

I. SYMPTOMS DURING SLEEP

1. Circle any of the following symptoms that you currently have when sleeping or trying to sleep.

Toss & Turn	Fall out of bed	Bed wetting
Heartburn	Sour belches	Pain
Regurgitation	Night sweats	Teeth grinding
Cold feet	Sleep walking	Sleep talking
Nightmares	Irresistible urge to move legs	Legs jerking

2. Circle any of the following that you experience during sleep.

Choking	Making whistling sounds	Gaspings for air
Loud Snoring	Struggling to breathe	Stop breathing
Sleeping with open mouth	Waking yourself with snoring	Snorting
Waking with dry mouth		

3. Do you snore in all positions? _____ If not, when? _____

II. SLEEP HABITS

1. What time do you usually go to bed? _____
 2. How long does it usually take you to fall asleep? _____
 3. How many times do you awaken at night? _____
 4. Why do you awaken at night? _____
 5. Do you have trouble returning to sleep? _____
 6. What time do you usually wake up in the morning? _____
 7. How do you wake up in the morning? (i.e., alarm clock, etc.) _____
 8. What time do you usually get up in the morning? _____
 9. Do you usually sleep longer when you don't have to get up? _____
How long? _____
 10. How many hours of actual sleep time do you think you get each night on the average? _____
 11. Upon awakening in the morning, do you feel: Completely rested? _____
Partially rested? _____ Not rested at all? _____
 12. Do you frequently have a headache during the night or in the morning? _____
 13. Do you take anything to help you sleep? _____ What? _____
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-

III. NARCOLEPSY

- | | YES | NO |
|--|-------|-------|
| 1. As you fall asleep or wake up, do you have vivid or lifelike visions (people in the room, etc.)? | _____ | _____ |
| 2. When you are angry or excited, do you have sudden weakness or have any part of your body go limp (head drop, knees buckle, etc.)? | _____ | _____ |
| 3. As you are trying to go to sleep or wake up, do you ever have an inability to move? | _____ | _____ |
| 4. Have you ever driven or traveled somewhere and did not remember how you got there? | _____ | _____ |
-
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IV. TREATMENT

Have you ever been treated for your sleep problems? _____

Explain: _____

V. PSYCHOLOGICAL

Circle any of the following symptoms that you have to an excessive degree:

- | | | |
|-----------------------|--------------------------|-------------------|
| Fatigue | Inability to concentrate | Memory impairment |
| Anxiety | Depression | Irritability |
| Suicidal thoughts | Family problems | Loss of appetite |
| Change in personality | | |
-
-

VI. SEXUALITY

- | | YES | NO |
|---|-------|-------|
| 1. Is your sexual drive normal? | _____ | _____ |
| 2. Men: a) Are your erections normal? | _____ | _____ |
| b) Do you sometimes have erections when you wake up in the morning? | _____ | _____ |

VII. WEIGHT

1. What do you weigh now? _____
1. What did you weigh one year ago? _____

VIII. MEDICAL HISTORY

YES **NO**

1. Do you have high blood pressure? _____ _____
2. Have you ever had problems with your tonsils, adenoids, nose or throat? _____ _____

If so what? _____

3. Have you ever had surgery on your tonsils, adenoids, nose, or throat? _____ _____
If so what? _____

4. Do you have sinus or allergy problems? _____ _____

5. Have you seen an allergist or an ENT doctor? _____ Which doctor? _____

6. Do you have a thyroid condition? _____ _____
If so what? _____

Have you had thyroid function studies? _____ _____

7. List any chronic medical condition that you have.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

8. List any surgery or injuries that you have had.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

9. List any drugs to which you are allergic.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

10. List any drugs that you take regularly. Include over-the-counter medications, hormones, birth control pills, etc.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

11. When was your last complete physical examination? _____
By whom? _____

YES **NO**

12. Did you have any recent blood work done? _____ _____

XI. STATE OF MIND

Please read the entire group of statements below and read each group carefully. Then pick out the one statement which best describes the way you feel **today** for each group. Circle the number (3, 2, 1, or 0) beside the statement you have chosen. If more than one statement in the group seems to apply equally well, circle each one.

Be sure to read all the statements in each group before making your choice.

- A. 3 I am so sad or unhappy that I can't stand it.
 2 I am blue or sad all the time and I can't snap out of it.
 1 I feel sad or blue.
 0 I do not feel sad.
- B. 3 I feel that the future is hopeless and that things cannot improve.
 2 I feel I have nothing to look forward to.
 1 I feel discouraged about the future.
 0 I am not particularly pessimistic or discouraged about the future.
- C. 3 I feel I am a complete failure as a person (i.e., parent, husband, wife).
 2 As I look back on my life, all I can see is a lot of failures.
 1 I feel I have failed more than the average person.
 0 I do not feel like a failure.
- D. 3 I am dissatisfied with everything.
 2 I don't get satisfied out of anything anymore.
 1 I don't enjoy things the way I used to.
 0 I am not particularly dissatisfied.
- E. 3 I feel as though I am very bad or worthless.
 2 I feel quite guilty.
 1 I feel bad or unworthy a good part of the time.
 0 I don't feel particularly guilty.
- F. 3 I hate myself.
 2 I am disgusted with myself.
 1 I am disappointed in myself.
 0 I don't feel disappointed in myself.
- G. 3 I would kill myself if I had the chance.
 2 I have definite plans about committing suicide.
 1 I feel I would be better off dead.
 0 I don't have any thoughts of harming myself.
- H. 3 I have lost all interest in other people and don't care about them at all.
 2 I have lost most of my interest in other people and have little feeling for them.
 1 I am less interested in other people than I used to be.
 0 I have not lost interest in other people.
- I. 3 I can't make any decisions at all anymore.
 2 I have great difficulty in making decisions.
 1 I try to put off making decisions.
 0 I make decisions about as well as ever.

- J. 3 I feel that I am ugly or repulsive looking.
 2 I feel that there are permanent changes in my appearance and they make me look unattractive.
 1 I am worried that I am looking old or unattractive.
 0 I don't feel that I look any worse than I used to.
- K. 3 I can't do any work at all.
 2 I have to push myself very hard to do anything.
 1 It takes extra effort to get started at doing something.
 0 I can work about as well as before.
- L. 3 I get too tired to do anything.
 2 I get tired from doing anything.
 1 I get tired more easily than I used to.
 0 I don't get any more tired than usual.
- M. 3 I have no appetite at all anymore.
 2 My appetite is much worse now.
 1 My appetite is not as good as it used to be.
 0 My appetite is no worse than usual.

Administrative Use Only

TOTAL: _____

XII. OTHER SYMPTOMS

The following items represent a number of different symptoms that people sometimes experience. Please indicate (by circling the number following each item) how much you have been bothered by each symptom over the past week.

Have you felt or experienced:	<u>Number of times during past week</u>					
1. Numbness or tingling.....	0	1	2	3	4	5+
2. Feeling hot.....	0	1	2	3	4	5+
3. Wobbliness in legs.....	0	1	2	3	4	5+
4. Unable to relax.....	0	1	2	3	4	5+
5. Fear of the worst happening.....	0	1	2	3	4	5+
6. Dizzy or light-headed.....	0	1	2	3	4	5+
7. Heart pounding or racing.....	0	1	2	3	4	5+
8. Unsteady.....	0	1	2	3	4	5+
9. Terrified.....	0	1	2	3	4	5+
10. Nervous.....	0	1	2	3	4	5+
11. Feelings of choking.....	0	1	2	3	4	5+
12. Hands trembling.....	0	1	2	3	4	5+
13. Shaky.....	0	1	2	3	4	5+
14. Fear of losing control.....	0	1	2	3	4	5+
15. Difficulty breathing.....	0	1	2	3	4	5+
16. Fear of dying.....	0	1	2	3	4	5+
17. Scared.....	0	1	2	3	4	5+
18. Indigestion or discomfort in abdomen.....	0	1	2	3	4	5+
19. Faint.....	0	1	2	3	4	5+
20. Face flushed.....	0	1	2	3	4	5+
21. Sweating (not due to heat)	0	1	2	3	4	5+



Kershaw Health
SLEEP DIAGNOSTICS CENTER

EPWORTH SLEEPINESS SCALE

Patient Name: _____ Date: ____/____/____

Directions: Read the list of situations below and answer how likely you would be to doze off or fall asleep, in contrast to just feeling tired, at these particular times.

This refers to the past three weeks. Even if you have not done, or been in some of these situations, try to guess 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

	0	1	2	3
Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly in a public place, (ex: in a theater or meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying down to rest in the afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and talking with someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TOTAL SCORE: _____



Sleep Diagnostics Center
1329 Haile Street
Camden, SC 29020
803-713-9231

Insomnia Index

This is a test to assess how you are feeling, in general, about your sleep. Answer the following questions rating how you feel about your sleep using a 0-4 point scale.

- 0= **No** problem
1= **Slight** problem with my sleep
2= **Moderate** problem with my sleep
3= **Moderately severe** problem with my sleep
4= **Big** problem with my sleep affecting all parts of my life.

Please circle the best answer about your sleep for each question.

- | | |
|--|-----------|
| 1. Overall describe your satisfaction with your sleep | 0 1 2 3 4 |
| 2. How easy is it for you to fall asleep? | 0 1 2 3 4 |
| 3. How worried are you that you won't be able to get to sleep? | 0 1 2 3 4 |
| 4. Are you easily awakened by sounds/noises in the night? | 0 1 2 3 4 |
| 5. When you sleep in a strange place or bed other than your own, how much trouble do you have trying to fall asleep? | 0 1 2 3 4 |
| 6. Is your sleep disturbed with frequent awakenings? | 0 1 2 3 4 |
| 7. Can you fall back asleep if you awaken during the night? | 0 1 2 3 4 |
| 8. Are you rested the next day after your night's sleep? | 0 1 2 3 4 |
| 9. Do you think you are getting enough hours of sleep each night? | 0 1 2 3 4 |
| 10. How much does the quality of the sleep affect your next day function? (ie; fatigue, mood, irritability) | 0 1 2 3 4 |

Total Score = _____