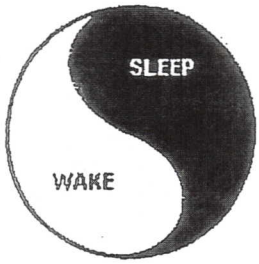
William S. Burkes, M.D.
Board Certified in Sleep Medicine and Clinical Sleep Disorders
Regents Park I,85 IH-10 N, Suite 202
Beaumont, Texas 77707-2502
409.835.0995 FAX 409.835.3700



SLEEP HISTORY

NAME: _____ SSN: _____
AGE: _____ HEIGHT: _____ WEIGHT: _____
MARITAL STATUS: _____ RACE: _____ SEX: _____
OCCUPATION: _____
WHY WERE YOU REFERRED TO US? _____
_____
REFERRING PHYSICIAN: _____
PRIMARY CARE PHYSICIAN: _____

1. Have you ever had a sleep evaluation or overnight sleep study done before? _____ If yes, please give the date and location _____

2. Please list any surgical procedures you have had.

_____ _____
_____ _____
_____ _____

3. Please list any current medical problems.

_____ _____
_____ _____
_____ _____
_____ _____

4. Please list all medications that you are currently taking or that have been discontinued within the last month. Include both prescription and over-the-counter medications.

Medication	Dosage	Medication	Dosage

5. Do you use tobacco products? _____ If yes, what type and what quantity do you use daily. Type: _____ Amount: _____

6. From the following list, please answer with the amount you consume per day.
Coffee: _____ Tea: _____ Soft drinks: _____ Alcohol: _____

7. Do you work nights or rotating shifts? If yes, please indicate the hours that you work.
Sun _____ Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____

8. Please describe in your own words the nature of the sleep problem that you are having.

_____

_____

_____

9. *When you work*, what is your normal bedtime? _____
What time do you wake up? _____
When you are off, what is your normal bedtime? _____
What time do you wake up? _____

10. What do you normally do the last hour of the day before you go to sleep for the night?

_____

_____

_____

11. Do you have a hard time falling asleep at night? _____

12. Do you have difficulty sleeping if lying flat? _____

13. Do you sleep well once you fall asleep? _____

14. Do you wake during the night? _____
How often: _____
Why: _____
What time(s): _____

15. Do you get enough sleep? _____ If not, why: _____

16. Do you have trouble concentrating during the day? _____

17. Have you had a car accident or near miss because of sleepiness? _____

18. Have you gained weight in the last year? _____ How much? _____

19. Have you had surgery for sleep apnea? _____ Which operation? _____
_____ When? _____
Did it help? _____ Any side effects? _____

20. Have you used nasal CPAP or BiPAP? _____
When? _____ Settings: _____

Do you use home oxygen? _____ Setting: _____liters/minute

Have you ever been treated for depression? _____

Using the following scale, please circle the rating of the following questions as they pertain to you

0 = never **1** = rarely **2** = occasionally **3** = frequently **4** = constantly

- Do you snore? ---------- 0 1 2 3 4
- Have you been told that you stop breathing in your sleep? ---------- 0 1 2 3 4
- Do you wake with a headache? ---------- 0 1 2 3 4
- Do you sweat heavily during the night? ---------- 0 1 2 3 4

- Are you excessively sleepy after you have wakened? ---------- 0 1 2 3 4
- Are you excessively sleepy later in the day after awakening? ---------- 0 1 2 3 4
- Do you fall asleep in situations where you try to stay awake? ---------- 0 1 2 3 4
- Do you fall asleep while driving? ---------- 0 1 2 3 4
- Do you fall asleep while at work? ---------- 0 1 2 3 4
- Do you have difficulty falling asleep once you go to bed for the day? ---- 0 1 2 3 4
- Do you wake during the night and find it difficult to go back to sleep? --- 0 1 2 3 4

- Do you experience vivid dreams upon falling asleep or awakening? ----- 0 1 2 3 4
- Do you feel paralyzed or unable to move while in bed? ---------- 0 1 2 3 4
- Do you feel sudden weakness as if you might fall during laughter or anger? 0 1 2 3 4
- Do you feel refreshed after a 15-20 minute nap during the day? ---------- 0 1 2 3 4

- Do you wet the bed? ---------- 0 1 2 3 4
- Do you have crawling sensations or feel you have to move your legs in bed? 0 1 2 3 4
- Have you been told that you kick your legs while you sleep? ---------- 0 1 2 3 4

- Do you sleepwalk? ---------- 0 1 2 3 4
- Do you talk in your sleep? ---------- 0 1 2 3 4
- Do you sit up or scream in your sleep & not remember when you wake? 0 1 2 3 4
- Have you been told that you grind your teeth in your sleep? ---------- 0 1 2 3 4

Please list any medication **allergies**: _____.

William S. Burkes, M.D.

Sleep History Questionnaire

Name Date

Birthdate Age

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your current lifestyle. 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

Circle one number on each line.

Situation:	**Chance of Dozing:**			
Sitting inactive in a public place such as a theatre or meeting	0	1	2	3
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Have you ever had a sleep test, either at home or in a sleep lab? _____ Yes _____ No

If yes, were you diagnosed or otherwise told that you had sleep apnea? _____ Yes _____ No

Please answer the following questions. Place a mark on the appropriate line for each question.

	Yes	No	Sometimes
Do you snore?	____	____	____
Has anyone said that you stop breathing at night?	____	____	____
Are you sleepy during the day?	____	____	____
Do you experience night sweats?	____	____	____
Do you have morning headaches?	____	____	____
Do you have a dry mouth in the morning?	____	____	____
Do you have reflux or heartburn that is worse at night?	____	____	____
Do you have more than 2 awakenings during the night?	____	____	____
Are these awakenings associated with choking, gasping for air, or shortness of breath?	____	____	____

PLEASE PLACE A CHECK MARK FOR ANY "YES" ANSWERS

Have you recently had problems with
Chills ❑
Fever ❑
Lightheadedness ❑

Have you recently had allergy symptoms such as
Congestion ❑
Cough ❑
Skin Rash ❑
Sneezing ❑
Watery eyes ❑
Wheezing ❑
Runny Nose ❑

Have you recently had
Dry Mouth ❑
Sinus Pain ❑
Sore Throat ❑

Have you recently had problems with
Shortness of Breath ❑
At rest ___
With exertion ___
Chest Pain ❑
At rest ___
With exertion ___
Abdominal Pain ❑

Have you had problems with fainting or loss of consciousness? ❑

Have you has problems with balance or an unsteady gait? ❑

Have you ever had a seizure? ❑
If so, when? _____

Have you ever had problems with tremors (shakes)? ❑

Have you ever been treated, diagnosed with, or had problems with anxiety? ❑

Do you have any previous history of substance abuse? ❑
If so, what substance(s)? _____

Name: _____ Date _____