SIDNEY HEALTH CENTER
Sleep Disorders Center
216 14th Ave SW
Sidney, MT 59270

Please complete this questionnaire and return it in the envelope provided as soon as possible.
This needs to be returned before your test can be scheduled.
Please call the Sleep Center with any questions at 406-488-2385 or 406-488-2033,
or the Outpatient Coordinator at 406-488-2195.

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____Cell: _____Work: _____

Sex: _____ Height: _____ Weight: _____ Referring physician: _____

1. What is your primary sleep problem? _____

   _____

2. Who initially suspected a sleep problem? _____

3. Do you currently have a bed partner/roommate? _____

   If yes, please have them assist you with this questionnaire.

4. Have you been seen by a sleep specialist before? _____

5. Have you had difficulty at work/school due to your sleep problem? _____

6. Have you had difficulty driving due to your sleep problems? _____

7. What is your primary work shift? _____

8. How many caffeinated drinks do you have daily? _____

9. If you snore, please rate the noise level:

4	3	2	1
heard outside room	wakes bed partner	easily heard	barely noticeable

10. Do you take naps during the day? _____Yes _____No

11. Have you ever smoked cigarettes? _____Yes _____No

    How many packs per day? _____

    How many years did you smoke? _____

    Have you quit smoking yet? _____Yes _____No

12. Has anyone ever observed you stop breathing when you sleep? _____Yes _____No

13. Do you awaken gasping or choking? _____Yes _____No

14. Do you have trouble falling asleep? _____Yes _____No

15. Do you kick or twitch your legs when you sleep? _____Yes _____No

16. How many times do you awaken during the night? _____

17. How many times do you get up to urinate at night? _____

18. Do you have creepy/crawly feelings, numbness of legs, when you are trying to fall asleep?

    _____Yes _____No

19. Have you ever used diet pills? _____Yes _____No

20. Have you ever used stimulant drugs before? _____Yes _____No
    Have you ever used marijuana? _____Yes _____No
    Have you ever used cocaine or other drugs? _____Yes _____No

21. Do you sit up and scream while asleep or suddenly wake up scared?

    _____Yes _____No

22. Do you walk while asleep, with no recall the next day? _____Yes _____No

23. Do you have frightening nightmare or dreams? _____Yes _____No

24. Have you felt paralyzed, unable to move, but mentally alert while falling asleep or awakening?

    _____Yes _____No

25. Have you had a sudden physical weakness of arms, legs, or face when laughing/crying or during

    other emotional situations? _____Yes _____No

26. Do you have palpitations or chest pain at night? _____Yes _____No

27. How much alcohol do you consume within three hours of bedtime? _____
    How much alcohol do you consume within a 24-hour period? _____

28. Please explain strange feelings or behavior you have or had during the night.

    _____

    _____

29. Please list any medication you are currently taking: (Include sleeping pill or Melatonin)

    _____ _____ _____

    _____ _____ _____

30. Have you now or in the past experienced any health problems in the following areas?

High blood pressure _____	Shortness of breath _____
Deviated nasal septum _____	Chronic cough _____
Sinus problems _____	Asthma _____
Tonsillectomy _____	Emphysema _____
Heart Disease _____	Thyroid Disease _____
Psychiatric _____	Diabetes _____
Heartburn _____	Reflux _____

Please list any other medical problems you have or have had:

_____

_____

_____

31. Sleepiness scale: Please use this scale to evaluate the following questions:

0 = would never doze 1 = slight chance of dozing

2 = moderate chance of dozing 3 = high chance of dozing

1. Sitting and reading _____

2. Watching T.V. _____

3. Sitting inactive in a public gathering _____

4. As a passenger in a car for an hour without break _____

5. Lying down in the afternoon circumstances permitting _____

6. Sitting and talking to someone _____

7. Sitting quietly after lunch not having consumed alcohol _____

8. Driving a car that has stopped briefly at a red light _____

Total Epworth Score _____

Epworth Sleepiness Score (ESS) by Diagnosis

0-9 = Normal 10-13 = Mild 14-19 = Moderate 20-23 = Severe