EMORY
SLEEP CENTER

EMORY SLEEP CENTER
Sleep and Health Questionnaire

Demographics Today's Date: _____/_____/_____

Name: _____ Date of Birth: _____/_____/_____

Address: _____ Sex: Male ☐ Female ☐

City/State/Zip: _____

Preferred Contact Number: _____ Work ☐ Home ☐ Cell ☐

Occupation: _____

Height: _____ ft _____ in Weight: _____lbs Shirt Collar Size _____inches

Name of doctor who referred you: _____

Doctor's Phone Number: _____

Doctor's Address: _____

City/State/Zip: _____

Reason for Referral
What would you say is your primary sleep problem? (If none, why did your doctor refer you to the sleep clinic?)

Describe how and when this problem began, and how often it is occurring.

Have you ever had a sleep study? Yes ☐ No ☐
If yes, when and where: _____

Describe any treatments you have received for your problem:

_____

EMORY
SLEEP CENTER

Your Sleep Habits

How many hours of sleep do you usually get per night?	
What time do you usually go to bed?	
What time do you usually wake up?	
How long does it take for you to fall asleep?	
How many times do you typically wake up at night?	
What awakens you?	
If you wake up, on average, do you have trouble going back to sleep?	
What hours do you work?	
Do you ever rotate shifts?	

Symptoms During Sleep

	Yes	No
Do you feel refreshed after a typical night's sleep?	☐	☐
Do you feel sleepy during the day even when you have slept all night?	☐	☐
Do you nap at least once per week?	☐	☐
Do you feel refreshed after a short nap?	☐	☐
Do you sleep better in a recliner or a chair than you do in bed?	☐	☐
Do you ever experience vivid dream-like scenes upon awakening or falling asleep?	☐	☐
When you are angry or laugh, do you ever feel weak in any part of your body?	☐	☐
Are you ever unable to move or speak for a short period of time as you are falling asleep or awakening?	☐	☐
Do you have a creeping or crawling sensation in your legs when you lie down to sleep?	☐	☐
Do you snore?	☐	☐
Is your bed partner disturbed by your snoring?	☐	☐
Has anyone every told you that your breathing stops for brief periods during the night?	☐	☐
Do you have a bitter taste in the back of your throat when you wake up?	☐	☐
Do you walk or talk in your sleep?	☐	☐
Do you grind or clench your teeth during your sleep?	☐	☐
Are you a restless sleeper, tossing and turning at night?	☐	☐
Do you feel drowsy while driving your car?	☐	☐
Have you ever fallen asleep while driving?	☐	☐

EMORY
SLEEP CENTER

Indicate, on average, how often you experience the following symptoms when sleeping or trying to sleep.

Symptom	Times Per Week			
	Daily	4-6	1-3	Never
My mind races with many thoughts when I try to fall asleep	☐	☐	☐	☐
I often worry whether or not I will be able to fall asleep	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Awaken with a dry mouth	☐	☐	☐	☐
Morning headaches	☐	☐	☐	☐
Irritability / Depression	☐	☐	☐	☐
Memory impairment / Inability to concentrate	☐	☐	☐	☐
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep	☐	☐	☐	☐
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep	☐	☐	☐	☐
Pain which delays, prevents, or awakens me from sleep	☐	☐	☐	☐
Irresistible urges to move my legs or arms while in bed	☐	☐	☐	☐
Creeping or crawling sensations in your legs before falling asleep	☐	☐	☐	☐
Legs or arms jerking during sleep	☐	☐	☐	☐
Frequent urination disrupting sleep	☐	☐	☐	☐
Sleep talking or Sleep walking	☐	☐	☐	☐
Snoring	☐	☐	☐	☐

Epworth Sleepiness Scale

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	
Watching tv	
Sitting, inactive in a public place (eg, a theatre or meeting place)	
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 traffic	

EMORY
SLEEP CENTER

Medical History

Please check all previously diagnosed medical conditions:

- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ Atrial fibrillation (A Fib)
- ☐ Depression
- ☐ Diabetes
- ☐ Asthma
- ☐ Congestive heart failure/Heart failure
- ☐ Reflux/Heartburn
- ☐ Stroke

Please list any other significant medical problems and any surgeries you have had:

Current Medications, prescriptions and otherwise (with doses if known)

Family Medical History

	Age	Medical Problems, (if deceased, list cause of death)
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

EMORY
SLEEP CENTER

Social History

Do you currently smoke? ☐ Yes ☐ No

Packs per day: _____ How many years have you smoked: _____

If not currently smoking, have you smoked in the past? ☐ Yes ☐ No
When was your last cigarette? _____

Number of alcoholic beverages per day: _____ / per week: _____ / per month: _____

How much caffeinated coffee do you drink per day? _____ cups

How much caffeinated tea (hot or iced) do you drink per day? _____ cups / _____ glasses

How much caffeinated soda to you drink per day? _____ cans

Review of Systems (please answer all questions, checking yes or no)

Yes	No	General	Comment
☐	☐	Weakness	
☐	☐	Fatigue	
☐	☐	Decreased appetite	
☐	☐	Increased appetite	
☐	☐	Weight loss	
☐	☐	Weight gain	
☐	☐	Chills	
☐	☐	Fever	
☐	☐	Night sweats	

Yes	No	Eyes, Ears, Nose, Throat	Comment
☐	☐	Decreased ability to see	
☐	☐	Blurred vision	
☐	☐	Spots before eyes	
☐	☐	Difficulty hearing	
☐	☐	Ringing in ears	
☐	☐	Pain in ears	
☐	☐	Discharge from ear	
☐	☐	Nosebleeds	
☐	☐	Nasal congestion	
☐	☐	Post-nasal drip	
☐	☐	Sinus trouble	
☐	☐	Sore throat	
☐	☐	Hoarseness	
☐	☐	Pain in neck	
☐	☐	Dental trouble	
☐	☐	Bleeding gums	

EMORY
SLEEP CENTER

Yes	No	Respirator	Comment
☐	☐	Cough	
☐	☐	Cough up phlegm	
☐	☐	Coughing up blood	
☐	☐	Wheezing	
☐	☐	Asthma	
☐	☐	COPD	
☐	☐	Shortness of breath	
☐	☐	Chest pain with cough or deep breathing	

Yes	No	Cardiovascular	Comment
☐	☐	Chest discomfort	
☐	☐	Shortness of breath when lying down	
☐	☐	Sitting up to breathe	
☐	☐	Heart racing	
☐	☐	Swelling of legs	
☐	☐	Varicose veins	
☐	☐	Leg pain with exertion	
☐	☐	Blue/purple color of hands/feet	

Yes	No	Gastrointestinal	Comment
☐	☐	Nausea	
☐	☐	Vomiting	
☐	☐	Diarrhea	
☐	☐	Constipation	
☐	☐	Heartburn	
☐	☐	Abdominal pain	
☐	☐	Bright red blood in stools	
☐	☐	Black stools	
☐	☐	Change in bowel habits	
☐	☐	Hemorrhoids	

Yes	No	Musculoskeletal	Comment
☐	☐	Painful joints	
☐	☐	Swelling of joints	
☐	☐	Redness of joints	
☐	☐	Stiffness of joints	
☐	☐	Deformities of joints or extremities	
☐	☐	Muscle pain	
☐	☐	Back pain	
☐	☐	Pain running down the back of your legs	

Yes	No	Endocrine	Comment
☐	☐	Goiter	
☐	☐	Heat intolerance	
☐	☐	Cold intolerance	
☐	☐	Tremulous hands	
☐	☐	Change in pitch of voice	
☐	☐	Increased body hair (face, under arms or pubic)	
☐	☐	Decreased body hair	
☐	☐	Loss of periods	
☐	☐	Increased thirst	
☐	☐	Increased urination	

Yes	No	Neurologic/Psychiatric	Comment
☐	☐	Nervousness/Anxiety	
☐	☐	Depression	
☐	☐	Difficulty with memory for past events	
☐	☐	Difficulty with memory for recent events	
☐	☐	Difficulty with thinking or problem solving	
☐	☐	Headaches	
☐	☐	Blackouts	
☐	☐	Dizziness	
☐	☐	Double vision	
☐	☐	Paralysis or weakness in limb(s)	
☐	☐	Loss of sensation	
☐	☐	Loss of balance	
☐	☐	Loss of coordination	
☐	☐	Difficulty in speaking	
☐	☐	Seizures or spells	

Yes	No	Hematologic/Allergy	Comment
☐	☐	Anemia	
☐	☐	Blood disorder	
☐	☐	Immunocompromised	
☐	☐	Seasonal allergies	
☐	☐	Drug allergies	

Yes	No	Skin	Comment
☐	☐	Itching	
☐	☐	Rash or ulcers	
☐	☐	Change in color	
☐	☐	Change in texture of hair or hair loss	
☐	☐	Nail changes	