CHARLOTTE EYE
EAR NOSE & THROAT
ASSOCIATES, P.A.

Sleep Questionnaire (The Modified Epworth Sleepiness Scale)

Name: _____ Date: _____ Account #: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to work out how they would affect 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 TV	_____
Sitting, inactive in a public place (theater, meeting, etc)	_____
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 to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____
Total points	_____

Please describe your sleep problem: _____

_____

What time do you usually go to bed? _____

What is your work schedule? _____

How long does it take you to fall asleep? _____

What do you usually do when you awaken during the night? _____

Do you have any unusual behavior during sleep of which you or others are aware? ☐Yes ☐No

If yes, please describe:

Do you take naps? ☐Yes ☐No

What times? _____ For how long? _____

Are your naps refreshing? ☐Yes ☐No

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DO YOU:

Remember your dreams	☐Yes	☐No
Have vivid dream like scenes upon awakening or going to sleep	☐Yes	☐No
Feel unable to move when waking or falling asleep	☐Yes	☐No
Experience loss of muscle tone when extremely emotional	☐Yes	☐No
Snore	☐Yes	☐No
Sleep with your mouth open	☐Yes	☐No
Wake with dry mouth	☐Yes	☐No
Have breathing problems	☐Yes	☐No
Awaken at night with heartburn	☐Yes	☐No
Belching or cough/wheezing	☐Yes	☐No
Sweat excessively at night	☐Yes	☐No
Awaken with a headache	☐Yes	☐No
Are awakened by pain at night	☐Yes	☐No
Kick during the night	☐Yes	☐No
Experience crawling and aching feelings in your legs	☐Yes	☐No
Experience any kind of leg pain during the night	☐Yes	☐No
Grind teeth during sleep or jaw pain	☐Yes	☐No
Have nightmares	☐Yes	☐No
Have thoughts racing through your mind	☐Yes	☐No
Feel sad or depressed	☐Yes	☐No
Take something to help you sleep	☐Yes	☐No

For each of the beverages below, write in the average number you drink per day.

Caffeinated coffee _____ cups per day

Tea _____ cups/glasses per day

Soft drinks _____ cans or bottles per day

Alcohol average # drinks during the week _____ type _____

Alcohol average # drinks on the weekends _____ type _____