

Vijay Pethkar, MD
Comprehensive Sleep Center
Accredited by the American Academy of Sleep Medicine
780 North Mt. Juliet Road
Mt. Juliet, TN 37122
P: 615-758-9273
F: 615-758-4821

Sleep Questionnaire for New Patient

Name: _____ Age: _____

Date: _____ Primary Physician _____

1. Do you feel excessively sleepy during the day? Yes _____ No _____
2. Has someone told you that you snore? Yes _____ No _____
3. Has someone told you that you stop breathing in your sleep? Yes _____ No _____
4. Do you ever wake up with a choking sensation? Yes _____ No _____
5. What time do you normally go to bed? _____
6. How long does it take you to go to sleep? _____
7. Do you wake up at night? What wakes you up? Yes _____ No _____

8. What time do you wake up in the morning? _____
9. Did you ever experience an irresistible desire to fall asleep? Yes _____ No _____
10. Did you ever experience inability to move one or both sides of your body or limbs when you are about to fall asleep or wake up from sleep? Yes _____ No _____
11. Did you ever experience weakness in you limbs, buckling of knees, sagging of the jaw or any other unusual symptoms when you were happy and laughing or sad or angry? Yes _____ No _____
12. Do you ever see or feel things that are not there when you are about to fall asleep or wake up from sleep? Yes _____ No _____

13. Do you have a achy, crawling sensation in your legs, especially in the evenings and bed time, when you cannot sit still and want to move your feet or walk around?

Yes_____No_____

14. Has anyone told you that you jerk and twitch during sleep?

Yes_____No_____

15. Has anyone told you that you kick, yell, or have violent activities during sleep?

Yes_____No_____

16. Do you regularly nap during the day and if so, how long?

Yes_____No_____

17. Do you consume alcohol regularly?

Yes_____No_____

18. Do you drink caffeinated beverages such as coffee, Tea, Coke, Pepsi? If so, how much?

Yes_____No_____

Please list all medical conditions:

Please list all medications including over the counter medications:

Epworth Sleepiness Scale

Name: _____ **Age:** _____

Date: _____ **Male/Female**

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just 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 chose 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 (e.g.- movie theater, meeting)	_____
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 lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

Total Score: _____