The Vine MEDICAL CENTER & Sleep Lab for Adults & Children

SLEEP STUDY QUESTIONNAIRE

ACCREDITED FACILITY MEMBER

Patient Name: _____ DOB: _____

Height: _____ Weight: _____ BMI: _____ Neck size: _____ Gender: M / F

Address: _____

Marital status: S M W Sep D Home Phone: _____ Emergency Contact: _____

Past Medical History:

☐ Anxiety ☐ Chronic pain ☐ Depression ☐ Hyperlipidemia ☐ Diabetes Mellitus ☐ Asthma

☐ Gastroesophageal Reflux Disease (GERD) ☐ COPD ☐ CHF ☐ STROKE ☐ Hypertension

Please mark the followings that you experience:

☐ daytime fatigue ☐ Snore while sleeping ☐ Wake up tired and unrefreshed

☐ Headache when waking up ☐ Dry mouth when waking up ☐ Wake up choking and gasping for air

☐ Witness stopped breathing during sleep

1. Have you had a sleep problem diagnosed before? a. Yes b. No
   a. If yes, when and where was your study performed? _____
   b. Are you currently using CPAP /BIPAP machine? a. Yes b. No Pressure: _____

EPWORTH SLEEPINESS SCALE

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 (0-3)
1. Sitting and reading	**1 2 3**
2. Watching TV	**1 2 3**
3. Sitting, inactive in a public place (ex. Movie theatre or a meeting)	**1 2 3**
4. Lying down to rest in the afternoon when circumstances permit	**1 2 3**
5. Sitting and talking with someone	**1 2 3**
6. Sitting quietly after a lunch without alcohol	**1 2 3**
7. In a car, while stopped for a few minutes in traffic	**1 2 3**
8. As a passenger in a car without a break	**1 2 3**

TOTAL SCORE: