



Pulmonary Disease and
Critical Care Associates, P.A

David O. Nyanjom, M.D.
Fernando C. De Leon, M.D.
Francis S. Chuidian, M.D., F.C.C.P.
Carmen G. Salvaterra, M.D., F.C.C.P.

THE EPWORTH SLEEPINESS SCALE

Name: _____

Today's Date: _____ Your Age (years): _____

Your Sex (M or F): _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out 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
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. a theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in the traffic	_____

THANK YOU FOR YOUR COOPERATION

SLEEP – WAKE QUESTIONNAIRE

Patient's Name: _____ Date: _____

MY MAIN COMPLAINT IS:

- | | YES | NO |
|---|-------|-------|
| 1. I have trouble sleeping at night | _____ | _____ |
| 2. I am sleepy all day | _____ | _____ |
| 3. I have unwanted behaviors when I am sleeping | _____ | _____ |

If yes, explain _____

UNUSUAL SLEEP HABITS

1. On weekdays (workdays), I usually go to bed at: _____
2. On weekdays (workdays), the earliest time in the last two weeks I have gone to bed is: _____
3. On weekdays (workdays), the latest time in the last two weeks I have gone to bed is: _____
4. My usual weekend (off days) bedtime is: _____
5. On weekdays, I wake up at: _____
6. On weekends, I wake up at: _____
7. To feel my best, I should go to bed at: _____
8. To feel y best, I would get up at: _____
9. In the evening, I usually start feeling tired at: _____
10. The amount of time that I usually take to fall asleep is: _____
11. I usually exercise at _____ for _____ minutes.
12. I wake up _____ naturally; _____ by using alarm.
13. I take a nap about _____ days each week.
14. After taking a nap, I usually feel
_____ Refreshed
_____ Groggy or sleepy

SLEEP – WAKE QUESTIONNAIRE

Patient's Name: _____ Date: _____

PARASOMNIAS

Please place a check beside any of the following statements that are true for you:

- _____ I have been told that I grind my teeth when I sleep.
- _____ As an adolescent or child, I have been seen sleepwalking.
- _____ As an adolescent or child, I have been seen sleep talking.
- _____ My dreams are often very vivid.
- _____ I feel that I dream too much.
- _____ My dreams often awake me.
- _____ I often have frightening dreams.
- _____ As an adult, I have wet my bed.
- _____ I have been told that I bang or twist my head at night.

DISTURBED SLEEP

Please place a check beside any of the following statements that are true for you:

- _____ I have been told that I snore very loudly.
- _____ Sometimes a person cannot sleep in the same room with me because he / she is bothered by my snoring.
- _____ My bed covers are very messy in the morning.
- _____ I am a restless sleeper.
- _____ I have been told that I kick or poke my bed partner while I am asleep.
- _____ I have hallucinations or dreamlike images when I am not actually asleep but while falling asleep or waking up.
- _____ I sometimes awaken with a choking sensation.
- _____ I have been told that I stop breathing when I sleep.
- _____ I have fallen out of bed.
- _____ I have been told that I make rolling and rocking movements during sleep.
- _____ I sometimes have felt paralyzed or unable to move when awake or falling asleep.
- _____ I wake up suddenly from sleep with an unpleasant feeling or fear, anxiety, tension or unhappiness.

SLEEP – WAKE QUESTIONNAIRE

Patient's Name: _____ Date: _____

.....

- _____ I wake up from sleep with a feeling of muscle tension or tightness in my arms or chest.
- _____ I have awakened from sleep once or more having vomited or with heartburn.
- _____ When I wake up during the night, I often have to get up and go to the bathroom.
- _____ I sweat a lot when I sleep.
- _____ I feel that the quality of my sleep is unsatisfactory.
- _____ I have been told that my legs twitch or jerk while I am sleeping.
- _____ Sometimes I wake up with a headache.

INSOMNIA

Please place a check beside any of the following statements that are true for you.

- _____ I have trouble falling asleep at night.
- _____ When I do not sleep, I worry about it the next day.
- _____ When I wake up during the night, I have trouble going back to sleep.
- _____ I wake up in the morning long before I have to.
- _____ Some nights, I never get to sleep no matter how hard I try.
- _____ When I try to go to sleep, my mind races with many thoughts.
- _____ At night when I go to bed, I do not feel sleepy.
- _____ I often sleep better in an unfamiliar bedroom, such as a hotel or motel room.
- _____ When I try to go to sleep, I feel anxious or nervous.
- _____ When I try to fall asleep I worry about whether or not I can sleep.
- _____ When I try to fall asleep I often feel hungry or thirsty.
- _____ When I try to sleep I feel pain.
- _____ Pain often wakes me up or keeps me from going back to sleep.
- _____ I have a creeping, crawling sensation in my legs when I lie down to sleep.
- _____ When I do sleep, I feel that I sleep very well.
- _____ I am a very light sleeper. I am easily awakened by noises.
- _____ My sleep is disturbed because of my partner.
- _____ Heat or cold disturbs my sleep.
- _____ Generally I get up in the middle of the night for a snack.

SLEEP – WAKE QUESTIONNAIRE

Patient's Name: _____ Date: _____

.....

DAYTIME SLEEPINESS

Please place a check beside any of the following that are most true for you.

_____ I have sometimes fallen asleep at very inappropriate times, such as while driving, eating or a conversation.

_____ I have sometimes been so sleepy that I become confused or lost track of a topic during a conversation.

_____ I am frequently so sleepy during the day that my work is poor.

_____ I have had accidents or near-accidents when driving because I felt so sleepy.

_____ When I have no plans or appointments the next day, I frequently go to bed late (compared to my usual bedtime)

_____ I frequently do not feel sleepy at bedtime and stay up until it is late so that as a consequence I get too little sleep.

_____ Other members of my family have been hyperactive or hyperkinetic as children.

_____ Other members of my family have the same problem that I do.

SLEEP – WAKE QUESTIONNAIRE

Patient's Name: _____ Date: _____

.....

DAILY SLEEP LOG

To help us understand your sleep problem, we need a record of the times when you sleep, nap, and wake up during sleep. In addition, we need to know when you drink coffee, tea, and alcoholic beverages. It is important that you keep this record for one week. You should give your best guess at the time needed to fall asleep. If you can not recall exactly the time of some events, give your best guess. Each column begins a new day: the first column is an example for you to study. If you have any questions, call our office. The number is on page 1 of this questionnaire. A – indicates a.m. (morning): P – indicates p.m. (evening).

Day of week	Monday							
Time went to bed	11 PM							
Time of final awaking	6:30AM							
Estimated time to fall asleep	20 Min							
Time of awakening during sleep/length of time awake	1 am / 10 Min 4 am / 35 min							
Coffee & tea number of cups & time drank	7a 1 8a 1 12p 2 4:30p 2							
Alcoholic drinks number & time drank	9p 2 11p 4							

SLEEP – WAKE QUESTIONNAIRE

Patient's Name: _____ Date: _____

TO BE COMPLETED BY BED PARTNER

Check any of the following behaviors that you have observed the patient doing while asleep.

- _____ Loud snoring
- _____ Light snoring
- _____ Twitching of legs or feet during sleep
- _____ Breathing Pauses
- _____ Grinding teeth
- _____ Sleep talking
- _____ Sleepwalking
- _____ Sitting up in bed not awake
- _____ Rocking or banging head
- _____ Kicking with legs during sleep
- _____ Getting out of bed while not awake
- _____ Biting tongue
- _____ Becoming very rigid and/or shaking

How long have you been aware of the sleep behaviors that you have checked above?

Describe the behaviors checked above in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

If you have noticed snoring do you remember hearing short pauses in the snoring or occasional loud "snorts"? _____