

TEL: 631.444.2500 FAX: 631.444.2580

Why are you being seen in the sleep clinic	c? 
Have you had a sleep evaluation in the payou receive?)	ast? (if yes, when/where and which CPAP machine did
SLEEP HABITS	
WHILE FALLING ASLEEP: What time do you usually go to be How long does it take you to fall as	d on weeldays/workdays? _ : _ am/pm sleep? minutes
What time do you usually go to be How long does it take you to fall as	d on weekends/days off? _ : _ am/pm sleep? minutes
As you are falling sleep, do you ex • Restless leg syndrome ( <i>Urge to itching sensation relieved by movii</i> • Visual, tactile, or auditory halluce • Often experiencing an inability to • Intense thoughts	move your legs, or a crawling, creeping, pulling, or ng your legs) inations
<ul> <li>WHILE ASLEEP, DO YOU:</li> <li>Snores heavily.</li> <li>Stop breathing.</li> <li>Awaken choking or gasping.</li> <li>Teeth grinding.</li> <li>Act out your dreams.</li> <li>Have nightmares.</li> <li>Sleep walk.</li> <li>Sleep talk.</li> <li>Eat while you are asleep.</li> </ul>	
How many times do you wake up i How long does it usually takes you What causes you to wake up (chee • Snoring • Choking/g • Pain • Hunger • Thirst • Worries	u to fall back to sleep? minutes. ck all that apply)?
<b>WAKING UP</b> : What time do you usually awaken	on weekdays/workdays?: am/pm

TEL: 631.444.2500 FAX: 631.444.2580

<ul> <li>To an alarm clock • Spontaneously</li> <li>How many hours do you sleep per weeknight/worknight? hours.</li> <li>How many hours do you spend in bed per weeknight? hours.</li> <li>Is it refreshing: • Never/Rarely • Sometimes • Often/Always</li> </ul>
What time do you usually awaken on weekends/days off? _ : _ am/pm  • To an alarm clock • Spontaneously  How many hours do you sleep on those nights? hours.  How many hours do you spend in bed on those nights? hours.  Is it refreshing: • Never/Rarely • Sometimes • Often/Always
Upon awakening, do you experience:
DURING THE DAY:  How many naps do you take daily?  How many minutes is each nap?  Do you feel refreshed after the nap(s)?  • Yes • Sometimes • No
Are you sleepy while driving?  • Yes • Sometimes • No  Are you honked at red lights?  • Yes • Sometimes • No  Have you had a motor vehicle accident related to sleepiness? • Yes • No  Do you have narcolepsy (overwhelming daytime drowsiness & sudden attacks of sleep) • Yes • No  Do you have cataplexy (sudden loss of muscle tone) • Yes • No

Do you have the following (central sensitization syndromes) somatic symptom disorders?

- Chronic Fatigue Syndrome
- Chronic migraine or tension-type headaches
- Temporomandibular joint (TMJ) syndrome
- Fibromyalgia
- Joint hypermobility Syndrome
- Mitral valve prolapse syndrome
- Irritable Bowel Syndrome (IBS)
- Erectile Dysfunction

<sup>\*</sup>Include Epworth Sleepiness Scale, Fatigue Severity Scale, & Body Sensation Questionnaire here, in a fillable form, that auto-calculates score and interpretation afterwards\*



TEL: 631.444.2500 FAX: 631.444.2580

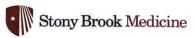


Sleep Disorders Center 240 Middle Country Road, Suite A Smithtown, NY 11787 631-444-2500

# **Epworth Sleepiness Scale**

How likely are you to doze off or fall asleep in the following situations, in contrast to have cted

feeling just tired? The not done some of the	nese things recen	otly to	to imagine how th	ey would it	ave allec
you. Use the following	na scale to choose	e the m	ost appropriate num	ber for eac	h situatio
0	1	week.	2	ა	
No chance	Slight chance		Moderate chance		
of dozing	of dozing		of dozing	of doz	ing
				A.	
1. Sitting and read	ing	,			
2 Motobing TV	or matter s.				100000
Z. Watching IV					
3 Sitting inactive i	in a public place (	e.a. the	eater or a meeting) .		
California minima					
4. As a passenger	in a car for an ho	our with	out a break		
		18 11 1			
			n circumstances per	mit	-
S. My faculty	ents sust in 1.				
6. Sitting and talki	ng to someone				
7. Sitting quietly a	fter a lunch witho	ut alco	hol		
8. In a car, while s	stopped for a few	minute	s in the traffic		
17					
				SUM	1000
,					
			Fax(631)444-2580		
	Telephone: (631)444-2500	1	Fax(031)444-2560		



TEL: 631.444.2500 FAX: 631.444.2580



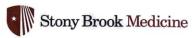
Sleep Disorders Center 240 Middle Country Road, Suite A Smithtown, NY 11787 631-444-2500

## **Fatigue Severity Scale**

Below are a series of statements regarding fatigue. By fatigue we mean a sense of tiredness, lack of energy or total body give-out. Please read each statement and choose a number from 1 to 7, where number 1 indicates that you completely disagree with the statement and number 7 means you completely agree. Please answers this questions a they apply to the last two weeks:

ques	stions a	they app	ly to the <u>last t</u>	wo weeks:				
1 Con	l nplety agree	2	3	4	5	6	7 Completely Agree	
		-K						
1.	Exercis	e brings	on my fatigue					-
2.	I am ea	sily fatigu	d					-
3.	Fatigue	interfere	s with my phy	sical functio	ning			_
4.	Fatigue	e causes	frequent prob	lems for me				-
5.	My fati	gue preve	ents sustained	d physical fur	nctioning			-
6.	Fatigue	e interfere	s with carryin	g out certair	duties and	responsi	bilities	<del>.</del>
7.	Fatigue	e is ṃy m	ost disabling	symptom				_
8.	Fatigue	e is amon	g my 3 most o	disabling syr	nptoms			-
9.	Fatigue	e interfere	s with my wo	rk, family or	social life			_
10.	Fatigue	e makes o	other sympton	ns worse				_
							SUM	_
			(X.))	<i>3</i> 1				
								_
		Te	lephone: (631)444-2	2500	Fax(631)44	4-2580		

S. Car



TEL: 631.444.2500 FAX: 631.444.2580



Sleep Disorders Center 240 Middle Country Road, Suite A Smithtown, NY 11787 631-444-2500

# **Body Sensations Questionnaire**

Below is a list of feelings, sensations, problems, and experiences that people sometimes have. Read each item and use the 1 to 5 scale below to select a rating that best describes how much you have felt or experienced things this way during the past week, including today. Use this scale when answering and select just one number for

eac	ch item:					
NI.	1	2,	3	4	5.	
Not	at all	A little bit	Moderately	Quite a bit	Extremely	
1.	Startled ea	asily				
2.	Hands we	re shaky				
3.	Was short	of breath				
5.						
6.						
				•		
		*				
	*1		¥		SUM	
	150					
		ž.				
		Telephone: (631)4	44-2500	Fax(631)444-2580	-	

TEL: 631.444.2500 FAX: 631.444.2580

#### **REVIEW OF SYSTEMS**

#### Check all boxes that apply to you:

GENERAL	ENDOCRINE	GASTROINTESTINAL
GENERAL	ENDOCKINE	GASTROINTESTINAL
Fever or chills	Heat/cold intolerance	Heartburn
Loss of appetite	Excessive thirst	Nausea or vomiting
EYES	BLOOD	Constipation
Visual changes	Anemia	Diarrhea
Eye dryness/ tearing	Easy bruising/bleeding	Abdominal pain
EARS/NOSE/THROAT	URINARY	Abdominal bloating
Hearing loss	Urinate frequently	NEUROLOGICAL
Bad breath	Urinary incontinence	Headaches
CARDIOVASCULAR	MUSKULOSKELETAL	Tremors
Chest pain	Joint pain	Numbness/Tingling
Palpitations	Muscle pain	Seizures
Swelling of feet	Cramps	Dizziness/Fainting
RESPIRATORY	SKIN	PSYCHIATRIC
Shortness of breath	Rashes	Anxiety/Nervousness
Cough	Dryness	Depression
Wheezing		Memory Loss

### PAST MEDICAL HISTORY Do you have any of the following medical conditions?

- High blood pressure
- Heart attack
- Heart failure
- Cardiac arrhythmia
- Depression
- Gastroesophageal reflux
   Attention deficit disorder
- Irritable bowel syndrome
- Asthma
- COPD/Emphysema
- Rhinitis/sinusitis
- Anemia
- Fibromyalgia
- Erectile dysfunction
- Stroke
- Seizures
- Diabetes
- Thyroid disease
- Chronic fatigue syndrome
- Migraine/tension headaches

Other: \_\_\_\_\_

#### SURGICAL HISTORY

Have you had a tonsillectomy: • Yes • No

Have you had any complications related to anesthesia? • Yes • No

List all other surgical procedures that you have had: \_\_\_\_



TEL: 631.444.2500 FAX: 631.444.2580

MEDICATIONS (Please list all the medications that you currently take.)

Medication name	Dose	Times per day	Medication name	Dose	Times per day
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

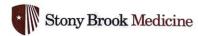
<u>ALLERGIES</u> Are you allergic to any medication? • Yes • No If yes, please list the medication and your reaction to it.

Medication name	Reaction	Medication name	Reaction

## **SOCIAL HISTORY**

Marriage status: Work status: • Full-time employment • Part-time employment Do you have a job that requires you to work	Student     Disabled
	oker – smoking packs per day, for years. e, smoked packs per day, for years.
Alcohol use: • Never • Once a month • On day	ce a week • 1 drink a day • More than 1 drink a
How many caffeine-containing beverages de Coffee(s) Tea(s) Soda(s)	o you consume on a typical day?

FAMILY HISTORY Does anyone in your immediate family have the following medical conditions?



TEL: 631.444.2500 FAX: 631.444.2580

	Father	Mother	Brother/Sister	Children
High blood pressure				
Heart attacks				
Asthma				
COPD/Emphysema				
Diabetes				
Depression				
Obesity				
Snoring				
Sleep apnea				
Narcolepsy				
Thyroid gland disease				
ADHD				
Parkinson's Disease				
Dementia				
Strokes				

What is your current: weight?	lbs. Height?	inchas	Collar size?	
Wilde is your cultons, wolunt:	ibs. Hiciani:	II IUI IUG.	Oulial Size:	