

Sleep Center Screening Questionnaire (v0601)

Patient Name _____

Date _____

EPWORTH SLEEPINESS SCALE

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. Please check one box per line.

--- CHANCE OF DOZING OFF ---

Never Slight Moderate High

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sitting and reading |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Watching TV |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sitting, inactive in a public place (example, a theater or a meeting) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | As a passenger in a car for an hour without a break |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lying down to rest in the afternoon when circumstances permit |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sitting and talking to someone |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sitting quietly after lunch without alcohol |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | In a car, while stopped for a few minutes in traffic |

BRIEF SLEEP SYMPTOM CHECKLIST *(Please check the boxes that best describes you)*

Never Rarely Frequently Always

- | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I snore loudly |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I awaken gasping or choking for breath |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I awaken in the morning unrefreshed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I have problems falling asleep or staying asleep (insomnia) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | My sleep is very restless |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | My sleep is disturbed by unusual behaviors (for example: nightmares, sleepwalking, dream enactments, tongue biting, bedwetting... etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I fall asleep while driving |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | I've been told that I stop breathing in my sleep |

(told by _____)

SLEEP SCHEDULE *(Please provide the following information)*

- What time do you go to bed on WEEKDAYS? _____ AM or PM Do you nap? [Yes] [No]
- What time do you get up on WEEKDAYS? _____ AM or PM How often do you nap? _____ times per week
- What time do you go to bed on WEEKENDS? _____ AM or PM How long are the naps? _____ minutes
- What time do you get up on WEEKENDS? _____ AM or PM Do you awaken refreshed? [Yes] [No]
- Are you a shift worker? [Yes] [No] If yes, what kind of shift do you work? _____