Dr. Avi Ishaaya
MD, FCCP, FAASM, FACGS, MACGS

Name: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to think how you would react. Use the following scale to choose the most appropriate number rating for each situation.

0 = would NEVER doze
1 = SLIGHT chance of dozing
2 = MODERATE chance of dozing
3 = HIGH chance of dozing

1.	Sitting and reading	○ 0	○ 1	○ 2	○ 3
2.	Watching TV	○ 0	○ 1	○ 2	○ 3
3.	Sitting, inactive in a public place	○ 0	○ 1	○ 2	○ 3
4.	As a passenger in a car for an hour without a break	○ 0	○ 1	○ 2	○ 3
5.	Lying down to rest in the afternoon when circumstances permit	○ 0	○ 1	○ 2	○ 3
6.	Sitting and talking to someone	◉ 0	○ 1	○ 2	○ 3
7.	Sitting quietly after lunch (without alcohol)	○ 0	○ 1	○ 2	○ 3
8.	In a car, while stopped for a few minutes in traffic	○ 0	○ 1	○ 2	○ 3

Berlin Questionnaire

Please check the box that best answers each question for all <u>three Categories</u>.

CATEGORY I

1. Do you snore?
   ☐ Yes ☐ No ☐ Don't know
2. How loud is your snoring?
   ☐ As loud as breathing ☐ As loud as talking ☐ Louder than talking ☐ Can be heard in next room
3. How frequently do you snore?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never
4. Does your snoring bother other people?
   ☐ Yes ☐ No ☐ Don't know
5. Has anyone ever noticed you stop breathing in your sleep?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never

CATEGORY II

6. How often do you feel tired after sleeping?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never
7. Do you feel tired during your waking time?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never
8. How often do you nod off or fall asleep while driving?
   ☐ Almost daily ☐ 3-4 times/wk ☐ 1-2 times/wk ☐ 1-2 times/mo ☐ Rarely or Never

CAT. III

9. Do you have high blood pressure?
   ☐ Yes ☐ No ☐ Don't know
10. Is your BMI (Body Mass Index) over 30?
    ☐ Yes ☐ No ☐ Don't know

FOR OFFICE USE ONLY

Category I _____ Category III _____

Category II _____ ___ High | ___ Low

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HEALTH & SLEEP HISTORY QUESTIONNAIRE

Name: _____ **Date:** _____

Birthdate: _____ **Age:** _____ **Occupation:** _____

Gender: _____ **Height:** _____ **Weight:** _____ **Weight *Last Year:*** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Referring Doctor: _____ **Primary Care Doctor:** _____

What is (are) your **current, main** sleep complaint(s)? Check only the ones that apply.

☐ Loud snoring ☐ Pauses in breathing while asleep ☐ Awaken gasping for breath
☐ Awaken from sleep still tired ☐ Difficulty falling asleep ☐ Difficulty staying asleep
☐ Awaken too early ☐ Excessive movement in sleep ☐ Excessive daytime sleepiness
☐ Unusual or unwanted behaviors during sleep, please explain: _____

_____

Previous Sleep Evaluations & Treatment - *Answer all that Apply*

(If this is your first evaluation, please skip to the next section)

1. My last sleep evaluation was *(check one)*:
   _☐_ less than 6 months ago _☐_ less than 1 year ago _____ years ago

2. I was diagnosed with: _____

3. I use a CPAP or Bi-Level device *(circle one)*: ◯ YES ◯ NO

4. I have had surgery to treat a sleep disorder *(circle one)*: ◯ YES ◯ NO
   If yes, what type of surgery was performed? _____

Current Medication List

Please list all current medications you take, prescribed and OTC (Over-the-Counter) below, including vitamins & supplements. Attach separate page if needed.

MEDICATION	REASON FOR TAKING	DOSAGE

Do you use supplemental oxygen? ☐ YES ☐ NO
If yes, when & what amount? ☐ PRN ☐ 24/7 at _____ l/min

Allergies

Please list known allergies: _____

_____

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Patient Medical History

Please answer all questions to the best of your ability, checking either YES or NO.

Have you ever had any of the following medical conditions?

Tuberculosis	☐ YES	☐ NO	Lung Disease	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Asthma	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO
Diabetes (Blood Sugar High / Low)	☐ YES	☐ NO	Thyroid Disease	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Stomach Disease	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO	Intestinal Disease	☐ YES	☐ NO
Other Heart Disease	☐ YES	☐ NO	Peptic Ulcer	☐ YES	☐ NO
Stroke	☐ YES	☐ NO	Liver Disease	☐ YES	☐ NO
Enlarged Tonsils/Adenoids	☐ YES	☐ NO	Depression/Anxiety	☐ YES	☐ NO
Deviated Nasal Septum / Polyps	☐ YES	☐ NO	Bipolar Disorder	☐ YES	☐ NO
COPD (Emphysema/Chronic Bronchitis)	☐ YES	☐ NO	Glaucoma	☐ YES	☐ NO

Sleep & Breathing

1. Do you snore?	☐ Never	☐ Sometimes	☐ Always
2. Does your snoring wake you up?	☐ Never	☐ Sometimes	☐ Always
3. Is your snoring broken by hesitations, gasps and snorts?	☐ Never	☐ Sometimes	☐ Always
4. Are the hesitations long enough to frighten your sleep partner?	☐ Never	☐ Sometimes	☐ Always
5. Has your snoring driven your bed partner from the bedroom?	☐ Never	☐ Sometimes	☐ Always
6. Do you awaken with a dry mouth?	☐ Never	☐ Sometimes	☐ Always
7. Do you awaken with headaches?	☐ Never	☐ Sometimes	☐ Always
8. Do you awaken choking or gasping for air?	☐ Never	☐ Sometimes	☐ Always
9. Have you ever fallen asleep while driving or stopped in traffic?	☐ Never	☐ Sometimes	☐ Always
10. When you wake, are your sinuses stuffed or clogged up?	☐ Never	☐ Sometimes	☐ Always
11. Do you take naps during the day?	☐ Never	☐ Sometimes	☐ Always
12. Do you wake up feeling your heart pounding or racing?	☐ Never	☐ Sometimes	☐ Always

Sleep Disturbances

13. Do you experience unpleasant leg sensations at bedtime?	☐ Never	☐ Sometimes	☐ Always
14. Do you kick or jerk your legs and/or arms during sleep?	☐ Never	☐ Sometimes	☐ Always
15. Do you have sweats or awaken from sleep feeling flushed?	☐ Never	☐ Sometimes	☐ Always
16. Do you awaken with a bitter or acid taste in your mouth?	☐ Never	☐ Sometimes	☐ Always
17. Do you frequently have nightmares or vivid dreams?	☐ Never	☐ Sometimes	☐ Always
18. Do you grind your teeth or have bitten your cheek during sleep?	☐ Never	☐ Sometimes	☐ Always
19. Have you ever walked or talked in your sleep?	☐ Never	☐ Sometimes	☐ Always
20. Have you ever felt unable to move after awakening?	☐ Never	☐ Sometimes	☐ Always
21. Have you ever seen or felt things from your dreams after awakening?	☐ Never	☐ Sometimes	☐ Always
22. Have you ever experienced weakness when laughing or angry?	☐ Never	☐ Sometimes	☐ Always
23. Have you ever had unusual movements or behaviors during sleep?	☐ Never	☐ Sometimes	☐ Always
Please describe: _____			
24. Outside of childhood, have you ever wet the bed?	☐ Never	☐ Sometimes	☐ Always
25. Do you sleep with the TV on?	☐ Never	☐ Sometimes	☐ Always
If yes, do you use a sleep timer?	☐ Never	☐ Sometimes	☐ Always
26. Is your sleep disturbed by a household member?	☐ Never	☐ Sometimes	☐ Always

Social Habits

1. Do you use tobacco (now or past)? *(circle type)* Smoking or Chewing ☐ YES ☐ NO
   a) If yes now, how many per day and for how many years: _____
   b) If yes now, what time of day did you last smoke: _____
   c) If quit, when did you quit: _____
   d) If quit, how many per day and for how long: _____
2. Do you drink alcohol (includes beer, wine & liquor)? ☐ YES ☐ NO
   a) If yes, how many drinks - per *(circle frequency)*: _____ per: ☐ day ☐ week ☐ month
   b) If yes, when was your last drink (date & time): _____
   c) If quit, when did you quit: _____
3. Do you drink/take caffeine (includes caffeine pills, energy drinks, coffee, tea & soda)? ☐ YES ☐ NO
   a) How many caffeinated beverages/pills per day: _____
4. What are your living arrangements? *If not alone, what are your sleeping arrangements:* ☐ Not Alone ☐ Alone ☐ Separate Rooms ☐ Same Room, Separate Beds ☐ Same Room, Same Bed
5. Occupation: _____ ☐ Employed ☐ Unemployed ☐ Retired ☐ Student
6. How frequently do you exercise? ☐ Rarely/Never ☐ 1-3 x/week ☐ 3-5 x/week ☐ 5-7 x/week
7. Do you use illicit/recreational drugs? ☐ YES ☐ NO
   a) Marijuana ☐ YES ☐ NO If yes, how often _____; last used _____
   b) Cocaine/Crack/Amphetamine ☐ YES ☐ NO If yes, how often _____; last used _____
   c) Heroin/Morphine/Methadone ☐ YES ☐ NO If yes, how often _____; last used _____
   d) LSD/Mushrooms/PCP ☐ YES ☐ NO If yes, how often _____; last used _____
   e) Other Uppers/Downers ☐ YES ☐ NO If yes, how often _____; last used _____
   _____