Center for Sleep Medicine
A Department of Berkeley Medical Center
210 Viking Way
Martinsburg, WV 25401
Phone: 304-821-1460

Patient Name: _____ Date: _____

Height: _____ Weight: _____

1. In your own words, what kind of problems are you having and why do you think your doctor ordered this test?

2. How long have you had this problem?

3. Do you have any other medical problems such as (diabetes, seizures, heart problems, chronic pain disorders)?

4. Are you taking any medications prescribed by a doctor or over the counter? Please list them:

Have you ever been told that you (check all that apply)

_____ Snore?
_____ Stop Breathing?
_____ Wake up choking or gasping for air"?
_____ Twitch or kick in your sleep?
_____ Walk or talk in your sleep?
_____ Act out your dreams?

During the past month, have you had trouble sleeping because of (check all that apply):

_____ Coughing, gasping or choking?
_____ Frequent need to urinate?
_____ Feeling too hot or cold?
_____ Having pain? If so, explain.
_____ On a scale of 1-10 how much physical pain are you in today? Please circle:
1 2 3 4 5 6 7 8 9 10
_____ Restless sleep?

Patient Name: _____ Date: _____

PLEASE ANSWER ALL QUESTIONS:

1. What time do you go to bed? _____
2. Do you keep the same sleep pattern every night? Yes or No
3. How long does it take you to fall asleep? _____
4. If you frequently awaken during the night, do you have trouble falling back to sleep? Yes or No
5. How often do you wake at night? _____
6. How long does it take you to get back to sleep? _____
7. What time do you get up in the morning? _____
8. How do you feel in the morning? _____
9. Do you awaken with a headache? Yes or No
10. Can you stay awake during the day? Yes or No
11. Have you fallen to sleep while driving? Yes or No
12. Do you drink or eat any caffeinated products after noon? Yes or No
13. Do you drink alcohol on a regular basis? Yes or No
14. Do you smoke before going to sleep or when you awaken during the night? Yes or No
15. Do you regularly sleep in a bed, in a recliner or on the couch?
16. How many pillows do you use? _____

Patient Name: _____ Date: _____

Have you had any alcohol today? If so, how much & when?

_____

Have you had any nicotine today? If so, how much & when?

_____

Have you had any caffeine today? If so, how much & when?

_____

Do you feel unsteady when standing or walking? Yes or No
Do you worry about falling? Yes or No
Have you fallen in the past year? Yes or NO
If yes, how many times have you fallen?
Were you injured from falling? Yes or No

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired: 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	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Total _____

Patient Name: _____ Date: _____

(Please rate as follows - 0 = Not at all 1 = Several Days 2 = More than ½ the days 3 = Nearly Every Day)

Over the past two weeks, have you been bothered with little interest in things 0 1 2 3
Over the past two weeks, have you been feeling down 0 1 2 3
Total: _____

If your total number is 3 or above, continue answering the following questions:

Over the past two weeks how often have you experienced the following:
(Please rate as follows - 0 = Not at all 1 = Several Days 2 = More than ½ the days 3 = Nearly Every Day)

Had trouble falling asleep, staying asleep or sleeping? 0 1 2 3
Feeling tired or having little energy? 0 1 2 3
Poor appetite or overeating? 0 1 2 3
Feeling bad about yourself or felt that you are a failure? 0 1 2 3
Had trouble concentrating on things? 0 1 2 3
Moving/speaking slowly or being fidgety or restless? 0 1 2 3
Thoughts you would be better off DEAD? 0 1 2 3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? ***(Please circle one of the following)***

Not difficult at all
Somewhat difficult
Very difficult
Extremely difficult

Patient Name: _____ Date:_____

RESTLESS LEG SYNDROME QUESTIONNAIRE

Do you have, or have you had, recurrent uncomfortable feelings or sensations in your legs while sitting or lying down? Yes or No

Do you, or have you ever had, a recurrent need to move your legs while sitting or lying down? Yes or No

Are you more likely to have these feeling when you are resting (either sitting or lying down)? Yes or No

Do these feelings usually start when you are resting (either sitting or lying down)? Yes or NO

If you get up to move around when you have these feelings, do the feelings get any better while you actually keep moving? Yes, No or don't know

Patient Name: _____ DOB: _____

A majority of the masks are now made with magnetic clips. Magnets are used in the lower headgear straps and frame of these masks. **These magnets are to be kept at least 2" (50 MM) away from any active medical implant to avoid possible effects from localized magnetic fields. The magnetic field strength is less than 400 mT.**

Do you or your partner have any of the following: Defibrillator, Pacemaker, etc? (YES/NO)

Do you or your partner have any metallic hemostatic clip implanted in your head to repair an aneurysm? (Yes/NO)

Do you or your partner have any metallic splinters in one or both eyes following a penetrating eye injury? (YES/NO)

Patient Signature: _____ Date: _____