METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Please complete and bring with you for your sleep study

*Thank you for choosing MetroWest Medical Center for your Sleep Study. Please complete this 3-page questionnaire. It will help us know about your current sleep habits and will be very helpful in completing a final diagnosis with your overnight sleep study.*

# Sleep Questionnaire-Page 1

Name: _____ Date: _____ DOB: _____

Referring Physician: _____ Primary Care Physician: _____

Do you have difficulty falling asleep? ❑ Yes ❑ No

Do you have difficulty staying asleep? ❑ Yes ❑ No

Would you call yourself excessively sleepy during the day? ❑ Yes ❑ No

What time do you usually go to bed on the WEEKDAYS? _____AM/PM

How long does it usually take you to fall asleep? ____Hr. _____Min.

What is the total amount of time of SLEEP you usually get a night? ____Hr. _____Min.

How many times do you usually wake up during a typical night of sleep? _____time(s)

How many times a night, after going to bed, do you get up to urinate? _____ time(s)

What is your usual morning wake time? _____AM/PM

How much of these fluids do you drink during a 24hr. period?

Coffee _____(cups) Tea _____(cups) Soda _____(cups)

Have you had your tonsils been removed? ❑ Yes ❑ No

Have you had your adenoids removed? ❑ Yes ❑ No

Do you take any regular medications to help you with your sleep? ❑ Yes ❑ No

What medication? _____ Any other medications in the past? _____

How many alcoholic beverages do you consume during a 24hr. period? _____

How many times a week do you participate in a sport or exercise? _____

How many packages of cigarettes do you smoke in a 24hr. period? _____pack(s)

How long does it usually take you to "get going" after you get out of bed? ____Hr. _____Min.

How many automobile accidents have you had from sleepiness? _____ Any near misses? _____

How long is your commute? ____Hr. _____Min.

How many naps do you take ON PURPOSE during a usual weekday? _____ On a weekend? _____

What is your body weight? Now: _____ Heaviest: _____

How much weight have you gained in the past 12 months? _____lb(s).

What is your height? _____feet _____inches

Do you suffer from any of the following?

❑ HBP ❑ Thyroid Disease ❑ Diabetes ❑ Chronic Lung Disease ❑ Sinus Issues ❑ Urinary Issues

Have you ever broken your nose? ❑ Yes ❑ No

Do you have any drug allergies? ❑ Yes ❑ No If yes, please list: _____

What medications do you take now? _____

Have you ever had a sleep study before? ❑ Yes ❑ No

If so, when and where? _____

over >>>>

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# Sleep Questionnaire-Page 2

How often do you (circle number):

| | **Always** | | **Occasionally** | | **Never** |
|---|---|---|---|---|---|
| Have restless disturbed sleep? | 1 | 2 | 3 | 4 | 5 |
| Disturb the sleep of your bed partner? | 1 | 2 | 3 | 4 | 5 |
| Have nasal congestion (stuffiness, nasal obstruction)? | 1 | 2 | 3 | 4 | 5 |
| Have nightmares? | 1 | 2 | 3 | 4 | 5 |
| Have dream-like images (hallucinations when Awake when you know you're not sleeping?) | 1 | 2 | 3 | 4 | 5 |
| Snore loudly and disruptively? | 1 | 2 | 3 | 4 | 5 |
| Notice that your heart pounds, beats rapidly or irregularly during the night? | 1 | 2 | 3 | 4 | 5 |
| Walk in your sleep? | 1 | 2 | 3 | 4 | 5 |
| Grind your teeth during sleep? | 1 | 2 | 3 | 4 | 5 |
| Twitch or kick your legs while you sleep? | 1 | 2 | 3 | 4 | 5 |
| Wake up from pain? | 1 | 2 | 3 | 4 | 5 |
| Have vivid dreams during naps? | 1 | 2 | 3 | 4 | 5 |
| Feel unable to move (paralyzed) while falling asleep or awakening from sleep? | 1 | 2 | 3 | 4 | 5 |
| Have episodes of sudden muscular weakness (paralysis or inability to move) when laughing, angry or in any other emotional situations? | 1 | 2 | 3 | 4 | 5 |
| Have trouble staying awake in the daytime? | 1 | 2 | 3 | 4 | 5 |
| Wake during the night with stressful thoughts on your mind? | 1 | 2 | 3 | 4 | 5 |

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# Sleep Questionnaire-Page 3

## Eppworth Sleepiness Scale

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 (0-3)** |
|---|---|
| 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 (as the driver) | _____ |

**If your score is 10 or more, you are considered to have excessive daytime sleepiness.**