LUTHERAN SLEEP DISORDERS CENTER QUESTIONNAIRE
7836 West Jefferson Blvd., Fort Wayne IN 46804
(260) 435-7403

Patient Name_____ DOB:_____ Date:_____

Weight _____ Height _____

Family Physician _____

Referring Physician _____

Medications I am currently taking are:

_____

_____

_____

Please complete the following questionnaire.

1. If you are currently employed, what shift do you work? ____1st ____2nd ____3rd ____Rotating
2. What time do you go to sleep? _____
3. What time do you wake up? _____
4. How many times do you awaken during your sleep? _____ Why? _____
5. Do you feel rested when awakening? ____Yes ____No
6. Do you nap during the day? ____Yes ____No
7. If you do nap, estimate frequency. ____Daily ____ Times per week ____Rarely ____ Nap Length
8. Do you perspire during sleep? ____Yes ____No
9. Do you snore? ____Yes ____No
10. Has your bed partner ever said you stop breathing during sleep? ____Yes ____No
11. Do you ever awaken from sleep gasping for breath or choking? ____Yes ____No
12. Do you often feel sleepy during the day? ____Yes ____No
13. Have you ever fallen asleep driving a vehicle or nearly so? ____Yes ____No
14. Have you ever had a car or work accident because of sleepiness? ____Yes ____No
15. Do you fall asleep easily during quiet activities (reading, TV, etc.)? ____Yes ____No
16. Are you often tired during the day? ____Yes ____No
17. Is your sleep restless? ____Yes ____No
18. Have you ever had a sudden irresistible sleep attack? ____Yes ____No
19. Do you ever suddenly feel very weak when laughing, sad, angry or otherwise excited in the knees, neck, arms or all over? ____Yes ____No
20. Do you ever feel you cannot move for a brief period just as you are falling asleep or when awakening? ____Yes ____No
21. Do you think you hallucinate when falling asleep or awakening? ____Yes ____No
22. Do you often experience confusion or poor memory during the day because you are too sleepy or tired? ____Yes ____No

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THE EPWORTH SLEEPINESS SCALE (ESS)

The ESS is a questionnaire designed to evaluate levels of excessive sleepiness. This test is a standardized screening tool that will help measure your patients' general level of sleepiness. It asks the patient to rate the chances of dozing off or falling asleep during common daily activities. Answers to the questions are rated from 0-3, with 0 meaning your patient would never doze or fall asleep in a given situation, and 3 meaning that there is a very high likelihood that your patient would fall asleep in that situation.*

0=would never doze
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place, for example, a theatre or meeting	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (when you've had no alcohol)	_____
In a car, while stopped in traffic	_____

The Epworth Sleepiness Scale Key

Total score of less than 10 suggests that you may not be suffering from excessive sleepiness.

Total score of 10 or more suggests that you may need further evaluation by a physician to determine the cause of your excessive sleepiness and whether you have an underlying sleep disorder.

*(Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep*. 1991; 14:540-545)

Signature:_____ **Date:**_____ **Time:**_____

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