WESTERN RESERVE HOSPITAL
Proudly Physician Owned
Partnering with University Hospitals

SLEEP ASSESSMENT

Please complete entire form and bring with you to your sleep study appointment

Name: ____ Date: ___________________________________

Referred by: ____ Family Doctor: ___________________________

Date of Birth___ /___ /______ Height: ______ Weight: ________

Authorization to speak to a family member □ No □ Yes Who? ____

Current Medications:

____
____
____
____

Sleep History

1. What is your major sleep complaint(s)?
   ____

2. How long have you had this/these problem(s)? Duration _____weeks ______ months ________ years

Testing (check all that apply):

3. Have you had any of the following sleep lab tests?
   - Home Sleep Test □ Yes □ No If so, what/where/when? ___________________________________
   - Sleep Study □ Yes □ No If so, what/where/when? ___________________________________
   - CPAP □ Yes □ No If so, what/where/when? ___________________________________

4. Are you currently on □ CPAP □ BIPAP __ Adapt SV

5. If yes, what is your current pressure setting? ____

6. If yes, who supplied you with your equipment? ____

7.Are you currently on Oxygen? □ YES □ NO If yes, how many liters are you currently using______________

8. Do you have a history of teeth grinding? □ YES □ NO

9. Do you wear an oral appliance for sleep apnea or mouth guard for teeth grinding ? □ YES □ NO
If yes, which one? ____

10. Have you had any upper airway surgeries for sleep apnea and if so, what surgery and when?_____________________________

11. Have you been told that you stop breathing during sleep? □ Yes □ No □ Unknown

12. How do you feel upon waking? (Check all that apply)
□ Dry mouth □ Headache □ Refreshed □ Unrefreshed □ Confused □ Covers messy □ Covers neat

- Do you ever have vivid dreams falling asleep? □ Never □ Occasional □ Frequent □ Always
- Do you sleepwalk? □ Never □ Occasional □ Frequent □ Always
- Do you ever have unusual movements in sleep? □ Never □ Occasional □ Frequent □ Always
- Do you sweat at night? □ Never □ Occasional □ Frequent □ Always
- Do you snore? □ Never □ Occasional □ Frequent □ Always
- Do you have excessive daytime sleepiness? □ Never □ Occasional □ Frequent □ Always

13. On weekdays I go to bed at _____ am/pm and wake up at _____ am/pm

    On weekends I go to bed at _____ am/pm and wake up at _____ am/pm

14. Do you take naps (intentional or unintentional)? □ Yes □ No (If yes, answer the next 5 questions)
    - For how long? _____
    - How many times per day? ________
    - How many times per week? ________
    - Do you wake up from naps feeling refreshed? □ Yes □ No
    - Are dreams present? □ Yes □ No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 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.

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 ………………………………………………………………………………	0 1 2 3
Watching television ………………………………………………………………………………	0 1 2 3
Sitting, inactive in a public place (e.g., a theater or a meeting) ……………	0 1 2 3
As a passenger in a car for an hour without a break ……………………………	0 1 2 3
Lying down to rest in the afternoon when circumstances permit ………	0 1 2 3
Sitting and talking to someone …………………………………………………………	0 1 2 3
Sitting quietly after lunch without alcohol ……………………………………………	0 1 2 3
In a car, while stopped for a few minutes in traffic ……………………………	0 1 2 3
TOTAL	_____

RESTLESS LEGS SYNDROME SCREENING QUESTIONNAIRE

1. Do you ever have uncomfortable, funny (creeping, crawling, tingling) or painful feelings in your legs?
   ___ Yes _______ No _______Don't Know (If no, ignore questions 2-5)

2. If yes, are they worse when lying down or sitting?
   ___ Yes _______ No _______Don't Know

3. Do you have partial relief with movement (wiggling feet, toes or walking).
   ___ Yes _______ No _______Don't Know

4. Do you notice if the feeling is worse at night?
   ___ Yes _______ No _______Don't Know

5. Do you have repeated jerking movements in toes, legs or whole body while sleeping?
   ___ Yes _______ No _______Don't Know

6. Has anyone in the family been diagnosed with restless legs syndrome or periodic movements of sleep?
   ___ Yes _______ No _______Don't Know

7. Have you ever been treated for anemia?
   ___ Yes _______ No