Sleep Questionnaire

Charlotte Eye Ear Nose & Throat Associates, P.A.

South Park Office/ Belmont Office

SP Phone (704) 295-3000/Belmont (704) 295-3700

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_ Account #:\_\_\_\_\_\_\_\_\_

**THE MODIFIED EPWORTH SLEEPINESS SCALE**

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 time do you usually get up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**DO YOU: YES NO**

Remember your dreams \_\_\_\_\_ \_\_\_\_\_

Have vivid dream like scenes

upon awakening or going to sleep \_\_\_\_\_ \_\_\_\_\_

Feel unable to move when waking or falling asleep \_\_\_\_\_ \_\_\_\_\_

Experience loss of muscle tone when extremely emotional \_\_\_\_\_ \_\_\_\_\_

Snore \_\_\_\_\_ \_\_\_\_\_

Sleep with your mouth open \_\_\_\_\_ \_\_\_\_\_

Wake with dry mouth \_\_\_\_\_ \_\_\_\_\_

Have breathing problems \_\_\_\_\_ \_\_\_\_\_

Awaken at night with heartburn, \_\_\_\_\_ \_\_\_\_\_

Belching or cough/wheezing \_\_\_\_\_ \_\_\_\_\_

Sweat excessively at night \_\_\_\_\_ \_\_\_\_\_

Awaken with a headache \_\_\_\_\_ \_\_\_\_\_

Are awakened by pain at night \_\_\_\_\_ \_\_\_\_\_

Kick during the night \_\_\_\_\_ \_\_\_\_\_

Experience crawling and aching feelings in your legs \_\_\_\_\_ \_\_\_\_\_

Experience any kind of leg pain during the night \_\_\_\_\_ \_\_\_\_\_

Grind teeth during sleep or jaw pain \_\_\_\_\_ \_\_\_\_\_

Have nightmares \_\_\_\_\_ \_\_\_\_\_

Have thoughts racing through your mind \_\_\_\_\_ \_\_\_\_\_

Feel sad or depressed \_\_\_\_\_ \_\_\_\_\_

Take something to help you sleep \_\_\_\_\_ \_\_\_\_\_

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 \_\_\_\_

THANK YOU FOR YOUR COOPERATION