

SUSSEX COUNTY MEDICAL ASSOCIATES
123 NEWTON-SPARTA ROAD, NEWTON, NJ 07860

SCREENING QUESTIONS FOR SLEEP RELATED DISORDERS:

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

Referring Physician [if any] _____

Please answer the following questions. If you are not sure how to answer a question, leave the space blank and we will assist you with the answer when you are seen at our facility. All answers will be kept in strict confidence and treated as medical record information.

1. What is your chief complaint:

- a) _____
- b) _____
- c) _____
- d) _____
- e) _____

2. Screening questions for sleep apnea:

- a. Do you snore? _____. If so, are you heard outside the bedroom? _____. Is it worse on your back or on your side? _____. Do others complain about your snoring? _____. How many nights per week does it occur? _____.
- b. 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? _____.
- c. Do you awaken from sleep short of breath or with a feeling of being choked? _____.
- d. Do perspire at night? _____.
- e. Do you have a morning headache? _____. If so, how bad is it, how long does it last and where is it located? _____.
- f. Do you awake frequently during the night? _____. If so, what wakes you, when, and how many times per night? _____.
- g. What is your weight gain or loss over your lifetime? _____.
Height? _____. Collar size? _____.

h. Try to quantitate your daytime sleepiness:

- Do you fall asleep before noon if you are not active? _____.
- Do you fall asleep during active tasks before noon? _____.
If so, what tasks are you performing _____.
- Do you experience sleepiness after lunch? _____.
- Do you fall asleep during the afternoon if you are not active? _____.
- Do you fall asleep during active tasks in the afternoon? _____.
If so, what tasks are you performing? _____.
- Do you fall asleep while driving? _____
- Do you have trouble falling asleep during school or work? _____
- Do you take naps upon arrival home from school or work? _____

3. Measures of sleepiness:

a. Epworth Sleepiness 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

<u>Situation</u>	<u>Chances of Dozing</u>
▪ Sitting and reading	_____
▪ Watching TV	_____
▪ Sitting, inactive in a public place (ex: theatre 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 with someone	_____
▪ Sitting quietly after a lunch without alcohol	_____
▪ In a care, while stopped for a few minutes in traffic.	_____
 Total (Range 0-24)	 _____

b. Stanford Sleepiness Scale:

Circle the ONE number that best describes your level of alertness or sleepiness RIGHT NOW.

1. Wide awake, fully awake, functioning at high level; head clear.
2. Functioning at a high level, but not at peak; able to concentrate.
3. Relaxed; awake; not at full alertness; responsive.
4. A little groggy; clearly not at peak; let down.

5. Fogginess; beginning to lose interest in remaining awake; slowed down.
6. Sleepiness; prefer to be lying down; fighting sleep, woozy.
7. Almost in reverie; sleep onset soon; lost struggle to remain awake.

c. Visual Analog Scale (VAS) of Alertness and Well-Being; [Please circle]

How alert do you feel? Very sleepy 1 2 3 4 5 6 7 Very alert

How good do you feel? Very bad 1 2 3 4 5 6 7 Very good

4. **Screening questions for Narcolepsy:**

- a. Do you feel your knees buckle or, your arms feel weak, or jaw drop when you are happy or sad? _____.
- b. 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? _____.
- c. Do you feel paralyzed when waking or falling asleep? _____.
- d. Do you have automatic behavior? For instance, while driving, do you have periods when you go past certain exits and you are uncertain whether you've done something only to find out that it was already done, or find yourself in places where you are not sure where you should be at? _____.
- e. Do you have a history of head trauma or loss of consciousness? _____.

5. **Screening for Periodic Leg Movements of Sleep:**

- a. Do you have leg cramps at bedtime? _____.
- b. Do you experience crawling and achy feelings in your legs during the day or night which makes you want to move them or walk them? _____.
- c. Do you notice that these achy feelings in your legs are worse at nighttime? _____.
- d. Have you been told that your legs or arms move every 20 seconds or so during the night? _____.
- e. Are your bedcovers in total disarray in the morning? _____.
- f. Have you ever awakened suddenly with a jerk after falling asleep? _____.

6. **Screening for Parasomnias:**

- a. Do you remember your dreams? _____.
- b. Do you have nightmares? _____.
- c. Are you told that you act out your dreams in nightmares by swinging your arms, legs, or by moving or yelling? _____. If so, do they occur early or late during the sleep period? _____.
- d. Have you hurt yourself or anyone else associated with these movements during the night? _____.
- e. Have you been told that you sleepwalk? _____.
- f. Do you sleep talk? _____. If so, can you be understood? _____. Does this occur in the first third of the night or in the latter third of the night? _____.
- g. Have you been told that you arouse from sleep totally confused or inconsolable? _____.
- h. Have you awakened feeling panicked with your heart beating uncontrollably? _____.
- i. Have you experienced uncontrolled urination in your sleep either as a child or as an adult? _____.
- j. Do you have a history of seizures? _____.

7. Screening for Insomnia:

- a. Are you unable to fall asleep in 15 minutes or less? _____.
- b. Do you wake up several times during the night and cannot get back to sleep? _____.
- c. Do you wake up one or two hours early in the morning? _____.
- d. Do you have thoughts racing through your mind while trying to fall asleep? _____.
- e. Do you watch a clock while trying to sleep? _____.
- f. Do you have anxiety which keeps you from sleeping? _____.
- g. Do you have muscle tension which can disrupt sleep onset? _____.
- h. Are you bothered by pain during the day or night? _____.
- i. Do you wake up feeling stiff in the morning or have sore, achy muscles? _____.

8. Screening for Bruxism

- a. Do you have morning jaw pain? _____.
- b. Do you grind your teeth during sleep? _____.

9. Sleep hygiene :

- What time do you go to bed on weeknights? _____.
- What time do you go to bed on weekend nights? _____.
- What time do you wake up on weekdays? _____.
- What time do you wake up on weekends? _____.

10. Nocturnal awakenings:

How many times do you wake up during your sleep? _____. If so, what part of the night is it, and what are the usual causes? _____.

11. Work schedule:

- Do you work day shift, middle shift or night shift? _____.
- Do you change shifts from one week to the next? _____.
- Do you travel for you work? _____. If so, do you experience jet lag? _____.

12. Circadian Rhythm:

- Do you have trouble waking up in the morning and would rather stay up later? (i.e. 2-3 am) and sleep in until noon? _____.
- Do you go to bed at 8 pm only to find that you wake up at 3 am? _____.

13. Medications:

- Have you taken any medication or had any surgery to help correct your sleep problem? _____.
- If so, please list _____.
- Are you taking any other over-the-counter medications or herbal remedies? _____.
- If so, please list _____.
- List all prescription medications you take _____
- _____
- _____

14. Habits:

Do you take caffeine? _____. If so, how much per day? _____, and at what times during the day are they consumed? _____.

Do you take alcohol? _____. If so, how much? _____, and how long before bedtime? _____.

Do you smoke? _____. If so, how many packs per day over how many years? _____.

15. Allergies:

Do you have any allergies to foods, medications, other? _____.

16. Physical Examination:

Blood pressure

Puls

Pulsox(R/A):

Height:

Weight:

BMI:

Collar size: