Southern Regional Medical Center

Sleep Diagnostic Center
11 Upper Riverdale Road, Building 33, Suite 100
Riverdale, GA 30274
Phone: 770-909-2638 Fax: 770-991-8580

Sleep History Questionnaire

(To be completed by patient)

Name:____ DOB:_________________ Date: ____________

Symptoms during sleep:

Indicate by **placing a check mark** if you experience any of these symptoms when sleeping or trying to sleep:

___Loud snoring
___Breathing or snoring stops during sleep
___Awaken gasping for breath
___Becomes sleep during the day
___Difficulty falling to sleep
___Difficulty remaining asleep
___Awakens too early
___My mind races with many thoughts when I try to fall asleep
___ I often worry whether or not I will be able to fall asleep
___ Fatigue
___Awaken with dry mouth
___Morning headaches
___Irritability/Depression
___Memory impairment or inability to concentrate
___Sinus trouble, nasal congestion or Post-nasal drip interfering with sleep.
___Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep
___Inability to move as you are trying to go to sleep or awaken
___Vivid dreams or nightmares
___Sudden weakness or feel your body go limp when You are excited or angry
___Irresistible urge to move legs or arms
___Creeping or crawling sensation in your legs before falling asleep
___Legs or arms jerking during sleep
___Frequent urination disrupting sleep
___Sleep talking or Sleep walking
___Pain which awakens me from sleep

*** If these symptoms are bothering you and your score is greater than 10 please speak with your physician and feel free to contact Southern Regional Medical Center's Sleep Diagnostic Center at **770-909-2638.***

Questionnaire:

1.) How long have these symptoms been present?
Please check

____ Between 1-3 months
____ 3-6 months
____ Over 6 months

2.) What is your neck circumference? _____________
3.) Are you on oxygen at home? ________________
4.) Do you work at night? ______________________
5.) Do you have insomnia? _____________________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situation, in contrast to feeling just tired? This refers to your usual way of life in recent time. 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 T.V.	________
Sitting, inactive, in a public place (e.g., a theater or meeting)	________
As a passenger in a car for an hour without a break	________
Lying down to rest in the afternoon	________
Sitting and talking to someone	________
Sitting quietly after lunch with out alcohol	________
In a car stopped at a traffic signal	________
Total:	________

(Greater than 10 indicates Sleepiness)