Pulmonary and Sleep Medicine Consultants

Accredited by the American Academy of Sleep Medicine (AASM)

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Madhukar Kaloji, M.D. FCCP

Sleep Study Questionnaire I

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you haven't encountered some of these situations, try to assume how it would have affected you.

Use the following scale of 0-3 to choose the most appropriate number for each situation:

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

Situation	**Chance of dozing (0-3)**
o Sitting and reading	_____
o Watching TV	_____
o Sitting, inactive in a public place	_____
o As a passenger in a car for an hour without a break	_____
o Lying down to rest in the afternoon *when circumstances permit*	_____
o Sitting and talking to someone	_____
o Sitting quietly after a lunch without alcohol	_____
o In a car, stopped in traffic for a few minutes	_____ Score:___/24

Sleep History:

Bedtime: _____
Wake up time: _____
When do you actually get up? _____
How long does it take you to fall asleep? _____

Do you sleep longer on the weekends or holidays? YES NO

Do you wake up at night? YES NO
If so, how many times? Reasons? _____

Do you move your legs at night? YES NO

Do you suffer from unpleasant sensations in your legs? YES NO
(cramps, tingling, or numbness)

What was your weight 10 years ago? _____ lbs

Doctor's notes (***please leave blank***)
Chief Complaint:

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Sleep Study Questionnaire II

Are your symptoms getting: (Circle one)
WORSE SAME IMPROVING

Check if applicable:

SYMPTOMS	X ✓
Difficulty falling asleep	
Difficulty staying asleep	
Snoring	
Choking or gasping when awakening	
Not refreshed upon awakening	
Sleepy during the day	
Dry throat	
Dry mouth	
Nasal congestion	
Postnasal drip	
Cough	
Wheezing	
Breathing pauses as noted by bed partner	
Restless sleep	
Acting out during sleep	
Sleep talking	
Sleep walking	
History of nightmares	
Panic attacks, etc.	
Headaches	

To be filled out by doctor*: *(please leave blank)

Assessments/Diagnoses:

Plan:

Prescriptions:

Pharmacy:

CPAP Machine? YES NO

Prior sleep studies: YES NO
Date(s):
Copy of study YES NO

Name of DME if applicable:

Due for supplies? YES NO