Hendricks NEUROLOGY

Hendricks Neurology

Sleep Problems Checklist

Patient Name____ Date____________________

What problem causes you to seek our help and how does it affect your life?__________________________

____

____

CHECK the box for each problem you CURRENTLY HAVE:

☐ loud snoring with frequent awakenings
☐ crawling feelings in legs when trying to sleep
☐ leg-kicking during sleep
☐ leg cramps in sleep
☐ trouble falling asleep at night
☐ trouble staying asleep at night
☐ racing thoughts when trying to sleep
☐ increased muscle tension when trying to sleep
☐ fear of being unable to sleep
☐ laying in bed worrying when trying to sleep
☐ waking too early in the morning
☐ sleep talking
☐ sweating a lot at night
☐ waking up with reflux (and/or heartburn)
☐ waking up to urinate 2 or more times nightly
☐ nightmares
☐ teeth grinding during sleep
☐ morning headaches
☐ morning dry mouth
☐ sleepwalking
☐ tongue biting in sleep
☐ bedwetting
☐ acting out dreams
☐ uncontrollable daytime sleep attacks
☐ falling asleep unexpectedly
☐ falling asleep at work
☐ falling asleep at school
☐ I use sleeping pills to help me sleep
☐ I use alcohol to help me sleep
☐ pain interfering with sleep

Where is the pain?______________________________

For each symptom, please CHECK the boxes that BEST DESCRIBES YOU.

never	rarely	sometimes	usually	always	
☐	☐	☐	☐	☐	When falling asleep, I feel paralyzed (unable to move)
☐	☐	☐	☐	☐	I feel unable to move (paralyzed) after a nap
☐	☐	☐	☐	☐	I have dream-like images (hallucinations) when I awaken in the morning even though I know I am not asleep.
☐	☐	☐	☐	☐	I see dream-like images (hallucinations) either just before or just after a daytime nap, yet I am sure I am awake when they happen.
☐	☐	☐	☐	☐	I am often unable to move (paralyzed) when I am waking up in the morning
☐	☐	☐	☐	☐	I get "weak knees" when I laugh
☐	☐	☐	☐	☐	I get sudden muscular weakness (or even brief periods of paralysis, being unable to move) when laughing, angry or in situations of strong emotion

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Patient Name:____ Date:_____________

EPWORTH SLEEPINESS SCALE FORM

Instructions: Be as truthful as possible. Print the form. Read the situation in the first column; select your response from the second column; enter that number in the third column. Total all of the entries in the third column; and enter the total in the last box.

Situation	Responses	Score
Sitting and Reading	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	
Watching Television	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	
Sitting inactive in a public place, for example, a theater or a meeting	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	
As a passenger in a car for an hour without a break	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	
Lying down to rest in the afternoon	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	
Sitting and talking to someone	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	
Sitting quietly after lunch when you've had no alcohol	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	
In a car while stopped for traffic	**0=would never doze** **1=slight chance of dozing** **2=moderate chance of dozing** **3=high chance of dozing**	

TOTAL SCORE	

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Hendricks Neurology Sleep Clinic

Screening Questionnaire

Name:____ Date:_______________

BRIEF SLEEP SYMPTOM CHECKLIST (*Please check the boxes that best describe you)*

never	rarely	frequently	always	
☐	☐	☐	☐	I snore loudly
☐	☐	☐	☐	I awaken gasping or choking for breath
☐	☐	☐	☐	I awaken in the morning unrefreshed
☐	☐	☐	☐	I have problems falling asleep or staying asleep (insomnia)
☐	☐	☐	☐	My sleep is very restless
☐	☐	☐	☐	My sleep is disturbed by unusual behaviors (for example, nightmares, sleepwalking, dream enactments, tongue biting, bedwetting…etc.)
☐	☐	☐	☐	I fall asleep while driving
☐	☐	☐	☐	I've been told that I stop breathing in my sleep (told by___________________________________)

SLEEP SCHEDULE (*please provide the following information)*

What time do you go to bed on WEEKDAYS? _____ AM or PM Do you nap? Yes or No

What time do you get up on WEEKDAYS? _____ AM or PM How often do you nap? _____times per week

What time do you go to bed on WEEKENDS? _____ AM or PM How long are the naps? _____ minutes

What time do you get up on WEEKENDS? _____AM or PM Do you awaken refreshed? Yes or No

Are you a shift worker? Yes or No If yes, what kind of shift do you work?_______________________________

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Hendricks Neurology Sleep Clinic

Sleep Clinic Health and Family Questionnaire

Patient Name: ______________________ **Date:** __________

1. How would you rate your current general health?

☐ very poor ☐ poor ☐ average ☐ good ☐ very good

2. Check (✓) if you now have, or in the past had the following:

Diabetes	☐ now	☐ past
High Blood Pressure	☐ now	☐ past
Stroke	☐ now	☐ past
Heart Disease or CHF	☐ now	☐ past
Heart Attack	☐ now	☐ past
Angina	☐ now	☐ past
Emphysema or COPD	☐ now	☐ past
Asthma	☐ now	☐ past
Tuberculosis	☐ now	☐ past
Other Lung Disease	☐ now	☐ past
Nasal Allergies	☐ now	☐ past
Runny or Blocked Nose	☐ now	☐ past
Hormonal Problem	☐ now	☐ past
Urological Problem	☐ now	☐ past
Prostate Disease	☐ now	☐ past

Anemia	☐ now	☐ past
Peptic Ulcers	☐ now	☐ past
Acid Reflux (heartburn)	☐ now	☐ past
Kidney Disease	☐ now	☐ past
Thyroid Disease	☐ now	☐ past
Arthritis	☐ now	☐ past
Back Pain	☐ now	☐ past
Head Trauma	☐ now	☐ past
Severe Headaches	☐ now	☐ past
Epilepsy (seizures)	☐ now	☐ past
Passing Out Spells (fainting)	☐ now	☐ past
Depression	☐ now	☐ past
Anxiety Disorder	☐ now	☐ past
Problems with Alcohol	☐ now	☐ past
Problems with Drugs	☐ now	☐ past

3. Please list hospitalizations. Please give the reasons for each hospitalization and the dates (as best you can remember).

REASONS FOR HOSPITALIZATION	DATE

4. Please give important details about your medical conditions.

____
____
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