PULMONARY CRITICAL CARE AND SLEEP SPECIALISTS, PA

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 feeling 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
- ☐ Walking 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 with injury
- ☐ Acting out dreams without injury
- ☐ 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 DESCRIBE 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) 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 or strong emotion

PULMONARY CRITICAL CARE AND SLEEP SPECIALISTS, PA

Patient Name: _____ Date: _____

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 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. Please check one circle per line.

- CHANCE OF DOZING OFF –

Never	Slight	Moderate	High	
O	O	O	O	Sitting and reading
O	O	O	O	Watching TV
O	O	O	O	Sitting, inactive in a public place (a theater or in a meeting)
O	O	O	O	As a passenger in a car for an hour without a break
O	O	O	O	Lying down to rest in the afternoon when circumstances permit
O	O	O	O	Sitting and talking to someone
O	O	O	O	Sitting quietly after lunch without alcohol
O	O	O	O	In a car, while stopped for a few minutes in traffic

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

Never	Rarely	Frequently	Always	
O	O	O	O	I snore loudly
O	O	O	O	I awaken gasping or choking for breath
O	O	O	O	I awaken in the morning unrefreshed
O	O	O	O	I have problems falling asleep or staying asleep (insomnia)
O	O	O	O	My sleep is very restless
O	O	O	O	My sleep is disturbed by unusual behaviors (nightmare, sleepwalking, dream enactments, tongue biting, bedwetting, etc)
O	O	O	O	I fall asleep while driving
O	O	O	O	I've been told that I stop breathing in my sleep (told by _____)

SLEEP SCHEDULE (*Please provide the following information)*

What time to you go to bed on WEEKDAYS? _____ AM or PM

What time do you get up on WEEKDAYS? _____ AM or PM

What time do you go to bed on WEEKENDS? _____ AM or PM

What time do you get up on WEEKENDS? _____ AM or PM

Do you nap? [Yes] [No] How often do you nap? _____ times per week

How long are the naps? _____ minutes Do you awaken refreshed? [Yes] [No]

Are you a shift worker? [Yes] [No] If yes, what kind of shift do you work? _____