Bluepoint MEDICAL ASSOCIATES

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SCREENING QUESTIONS - SLEEP HISTORY

Patient's Name:			Date:
Height:	Weight:	Neck Circumference:	Date of Birth:

Sleep related complaints include: (check all that apply)

- ❒ Snoring
- ❒ Restless sleep
- ❒ Overweight
- ❒ Irritability
- ❒ Hypertension (High Blood Pressure)
- ❒ Morning Headaches
- ❒ Difficulty maintaining sleep/frequent awakenings
- ❒ Daytime fatigue
- ❒ Been told you stop breathing while asleep
- ❒ Wake up gasping or short of breath during your sleep?

What is your primary sleep problem?			
How long have you had that problem?			
What time do you usually go to bed and get up?	Weekdays	Go to bed:	Wake Up:
	Weekends	Go to bed:	Wake Up:

How many nights a week do you get:				
9+ hours of sleep?	8 hours of sleep?	7 hours of sleep?	6 hours of sleep	5 or less hours of sleep?
nights	nights	nights	nights	nights

How often do you nap? _____days/wk For how long? _____/min

Do you wake up feeling unrefreshed?	❒ Yes ❒ No
Do you have trouble during the day because you are not getting enough sleep?	❒ Yes ❒ No

SLEEP APNEA:

Do others complain about your snoring?	❒ Yes ❒ No
Has anyone witnessed you during an apneic event? (Have you been told that you stop breathing during sleep, or is there a silent period when there is no longer snoring followed by a loud snort or a body jerk?) If so, how often?	❒ Yes ❒ No _____nights/wk
Do you awaken from sleep short of breath or with a feeling of being choked?	❒ Yes ❒ No
Do you have nighttime sweating?	❒ Yes ❒ No
Do you have morning headaches?	❒ Yes ❒ No
Do you have multiple nocturnal awakenings? What wakes you up, when, how many times a night? _____	❒ Yes ❒ No
Weight gain or loss over the past 12 months?	❒ Yes ❒ No

NARCOLEPSY— includes the uncomfortable urge to sleep during the day, especially during emotional events:

Do you feel your knees buckle, arms feel weak, or jaw drop with strong emotions (startled, angry, happy, or sad)? (cataplexy)	❒ Yes ❒ No
Do you experience vivid dream-like episodes or scenes upon awakening or falling asleep that you can't tell whether they are real or not? (hypnagogic hallucinations)	❒ Yes ❒ No
Do you feel paralyzed when waking or falling asleep? (sleep paralysis)	❒ Yes ❒ No
Do you fall asleep at inappropriate times or experience sleep attacks?	❒ Yes ❒ No

RESTLESS LEG SYNDROME/ PERIODIC LEG MOVEMENTS OF SLEEP:		
	Do you experience discomfort in your legs during night which makes you want to move them or stretch them?	❒ Yes ❒ No
	Do you notice that these feelings in your legs are worse at night time?	❒ Yes ❒ No
	Do the symptoms occur with (or worsened by) rest?	❒ Yes ❒ No
	Do you have relief with movement?	❒ Yes ❒ No
	Do you wake yourself with body jerks (arms or legs)?	❒ Yes ❒ No
	Have you been told that your legs or arms move every 20 seconds or so during the night?	❒ Yes ❒ No
PARASOMNIAS (or things that go "bump" in the night including REM behavior disorder and include disorders of sleep walking or sleep talking):		
	Do you have nightmares?	❒ Yes ❒ No
	Do you often move violently during your sleep while dreaming, and sometimes even hurt yourself or your partner by accident or fall out of bed?	❒ Yes ❒ No
	Have you been told that you sleepwalk?	❒ Yes ❒ No
	Have you been told that you arouse from sleep totally confused or are inconsolable?	❒ Yes ❒ No
	Do you have a history of seizures?	❒ Yes ❒ No
INSOMNIA: Check if you are currently diagnosed with: ❒ Depression ❒ Anxiety		
	Do you routinely require more than 30 minutes to fall asleep?	❒ Yes ❒ No
	Do you wake up several times during the night and cannot get back to sleep? What causes you to wake up? _____	❒ Yes ❒ No
	Do you often wake up one or two hours before your scheduled wake time and can't get back to sleep?	❒ Yes ❒ No
	Do you have thoughts racing through your mind while trying to fall asleep?	❒ Yes ❒ No
	Do you watch a clock while trying to sleep?	❒ Yes ❒ No
	Do you read or watch TV in bed?	❒ Yes ❒ No
BRUXISM:		
	Do you have morning jaw pain?	❒ Yes ❒ No
	Do you grind your teeth during sleep?	❒ Yes ❒ No

Epworth Sleep 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., school or movie)	
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	
In a car, while stopped for a few minutes in traffic	
Total (Range 0-24):	