ENTICARE
Ear · Nose · Throat

Policy and Procedure: Direct Referral for Sleep Studies
Policy #: OS5.2
Effective Date: 9/29/11
Last Revision Date:
Category: Office and Scheduling Procedures
Approved:

Initial Questionnaire

Patient Name _____ Age _____ Date _____

Height _____ Weight _____

Main Complaint _____

Please select the best answer that represents your normal sleep.

1. Do you feel that you:

• get too little sleep at night?	☐ Yes	☐ No
• get too much sleep at night	☐ Yes	☐ No
• have trouble getting a good night's sleep?	☐ Yes	☐ No
• have trouble getting to sleep at night?	☐ Yes	☐ No
• have trouble staying asleep at night?	☐ Yes	☐ No
• have trouble getting up in the morning?	☐ Yes	☐ No
• have non-refreshing sleep?	☐ Yes	☐ No
• are sleepy during the day?	☐ Yes	☐ No
• are tired (fatigued) during the day?	☐ Yes	☐ No

2. What time do you usually go to bed? _____

3. Does this time vary?_____

4. How long does it usually take you to fall asleep? _____

5. On average, how many hours of sleep do you get each night? _____

6. When trying to fall asleep, how often do you:

	Never	Some	Often
• have thoughts racing through your mind?	☐	☐	☐
• feel sad or depressed?	☐	☐	☐
• have anxiety/worry about things?	☐	☐	☐
• feel muscular tension?	☐	☐	☐
• feel afraid of not being able to sleep?	☐	☐	☐
• feel unable to move?	☐	☐	☐

	Never	Some	Often
• have a creeping, crawling, aching or twitching in your limbs making you feel you have to move them?	☐	☐	☐
• have any kind of pain or discomfort?	☐	☐	☐
• feel afraid of the dark or anything else?	☐	☐	☐
• feel afraid you won't return to sleep?	☐	☐	☐

7. How many times do you usually awaken each night? _____

8. Do you have trouble getting back to sleep? _____

9. On a typical night, what is your longest period of wakefulness? _____

10. How long are you awake all together during the night? _____

11. Do you usually wake up during the first or latter part of the night? _____

12.

How often do you:	Never	Some	Often
• sleep with someone else in your bed?	☐	☐	☐
• sleep with someone else in your room?	☐	☐	☐
• have restless, disturbed sleep?	☐	☐	☐
• get up at night to attend to your children?	☐	☐	☐
• snore loudly and/or disruptively?	☐	☐	☐
• hold your breath or stop breathing while you sleep?	☐	☐	☐
• have nasal congestion during the night?	☐	☐	☐
• suddenly awaken gasping for air?	☐	☐	☐
• have some other breathing problem at night?	☐	☐	☐
• feel your heart pounding during the night?	☐	☐	☐
• sweat a lot during the night?	☐	☐	☐
• walk in your sleep?	☐	☐	☐
• fall out of bed while asleep?	☐	☐	☐
• wake up screaming, violent or confused?	☐	☐	☐
• have unusual movements while asleep?	☐	☐	☐
• wet the bed?	☐	☐	☐
• grind your teeth at night?	☐	☐	☐
• have a night full of intense, vivid dreams?	☐	☐	☐
• have nightmares?	☐	☐	☐

- wake up from a dream? ☐ ☐ ☐
- have racing thoughts during your sleep? ☐ ☐ ☐
- have a recurring dream that disturbs your sleep? ☐ ☐ ☐

13. What time do you usually wake up in the morning? _____

14. What time do you usually get out of bed? _____

15. How often do you:

	Never	Some	Often
• depend on an alarm clock to wake you up?	☐	☐	☐
• "sleep-in" in the morning (more than one hour past your normal time to get up)?	☐	☐	☐
• have a very hard time waking up?	☐	☐	☐
• feel unable to move when waking up?	☐	☐	☐
• have dream-like images when waking up even when you know that you are not sleeping?	☐	☐	☐
• wake up confused or disoriented?	☐	☐	☐
wake up with a headache?	☐	☐	☐
wake up with a dry mouth?	☐	☐	☐

16. Have you ever slept or been overwhelmingly sleepy for several days at a time? ☐ Yes ☐ No

17. Have you ever been unable to sleep for several days at a time? ☐ Yes ☐ No

18. Do you feel that your sleep is abnormal? ☐ Yes ☐ No

19. If you have or have had a sleep or sleepiness problem, was it worse at any time in the past? ☐ Yes ☐ No

20. Have you ever had any trouble with sleep during your childhood? ☐ Yes ☐ No

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	Never	Some	Often
21. How often do you feel extremely alert and energetic during the day?	☐	☐	☐
22. How great a problem do you have with *fatigue* (tiredness, exhaustion or lethargy) even when you are not sleepy?	☐	☐	☐
23. How great of a problem do you have with *sleepiness* (sleepy or struggling to stay awake) in the daytime?	☐	☐	☐
24. How often do you fall asleep unintentionally? Please give an example: _____	☐	☐	☐
25. How often do you feel sad or depressed?	☐	☐	☐
26. How often do you feel muscular tension?	☐	☐	☐
27. How often do you feel weakness in you muscles when laughing, being surprised, angry, excited, etc.?	☐	☐	☐
28. How great of a problem do/did you have with your education because of sleepiness/fatigue?	☐	☐	☐
29. How great of a problem do you have with your performance at work because of sleepiness/fatigue?	☐	☐	☐
30. How many times have you ever had accidents at work because of sleepiness/fatigue?	☐	☐	☐

31. How many times have you been involved in automobile accidents? _____

32. How many rest (not sleeping) periods do you usually take in a weekday? _____

33. How many times in a usual weekday do you try to take a nap but can't sleep? ____

34. How long is your nap and/or rest periods? _____

35. Do you feel refreshed after your naps? _____ rest periods? _____

36. How long do you feel refreshed after a nap? _____ rest periods? _____

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37. How often do you:	Never	Some	Often
• experience vivid dream like images while falling asleep or awakening from a nap even though you know you are still awake?	☐	☐	☐
• have vivid dreams during a nap?	☐	☐	☐
• feel unable to move while falling asleep or waking up?	☐	☐	☐
• discover that you have performed a complex act such as driving a car, and not remembered how you did it?	☐	☐	☐
find yourself doing things which make no sense (such as writing nonsense or mixing chocolate and gravy)?	☐	☐	☐
• get told that you were acting strangely without your being aware of it at the time?	☐	☐	☐
• have a feeling of "weak knees" when you laugh?	☐	☐	☐
• have episodes of sudden muscular weakness (paralysis or inability to move when laughing, angry, emotional situations?	☐	☐	☐

38. Do you think you are excessively sleepy during the daytime? ☐ Yes ☐ No

39. Do you have any problems with:

• nasal congestion, obstruction or discharge?	☐ Yes	☐ No
• swallowing?	☐ Yes	☐ No
• a lump of obstruction in your throat?	☐ Yes	☐ No
• has your voice changed in the last year?	☐ Yes	☐ No

40. Please check any problems or illnesses you have or have had:

☐ heart disease	☐ high blood pressure	☐ low blood pressure
☐ heart attack	☐ headaches	☐ black outs
☐ fainting	☐ dizziness	☐ ringing in ears
☐ epilepsy/seizures	☐ hemophilia	☐ ulcers
☐ hernias	☐ prostrate trouble	☐ mental illness
☐ back problems	☐ gout	☐ asthma
☐ allergies	☐ bronchitis	☐ kidney trouble
☐ bladder trouble	☐ eye trouble	☐ hearing trouble
☐ pneumonia	☐ meningitis	☐ heartburn/gas
☐ muscle cramps	☐ tuberculosis	

41. Surgeries & Hospitalizations – Please list any hospitalizations and/or surgeries you have had. Include where, what, why and when.

- _____
- _____
- _____
- _____
- _____

42. Medications – List name/dose of all medication you are taking now or in the last 30 days.

- _____
- _____
- _____
- _____
- _____

43. How much of these fluids do you drink?

	During a 24 hour period	Within 2 hours of bedtime
Coffee	_____ cups	_____ cups
Tea	_____ cups	_____ cups
Cola drinks	_____ cups	_____ cups

44. How many alcoholic drinks do you have during a 24 hour period?

Please list for weekends _____
Please list for weekdays _____

45. How often have you:

	Never	Some	Often
• used alcohol in order to get to sleep?	☐	☐	☐
• had DT's, rumfits, shakes or hallucinations associated with drinking alcohol?	☐	☐	☐
• had detoxification or other treatments for excessive drinking?	☐	☐	☐

46. How much do you typically smoke in a 24 hour period?

- packs of cigarettes _____
- cigars _____
- pipe _____

47. How often do you use:

	Never	Some	Often
• marijuana?	☐	☐	☐
• cocaine?	☐	☐	☐
• hallucinogens (LSD, angel dust, etc.)	☐	☐	☐
• stimulants (uppers)	☐	☐	☐
• depressants (downers)	☐	☐	☐
• narcotics (heroin, morphine, opium, etc.)	☐	☐	☐

Conclusion

1. Do you feel that your sleep or daytime alertness is abnormal?
   _____

2. What is you personal interpretation as to why you have your particular sleep/wake problem? Please describe:
   _____
   _____
   _____
   _____
   _____

Please check through the questionnaire to see if you have answered all the questions.

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Policy and Procedure: Epworth Sleepiness Scale
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THE EPWORTH SLEEPINESS SCALE

Please answer the questions below and return to your physician

Even, if you have not performed the tasks below as of late, think about how they may have affected you in the past. How likely are you to doze off or fall asleep in the following situations?

Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing
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 a 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 traffic	

Name:_____Phone:_____
Date:_____

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Policy and Procedure: Patient Sleep Diary
Policy #: OSS.4
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Patient Sleep Diary

Patient Name: _____ Date Started: _____
(Please Print)

DAY/DATE:	SUN	MON	TUES	WED	THUR	FRI	SAT
Time that you woke up							
Time that you got out of bed							
Did you wake up refreshed?							
Note number of naps taken throughout day							
Duration of longest nap (in minutes)							
Time that you went to bed							
Approximate time that you fell asleep							
Number of times that you woke up during night							
Note any information affecting sleep for the day							

DAY/DATE:	SUN	MON	TUES	WED	THUR	FRI	SAT
Time that you woke up							
Time that you got out of bed							
Did you wake up refreshed?							
Note number of naps taken throughout day							
Duration of longest nap (in minutes)							
Time that you went to bed							
Approximate time that you fell asleep							
Number of times that you woke up during night							
Note any information affecting sleep for the day							

COMMENTS:

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Policy and Procedure: Bed Partner Questionnaire
Policy #: OSS.5
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Bed Partner Questionnaire

Name of patient:_____ Date:_____

Name/Relationship of person filling out this form:_____

Please describe any sleep behaviors you have observed in detail. Include a description of the activity, the time during the night when it occurs, frequency it occurs and whether it happens every night: _____

_____

_____

_____

_____

_____

_____

_____

_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? _____ If yes please explain: _____

_____

_____

_____

_____

_____

Do you have concerns with this persons:	Yes	No
breathing at night?	☐	☐
restlessness during sleep?	☐	☐
sleepwalking/talking?	☐	☐
becoming very rigid or shaking during sleep?	☐	☐