **Naps (frequency and time spent:_____**

Usual work or school night bedtime:_____

Usual weekend/holiday wake time_____

Usual work or school wake time:_____

History:

_____

_____

_____

_____

_____

_____

Surgical History:

_____

_____

_____

_____

_____

_____

Have you had your tonsils and/or adenoids removed? yes or no

Any history of head or face trauma? Yes or no, if so how and when_____

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Occupation:_____

Any difficulty driving due to your sleep problem? ☐☐ YES ☐☐ NO

If yes, describe here:

_____

_____

_____

Do you smoke? ☐☐ YES ☐☐ NO

If yes how many packs per day? _____

Have you ever smoked? ☐☐ YES ☐☐ NO

Do you drink alcohol? ☐☐ YES ☐☐ NO

If so how many drinks per day? _____

Do you use any recreational drugs? ☐☐ YES ☐☐ NO

Current Medications:

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

_____

_____

_____

_____

_____

_____

_____

_____

Please check any current symptoms/issues you are having:

General: ☐☐ weight gain ☐☐ weight loss

Skin: ☐☐ rash ☐☐ itching

Nose/sinuses/throat: ☐☐ nasal congestion ☐☐ runny nose ☐☐ post-nasal drip ☐☐ sore throat

Eyes: ☐☐ blurry vision ☐☐ eye pain ☐☐ eye redness

Cardiac: ☐☐ chest pain ☐☐ heart palpitations

Respiratory: ☐☐ cough ☐☐ shortness of breath ☐☐ wheezing

GI: ☐☐ heartburn ☐☐ reflux ☐☐ nausea ☐☐ vomiting ☐☐ diarrhea ☐☐ constipation

Urinary: ☐☐ difficulty urinating ☐☐ kidney stones

Musculoskeletal: ☐☐ muscle aches ☐☐ back pain ☐☐ joint pain ☐☐ gout

Allergies: ☐☐ food ☐☐ medication ☐☐ environmental allergies

Neurologic: ☐☐ seizures ☐☐ headaches

Psychiatric: ☐☐ depression ☐☐ anxiety ☐☐ memory loss

Riverside MEDICAL GROUP
SLEEP MEDICINE

EPWORTH SLEEPINESS SCALE

(18 YRS AND OVER)

Name: _____ Today's date: _____Age: _____

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 haven't 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*

It is important that you answer each question as best you can.

Situation:	**Chance of Dozing (0-3):**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theatre 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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic **(you as the driver)**	_____