BSL Bastrop Sleep Lab

Pre-study Questionnaire

Patient Name: ______________________________ Date: __________

Date of Birth: ______________ Your Height: __________ Your Weight: ______________

Epworth Sleepiness Scale

How likely are you to **doze off** or **fall asleep** in the following situations, in contrast to just feeling tired?

Chance of Dozing Off	Never	Slight	Moderate	High
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting quietly in a public place (theater or a meeting)	◯	◯	◯	◯
As a passenger in a car for an hour without eating	◯	◯	◯	◯
Lying down to rest in the afternoon	◯	◯	◯	◯
Sitting while talking with someone	◯	◯	◯	◯
Sitting quietly after lunch without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes in traffic	◯	◯	◯	◯

Please check one box per line

Brief Sleep Symptom Checklist

Please check the boxes that best describe you

Never	Rarely	Often	Always	
◯	◯	◯	◯	I snore loudly
◯	◯	◯	◯	I wake gasping or choking for breath
◯	◯	◯	◯	I awaken in the morning unrefreshed
◯	◯	◯	◯	I have problems falling asleep or staying asleep(insomnia)
◯	◯	◯	◯	My sleep is very restless
◯	◯	◯	◯	My sleep is disturbed by unusual behaviors (ex: nightmares, sleepwalking, dream enactments tongue biting, bed-wetting)
◯	◯	◯	◯	Fall asleep while driving
◯	◯	◯	◯	I've been told that I stop breathing in my sleep (told by______________________________)

Sleep Schedule

Please provide the following information

What time do you go to bed on **weekdays**? ______ AM or PM

What time do you get up on **weekdays**? ______ AM or PM

What time do you go to bed on **weekends**? _______AM or PM

What time do you get up on **weekends**? ______AM or PM

Do you take naps? ◯ Yes ◯ No

If yes, how often do you nap? times per week

How long are the naps? ______ minutes

Do you awaken refreshed? ◯ Yes ◯ No

Are you a shift worker? ◯ Yes ◯ No If yes, what kind of shift do you work? _______________________

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Sleep Problems Checklist

What problem caused you to seek to our help? ______________________________
____
____
____

How does this problem affect your life? ______________________________
____
____
____

Check the circle for each problem you currently have.

- ◯ Loud snoring
- ◯ Frequent awakenings at night
- ◯ Choking for breath at night
- ◯ Gasping during sleep
- ◯ I've been told that I stop breathing when asleep
- ◯ Restless sleep
- ◯ Awaken unrefreshed
- ◯ Crawling feeling in legs when trying to sleep
- ◯ Leg-kicking during sleep
- ◯ Leg cramps in sleep
- ◯ Trouble falling asleep at night
- ◯ Trouble staying asleep at night
- ◯ Racing thoughts when trying to sleep
- ◯ Increased muscle tension when trying to sleep
- ◯ Fear of being unable to sleep
- ◯ Laying in bed worrying when trying to get to sleep
- ◯ Waking too early in the morning
- ◯ Sleep talking
- ◯ Sweating a lot at night
- ◯ Waking up with heartburn
- ◯ Waking up with reflux
- ◯ Waking up to urinate
- ◯ Nightmares
- ◯ Fear of being unable to return to sleep after waking at night
- ◯ Teeth grinding during sleep
- ◯ Morning Headaches
- ◯ Morning dry mouth
- ◯ Sleep walking
- ◯ Sleep terrors
- ◯ Tongue biting during sleep
- ◯ Bed wetting
- ◯ Acting out dreams
- ◯ Feeling paralyzed when falling asleep or waking up
- ◯ Dreamlike images when falling asleep or waking up
- ◯ Sudden weakness when laughing
- ◯ Sudden weakness when afraid
- ◯ Uncontrolled daytime sleep attacks
- ◯ Falling asleep unexpectedly
- ◯ Falling asleep at work
- ◯ Falling asleep at school
- ◯ Falling asleep while driving
- ◯ Recent change in sleep schedule
- ◯ I use sleeping pills to help me sleep
- ◯ I use alcohol to help me sleep
- ◯ Pain interferes with sleep
  - Where is the pain? ____________________

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Medication History & Use

We need to know what drugs, vitamins, and herbal substances you have taken in the past six months. Please complete the form below. Check your medicine cabinet and your medical records for drugs. Think back about the health problems you have had and the medications you took for them.

Name of drug, vitamin, or herbal substance used	Dose	# of pills	Taken for how long?	Taken for what problem?	Still Taking?
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N
					Y N