Hendricks NEUROLOGY

A member of Hendricks Regional Health Medical Group

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

Do you nap? Yes or No
How often do you nap? _____times per week
How long are the naps? _____minutes
Do you awaken refreshed? Yes or No

Drug allergies & type of reaction: 1._____ 2._____
3._____ 4._____ 5._____

CURRENT MEDICATIONS

Please list drug, strength, instructions, vitamins, herbs, and medicine only taken when needed

_____

_____

_____

_____

_____

_____

Hendricks
NEUROLOGY

Hendricks Neurology Sleep Clinic

Name: _____ Date: _____

LIFESTYLE

Number of **alcoholic** drinks per week_____ month_____ Year_____

Do you have a history or prior alcohol or other drug dependency problems _____

_____

Number of packs/day you smoke? _____

Do you want to quit? Yes or No Never Smoked_____

If you quit, when? _____ Smoked how many packs/day _____ How many years? _____

How many cups of coffee per day? _____

Number of caffeinated drinks per day _____

Number of days you exercise _____

What type of exercise? _____

HOSPITLIZATIONS

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

DATE:	REASON:

Family History (Blood relative Not yourself)

Migraine Headache	Yes	No
Fainting/Passing out	Yes	No
Motion Sickness	Yes	No
Seizures	Yes	No
Stroke	Yes	No
Heart Attack	Yes	No
Open Heart Surgery	Yes	No
Diabetes	Yes	No
High Cholesterol	Yes	No
Alzheimer Disease	Yes	No
Parkinson's Disease	Yes	No
Cancer	Yes	No
Muscle Disease	Yes	No
Mental Disease	Yes	No

Constitutional:

Weight Gain	Yes	No
Loss of Appetite	Yes	No
Fever	Yes	No
Weight Loss	Yes	No
Chills	Yes	No

Dermatology:

Rash	Yes	No
Change in skin, hair, nails	Yes	No

Endocrinology:

Sugar Problems	Yes	No
Thyroid Problems	Yes	No

Current Problems or Conditions

Your Surgeries:

Appendix	Yes	No
Cataracts/Lens Implants	Yes	No
Carotid Artery	Yes	No
Heart	Yes	No
Gallbladder	Yes	No
Hysterectomy	Yes	No
Sinus	Yes	No
Tonsils	Yes	No
Neck or Back	Yes	No
Other Eye Surgery	Yes	No
Other Vascular	Yes	No
Joint Surgery	Yes	No
Joint Replacement	Yes	No

Any Other Surgery?

List: 1._____

2._____

Medical Conditions During Your Life (add any not listed)

Diabetes	Yes	No
High Blood Pressure	Yes	No
Stroke or TIA	Yes	No
Heart Rhythm Problems	Yes	No
Heart Disease or Heart Attack	Yes	No
Pacemaker	Yes	No
Head Trauma	Yes	No
Hearing Loss	Yes	No
Migraine Headache	Yes	No
Cancer	Yes	No
Restless Legs	Yes	No
Sleep Apnea	Yes	No
Fibromyalgia	Yes	No
Seizures	Yes	No
Difficulty Learning	Yes	No
Sinus Infections	Yes	No

Cardiology:

Palpitations	Yes	No
Shortness of Breath	Yes	No
Chest Pain	Yes	No
Syncope	Yes	No
Heart Disease	Yes	No
Heart Attack	Yes	No
Angina	Yes	No

ENT:

Hoarseness	Yes	No
Nasal Allergies	Yes	No
Runny or Blocked Nose	Yes	No

Gastroenterology:

Nausea	Yes	No
Vomiting	Yes	No
Diarrhea	Yes	No
Blood in Stool	Yes	No
Heartburn	Yes	No
Change in Bowel Habits	Yes	No
Black Stools	Yes	No

Hematology/Lymph:

Anemia	Yes	No
Increased susceptibility	Yes	No
Unusual Bleeding or Bruising	Yes	No

Musculoskeletal:

Joint Pain	Yes	No
Muscle Weakness	Yes	No

Neurology:

Tingling/Numbness	Yes	No
Memory Loss	Yes	No
Gait Abnormality	Yes	No
Sleep Problems	Yes	No
Weakness	Yes	No
Vertigo	Yes	No
Difficulty Controlling Temper	Yes	No
Difficulty Reading or Writing	Yes	No

Ophthalmology:

Vision Loss	Yes	No
Double Vision	Yes	No
Can you read newspaper	Yes	No

Psychology:

Depression	Yes	No
Anxiety	Yes	No

Urology:

Times per night go to bathroom	_____	
Kidney Stones	Yes	No
Pain with Urination	Yes	No
Sexual Difficulties	Yes	No

Hendricks NEUROLOGY

A member of Hendricks Regional Health Medical Group

Hendricks Neurology

Sleep Problems Checklist

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
- ❑ Lying in bed worrying when trying to sleep
- ❑ Waking up 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 even though I know I'm 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

Hendricks
NEUROLOGY

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		