The Bariatric Center
GEORGETOWN COMMUNITY HOSPITAL

Sleep History Questionnaire

Dr. Ronald Shashy, MD

Please fill this form out and return it with your Patient Profile Packet.

Patient Name:_____   Date:_____

Symptoms During Sleep

Check all that apply.

__ Loud Snoring
__ Gasping
__ Daytime Sleepiness
__ Difficulty falling asleep
__ Difficulty staying asleep
__ Awaken too early
__ I worry that I won't be able to fall asleep
__ Fatigue
__ Morning Headaches
__ Irritability/Depression
__ Inability to concentrate
__ Sinus symptoms interfere with sleep
__ Heartburn, indigestion, sour taste
__ Inability to move while going to sleep
   or waking up
__ Vivid or life-like visions (people in room, etc.)
   while going to sleep or waking up
__ Sudden weakness or feel your body go
   limp when angry or excited
__ Irresistible urge to move legs or arms
__ Creeping or crawling sensation in legs
   before falling asleep
__ Legs or arms jerking during sleep
__ Frequent urination disrupting sleep
__ Sleep talking or sleep walking

Diagnosis:_____

Machine: **Bi-Pap**
(Please Circle)
              C-Pap

              Other:_____

Sleep Habits

1. At what time do you usually get to bed?___
2. How long does it take to fall asleep after lights out?_____
3. How often do you awaken at night?_____
4. Total time spent awake in bed?_____
5. I usually wake up at?_____
6. Total length of naps daily?_____
7. Do you work a rotating shift?_____
8. Do you have an unusual work schedule?____
   _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done these things, 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 dose   **1**=slight chance
2=moderate chance of dosing
3=high chance of dosing

Sitting and Reading............................._____
Watching TV......................................._____
Sitting, inactive, in a public place
        (movie theatre or a meeting)..._____
As a passenger in a car for an hour
        without a break......................._____
Lying down to rest in the afternoon......._____
Sitting & talking with someone.............._____
Sitting quietly after lunch with alcohol...._____
In a car, whole stopped for a
        few minutes in traffic..............._____

Total Points..............................._____

_____   ARNP   Date