Name:		Sex:	
Age:		Date:	
Date of birth:		Height:	
Weight:		Neck Size:	
Referring Physician:		Primary Care MD:	

MAIN SLEEP COMPLAINTS

- Trouble falling asleep
- Excessive sleepiness during the day
- Trouble remaining asleep
- Snoring
- Unwanted behaviour during the sleep, such as
- Other, explain:
- How long?

PRIOR SLEEPING DISORDER DIAGNOSIS OR STUDIES

I have a prior sleeping diagnosis of

Prior sleeping studies (where, when):				
I am currently prescribed:	CPAP		Bilevel pressure.	
Settings:				
Oxygen (liters per minute)	during the day		or night	
I have had surgery for sleep disorder:	Yes	No	UPPP	Tonsillectomy
Other:				
I use a dental device for sleep disordered breathing :	Yes	No		

SLEEP PATTERN

Typical weekday bedtime:		weekend:	
Typical weekday awakening time:		weekend:	
Typical hours in bed:			hours
Typical hours of sleep:			hours
Typical amount of time it takes to fall asleep:			hours
Typical number of awakenings per night:			
Time it takes to fall back asleep after awakening:			
My sleep pattern is irregular.		Yes	No
I awaken early in the morning still tired but unable to return to sleep.		Yes	No

SLEEP ENVIRONMENT HABITS

Typical sleep position(s):	back	side	stomach	head elevated	in a chair
I sleep alone:			I share a bed with someone:		
My bedroom is:	comfortable	noisy	too warm	too cold	
I have pets in the bedroom:				Yes	No
I watch TV in the bedroom prior to sleep:				Yes	No
I read in bed prior to sleep:				Yes	No
I drink alcohol prior to bedtime:				Yes	No
I smoke prior to bedtime or when i awaken during the night:				Yes	No
I eat a snack at bedtime:				Yes	No
I eat if I awaken during the night:				Yes	No

BREATHING

I have been told that I snore:	Loudly	Yes	No
I have been told that I snore only when sleeping on my back:		Yes	No
I have been awakenend by my own snoring:		Yes	No
I awaken at night choking or gasping for air:		Yes	No
I awaken short of breath:		Yes	No
I have trouble breathing when flat on my back:		Yes	No
I have trouble breathing through my nose:		Yes	No
I have morning headaches:		Yes	No
I sweat a great deal at night:		Yes	No

DAYTIME SLEEPINESS

I often feel drowsy during the day, more than i expect is normal:	Yes	No
I feel unrefreshed or tired in the morning despite sleeping at night:	Yes	No
I take I daytime naps. How many?	Yes	No
I have uncontrollable urges to fall asleep during the day:	Yes	No
I have experienced lapses in time or blackouts:	Yes	No
I have fallen asleep while driving:	Yes	No
I performed poorly in school or work because of sleepiness	Yes	No

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale and indicate 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 TV	
Sitting, inactive in a public place (e.g., a theater or 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 with someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL (Range of 0 to 24)	

RLS

I kick or jerk my legs excessively during sleep:	This bothers my bed partner	Yes	No
I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep:		Yes	No
I experience an inability to keep my leg still prior to falling asleep:		Yes	No
I experience the feeling of restlessness in my legs at night:		Yes	No

OREXIN RELATED		
I experience sudden muscle weakness in response to emotions such as laughter, anger or surprise:	Yes	No
I experience an inability to move while falling asleep or when waking up:	Yes	No
I have experienced hallucinations or dreamlike images when falling asleep or waking up:	Yes	No
I frequently dream during daytime naps:	Yes	No
I act on my dreams while asleep:	Yes	No
I have frequent nightmares:	Yes	No
I talk in my sleep:	Yes	No
I have sleep walked as an adult:	Yes	No
Frequently travel across two or more time zones:	Yes	No
I am more alert in the morning than evening:	Yes	No
I am more alert in the evening than morning:	Yes	No
I awaken alert in the morning earlier than it is time to get up:	Yes	No
I frequently have heartburn or acid reflux at night:	Yes	No
I feel depressed:	Yes	No
Chronic pain interferes with my sleep:	Yes	No
The need to urinate frequently interrupts my sleep:	Yes	No
I grind my teeth in my sleep:	Yes	No
I have bedwetting (enuresis):	Yes	No

RW

ROGER WASHINGTON, MD, FAAFP

SCHOOL OF MEDICINE

INSOMNIA

I have trouble falling asleep:	Yes	No
I Thoughts start racing through my mind when I try to fall asleep:	Yes	No
I have trouble remaining asleep:	Yes	No
I awaken frequently during the night:	Yes	No
I have difficulty returning to sleep if I awaken during the night:	Yes	No

HABITS

I smoke cigarettes (or other tobacco). If yes, how much?				Yes	No
I drink alcohol. If yes, how much and how often?				Yes	No
I have difficulty returning to sleep if I awaken during the night:				Yes	No
I drink caffeinated beverages during the day (cups/bottles/cans):					
	Tea	Coffee	soda per day	Yes	No

SOCIAL HISTORY

Marital status:	Single	Married	Separated	Divorced	Widowed
Employment status:	Employed	Unemployed	Disabled	Student	Retired
If employed (occupation):					
I regularly work night shifts:				Yes	No
I work rotating shifts, including nice shiftwork:				Yes	No

PAST MEDICAL HISTORY

Hypertension	Coronary artery disease	Congestive heart failure
Stroke	Seizures	COPD/asthma
Diabetes	Cancer	Thyroid problems
Depression or anxiety	Alcoholism or chemical dependency	Sinus disease
Allergic rhinitis/nasal congestion	Nasal fracture	Reflux (GERD)
Stomach or colon problems	Fibromyalgia	Back or joint problems (arthritis)

Other:				
Female:	Premenstrual syndrome		Menopause	
Male:	Prostate problems		Erectile dysfunction	
Prior surgeries:				
Prior surgeries Weight change during the past year:				
Weight change during the past year: (pounds)	gained		lost	

CURRENT MEDICATIONS (OR LISTED ON SEPARATE SHEET)

Medication	**Dose**	**Times per day**

Allergies:		

FAMILY HISTORY

Has an immediate blood relative had any of the following?	Obstructive sleep apnea	Narcolepsy
Other sleep disorders:		

SLEEP QUALITY ASSESSMENT (PSQI)

What is PSQI, and what is it measuring?

The Pittsburgh Sleep Quality Index (PSQI) is an effective instrument used to measure the quality and patterns of sleep in adults. It differentiates "poor" from "good" sleep quality by measuring seven areas (components): subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medications, and daytime dysfunction over the last month.

Instructions

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

DURING THE PAST MONTH

Question	Answer
1. When have you usually gone to bed?	
2. How long (in minutes) has it taken you to fall asleep each night?	
3. What time have you usually gotten up in the morning?	
4A. How many hours of actual sleep did you get at night?	
4B. How many hours were you in bed?	

5. During the past month, how often have you had trouble sleeping because you?	Not during the past month	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
A. Cannot get to sleep within 30 minutes				
B. Wake up in the middle of the night or early morning				
C. Have to get up to use the bathroom?				
D. Cannot breathe comfortably				
E. Cough or snore loudly				
F. Feel too cold				
G. Feel too hot				
H. Have bad dreams				

SLEEP QUALITY ASSESSMENT (PSQI)

	Not during the past month	Less than once a week (1)	Once or twice a week (2)	Three or more times a week (3)
I. Have pain				
J. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason (s):				
6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?				
7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?				
8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?				
9. During the past month, how would you rate your sleep quality overall?				

SCORING

Component 1	#9 Score	**C1**	
Component 2	#2 Score (<15min (0), 16-30min (1), 31-60 min (2), >60min (3)) + #5a Score (if sum is equal 0=0; 1-2=1; 3-4=2; 5-6=3)	**C2**	
Component 3	#4 Score (>7(0), 6-7 (1), 5-6 (2), <5 (3)	**C3**	
Component 4	(total # of hours asleep) / (total # of hours in bed) x 100 >85%=0, 75%-84%=!, 65%-74%=2, <65%=3	**C4**	
Component 5	# sum of scores 5b to 5j (0=0; 1-9=1; 10-18=2; 19-27=3)	**C5**	
Component 6	#6 Score	**C6**	
Component 7	#7 Score + #8 score (0=0; 1-2=1; 3-4=2; 5-6=3)	**C7**	
Add the seven component scores together		Global PSQI	

A total score of "5" or greater is indicative of poor sleep quality.
If you scored "5" or more it is suggested that you discuss your sleep habits with a healthcare provider