THIBODAUX REGIONAL
SLEEP DISORDERS CENTER

604 NORTH ACADIA ROAD, Suite 210
THIBODAUX, LA 70301
985-493-4759 FAX 985-449-2525

SLEEP HISTORY QUESTIONNAIRE

DATE: ___ / ___ / _____

NAME: AGE_____
(First) (Middle) (Last)
ADDRESS: _____

(Street) (City) (State) (Zip)
PHONE: Home( )_____Work:( )_____Cell ( )_____

Date of Birth___/___/___ Neck Size ____ Height_____ Weight_____Marital status___

E-mail address:_____

In Case of Emergency contact:_____

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Social Security #_____Phone # of Insurance Co._____
_Insurance Company_____Policy Number_____
_Policy Private or Group?_____Subscriber_____
_If Group, Name of Employer_____

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Was this a Self Referral or Physician Referral?
If Physician Referral, Physician Name:_____

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PLEASE STATE YOUR SLEEP RELATED PROBLEMS IF ANY – (example, snoring noted by you, bed partner, or family member).

_____
_____
_____
_____
_____
_____

Have you ever had a sleep study or sleep evaluation? ☐Yes ☐No
If so, What year?_____ Where?_____.
Are you currently on Cpap therapy? ☐Yes ☐No
If so, What DME company are you using?_____
How many vehicle accidents have you had in the last year? ☐Yes ☐No

MAIN SLEEP COMPLAINTS:

❑Trouble falling asleep ❑Trouble remaining asleep

❑Excessive sleepiness during the day

❑Snoring

❑Unwanted behaviors during sleep, such as _____

❑Other, explain _____

❑How long? _____

Time it takes to fall back asleep after awakening _____

☐YES ☐NO My sleep pattern is irregular.
☐YES ☐NO I awaken early in the morning still tired but unable to return to sleep.

PLEASE LIST ANY MEDICAL DISORDER (example, high blood pressure).

_____
_____
_____
_____
_____

PAST SURGERIES AND DATES:_____

_____
_____
_____
_____
_____
_____

List prescription and over-the-counter (non-prescription) medications taken daily.

Medication	Dosage	How Often	Reason	Prescribing MD

List your consumption of the following per day:

Coffee: _____
Tea:_____
Chocolate:_____
Nicotine: _____
Alcohol: _____
Cigarettes:_____

colas: _____
over the
counter drugs:_____
other drugs:_____

THE EPWORTH SLEEPINESS SCALE

NAME: _____

TODAY'S DATE:_____ YOUR AGE:_____

YOUR SEX_____

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

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation	***Circle one*** **Chance of Dozing**
Sitting and reading	0 – 1 – 2 - 3
Watching T.V.	0 – 1 – 2 - 3
Sitting inactive in a public place (e.g., a theater, or a meeting)	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 when circumstances permit	0 – 1 – 2 - 3
Sitting and talking to someone	0 – 1 – 2 - 3
Sitting quietly after lunch without alcohol	0 – 1 – 2 - 3
In a car, while stopped for a few minutes in traffic	0 – 1 – 2 - 3

Total _____

Thank you for your cooperation

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* The numbers for the eight situations are added together to give a global score between 0 and 24.

(From Johns MW: A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 14:540-545, 1991