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# **Professional Sleep Centers** *of Florida*

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Patient Paperwork Package

## EPWORTH SLEEPINESS SCALE

Name: \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex (M=Male, F=Female) \_\_\_\_\_

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 TV \_\_\_\_\_

Sitting, inactive in a public place such as 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 to someone \_\_\_\_\_

Sitting quietly after a lunch without alcohol \_\_\_\_\_

In a car, while stopped for a few minutes in traffic \_\_\_\_\_

Total Score (add all responses): \_\_\_\_\_

\_\_\_\_\_

## SLEEP & MEDICAL HISTORY – PAGE 1

Name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex:  Male:  Female Race: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone \_\_\_\_\_

Please check any of the following you have had or ever experienced:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Nightmares                                   | <input type="checkbox"/> Cataplexy                   | <input type="checkbox"/> Snoring                        |
| <input type="checkbox"/> Sleep walking                                | <input type="checkbox"/> Drop attacks                | <input type="checkbox"/> Pauses in breathing            |
| <input type="checkbox"/> Sleep talking                                | <input type="checkbox"/> Hallucinations-vivid dreams | <input type="checkbox"/> Choking spells                 |
| <input type="checkbox"/> Asthma attacks                               | <input type="checkbox"/> Naps                        | <input type="checkbox"/> Wake up gasping                |
| <input type="checkbox"/> Indigestion                                  | <input type="checkbox"/> Dry mouth                   | <input type="checkbox"/> Headaches                      |
| <input type="checkbox"/> Shortness of breath                          | <input type="checkbox"/> Weight gain                 | <input type="checkbox"/> Night sweats                   |
| <input type="checkbox"/> Excessive sleepiness                         | <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Restless sleep                 |
| <input type="checkbox"/> Allergies                                    | <input type="checkbox"/> Insomnia                    | <input type="checkbox"/> Leg cramping                   |
| <input type="checkbox"/> Cough (chronic)                              | <input type="checkbox"/> Sleep propped-up            | <input type="checkbox"/> Leg pain at night              |
| <input type="checkbox"/> Sleep paralysis                              | <input type="checkbox"/> Use a sleep aide, pill      | <input type="checkbox"/> Pain in legs while exercising  |
| <input type="checkbox"/> High blood pressure                          | <input type="checkbox"/> Trouble concentrating       | <input type="checkbox"/> Memory trouble                 |
| <input type="checkbox"/> Depression                                   |  | <input type="checkbox"/> Irregular heart beat           |
| <input type="checkbox"/> Heart Attack                                 |  | <input type="checkbox"/> Bad valve in your heart        |
| <input type="checkbox"/> Murmur or other abnormal sound in your heart |  | <input type="checkbox"/> Blood clots or clogged vessels |
| <input type="checkbox"/> Congestive heart failure                     |  | <input type="checkbox"/> Chest pain while exercising    |
| <input type="checkbox"/> Rheumatic fever                              |  | <input type="checkbox"/> Swollen ankles                 |
| <input type="checkbox"/> Heart enlargement                            |  |   |

Family Medical History: Has anyone in your immediate family ever had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Ulcers          |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Stomach Disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep Disorder  | <input type="checkbox"/> Heart Disease   |
| <input type="checkbox"/> Liver Disease       |  |  |

Have you had any surgery in the past five years?  Yes :  No

If yes, explain: \_\_\_\_\_

Are you planning on having surgery in the next year?  Yes :  No

If yes, explain: \_\_\_\_\_

Do you have nasal obstruction or sinus problems?  Yes :  No

Has your weight increased over the past year?  Yes :  No If yes, how much? \_\_\_\_\_

Has anyone ever told you that you stop breathing when you are asleep?  Yes :  No

Do you grind or clench your teeth while asleep?  Yes :  No

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## SLEEP & MEDICAL HISTORY – PAGE 2

Name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever been in an accident or suffered an injury because you have fallen asleep?  Yes :  No

If yes, explain \_\_\_\_\_

**Please answer the following questions about your sleep routine:**

How long does it take you to fall asleep? \_\_\_\_\_

What time do you go to bed? \_\_\_\_\_ What time do you wake up? \_\_\_\_\_

Do you use an alarm clock to wake up?  Yes :  No

How many times a night do you wake up? \_\_\_\_\_

If you wake up during the night, what usually awakens you? \_\_\_\_\_

How long do you normally sleep? \_\_\_\_\_

Are you easily awakened?  Yes :  No

Do you fall asleep easily?  Yes :  No

Do you take naps?  Yes :  No

If so, how often do you nap? \_\_\_\_\_ How long are your naps? \_\_\_\_\_

Do you now or have you ever used cigarettes or other products?  Yes :  No

If yes, indicate the quantity used per day: \_\_\_\_\_

Quit?  Yes :  No If yes, when \_\_\_\_\_

Do you now or have you ever used alcoholic beverages?  Yes :  No

If so, indicate weekly quantity consumed \_\_\_\_\_

Quit?  Yes :  No If yes, when \_\_\_\_\_

Do you now or have you ever used caffeinated beverages?  Yes :  No

If so, indicate weekly quantity consumed \_\_\_\_\_

Quit?  Yes :  No If yes, when \_\_\_\_\_

Choose the description that best fits you currently (only one choice)

- No complaints
- Always being sleepy
- Difficulty sleeping (getting to sleep or staying asleep)
- Not being able to sleep at the time desired
- Not getting enough sleep

Choose the description that best fits you currently (only one choice)

- Anxious/Nervous
  - Concerned about problems
  - Content
  - Depressed
  - Overworked
  - Stressed
-

## PRE-SLEEP QUESTIONNAIRE

Name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

1. What time did you go to sleep last night? \_\_\_\_\_  am  pm
2. What time did you wake up today? \_\_\_\_\_  am  pm
3. What time do you usually wake up? \_\_\_\_\_  am  pm
4. How long does it usually take you to fall asleep? \_\_\_\_\_
5. Approximately how many hours of sleep did you have last night? \_\_\_\_\_  
the night before? \_\_\_\_\_, the night before that? \_\_\_\_\_
6. In the past week, how many times has your bedtime varied by more than one hour? \_\_\_\_\_
7. Has anything out of the ordinary happened to you recently?  Yes  No  
If yes, what? \_\_\_\_\_
8. Did you get too little sleep last night?  Yes  No
9. Did you take any naps today?  Yes  No  
If yes, how long? \_\_\_\_\_ What time? \_\_\_\_\_
10. Have you had any alcoholic beverages today?  Yes  No
11. What time did you last eat? \_\_\_\_\_ Was this a meal or a snack? \_\_\_\_\_
12. Have you had any caffeinated beverages after 12:00 Noon?  Yes  No  
If yes, what? \_\_\_\_\_ How much? \_\_\_\_\_ When? \_\_\_\_\_
13. Do you wear dentures?  Yes  No
14. Do you wear contacts?  Yes  No
15. Do you take prescription medication?  Yes  No
16. If you answered yes to question #15 above, please circle or write in the medication you use:  
Ambien (zolpidem)      Ativan (lorazepam)      Klonopin (clonazepam)      Dalmane (flurazepam)  
Desyrel (trazodone)      Doxepin (sinequan)      Elavil (amitriptyline)      Posom (Estrazolam)  
Restoril (temazepam)      Valium (diazepam)      Xanax (alprazolam)

Other \_\_\_\_\_

17. Will you take any medication before bed tonight?  Yes  No  
If yes, list them \_\_\_\_\_

### Please complete the following right before bedtime:

Do you have any physical discomfort at the present time?  Yes  No

If yes, what? \_\_\_\_\_

1. Are you feeling anxious about sleeping in the lab:  
 Not at all       Slightly       Moderately       Very
2. Choose the statement that best describes the way you feel right now:  
 Active, vital, alert, wide awake  
 High level but not at peak, able to concentrate  
 Relaxed, awake, not at full alertness, responsive  
 A little foggy, not at peak, let down  
 Fogginess, losing interest in remaining awake, slow

## PATIENT QUALITY ASSURANCE QUESTIONNAIRE

Name: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Technologist Name \_\_\_\_\_ Appointment Time \_\_\_\_\_

- 1. Was your Technologist professional and courteous?     Yes    No
- 2. Did your Technologist explain the procedure fully?     Yes    No
- 3. Did your Technologist identify himself/herself to you?     Yes    No
- 4. Did your Technologist make you comfortable?     Yes    No
- 5. On a scale of 1-10 (1=worst, 10=best) how would you rate the overall performance of your Technologist? \_\_\_\_\_
- 6. On a scale of 1-10 (1=worst, 10=best) how would you rate our Scheduling & Patient Information? \_\_\_\_\_
- 7. On a scale of 1-10 (1=worst, 10=best) how would you rate your visit to our center overall? \_\_\_\_\_
- 8. How did you hear about the Sleep Center?  
 Doctor                                     Friend/Relative                                     Brochure  
 Radio                                         Newspaper Ad                                     TV  
 Other \_\_\_\_\_
- 9. Is this the first service you have used at this Hospital?     Yes    No

If there is anything you think would help us improve our service or if you have any comments, please indicate: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Signature \_\_\_\_\_

\_\_\_\_\_