

THE EPWORTH SLEEPINESS SCALE

Full name: _____ Male Female

Date: _____ Age: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 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

2 = **MODERATE** chance of dozing

1 = **SLIGHT** chance of dozing

3 = **HIGH** chance of dozing

SITUATION	CHANCE OF DOZING			
	0	1	2	3
Sitting and reading	0 _____	1 _____	2 _____	3 _____
Watching TV	0 _____	1 _____	2 _____	3 _____
Sitting, inactive in a public place (e.g. movie theatre 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 the traffic	0 _____	1 _____	2 _____	3 _____



SLEEP QUESTIONNAIRE

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

0 = **NONE**, not at all, never

2 = **MODERATE**, sometimes

1 = **SLIGHT**, just a few times

3 = **HIGH**, a lot, usually, always or almost always

SITUATION					
1	Do you feel that you get too little sleep at night?	0 _____	1 _____	2 _____	3 _____
2	Do you feel that you get too much sleep at night?	0 _____	1 _____	2 _____	3 _____
3	Have you ever had a poor night's sleep?	0 _____	1 _____	2 _____	3 _____
4	How great a problem do you have with getting to sleep at night?	0 _____	1 _____	2 _____	3 _____
5	How great a problem do you have because of waking up at night?	0 _____	1 _____	2 _____	3 _____
6	How great a problem do you have with non-restorative sleep (no matter how much sleep you get, you do not wake up rested)?	0 _____	1 _____	2 _____	3 _____
7	How great a problem do you have with tiredness (not sleepiness) during the day?	0 _____	1 _____	2 _____	3 _____
8	How great a problem do you have with sleepiness during the day?	0 _____	1 _____	2 _____	3 _____
9	On a weekday, what time do you usually go to bed?	_____ AM	_____ PM		
10	On a weekday, what time do you usually get up?	_____ AM	_____ PM		
11	On a weekday, what time do you usually take a nap?	_____ AM	_____ PM		
12	On a weekend or day off, what time do you go to bed?	_____ AM	_____ PM		
13	On a weekend or day off, what time do you get up?	_____ AM	_____ PM		
14	On a weekend or day off, what time do you take a nap?	_____ AM	_____ PM		
15	Do you watch TV or read in bed before going to sleep?	_____ YES	_____ NO		
16	Do you use sleeping aids or medication?	_____ YES	_____ NO		
17	How long after going to bed does it take you to decide to go to sleep?	_____ HRS	_____ MIN		
18	How long does it take you to fall asleep, after you decide to?	_____ HRS	_____ MIN		
19	What is the total number of hours of sleep that you usually get? (Do not include time awake in bed)	_____ HRS	_____ MIN		

SLEEP QUESTIONNAIRE CONTINUED

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SITUATION

20	How many times do you wake up during a typical night?	_____ TIMES			
21	How long is a typical wake time?	_____ HRS		_____ MIN	
22	If you do awaken during your normal sleep time, which part(s) of your sleep time is it likely to have happened?	First – 1/3	Middle – 1/3	Last – 1/3	
23	How many times do you get out of bed during a typical night?	_____ Times			
24	How long is the typical longest time out of bed?	_____ HRS		_____ MIN	
25	When falling asleep, how often do you have thoughts racing through your mind?	0 _____	1 _____	2 _____	3 _____
26	When falling asleep, how often do you feel sad or depressed?	0 _____	1 _____	2 _____	3 _____
27	When falling asleep, how often do you have anxiety (worry about things)?	0 _____	1 _____	2 _____	3 _____
28	When falling asleep, how often do you feel muscular tension?	0 _____	1 _____	2 _____	3 _____
29	When falling asleep, how often do you feel afraid of not being able to go to sleep?	0 _____	1 _____	2 _____	3 _____
30	When falling asleep, how often do you feel unable to move, or feel paralyzed?	0 _____	1 _____	2 _____	3 _____
31	When falling asleep, how often do you notice parts of your body startle or jerk?	0 _____	1 _____	2 _____	3 _____
32	When falling asleep, how often do you experience restless legs (crawling or aching feelings, unable to keep legs still)?	0 _____	1 _____	2 _____	3 _____
33	When falling asleep, how often do you experience vivid, dream-like scenes (hallucinations) even though you are still awake?	0 _____	1 _____	2 _____	3 _____
34	When falling asleep, how often do you experience any pain or discomfort?	0 _____	1 _____	2 _____	3 _____
35	During the night, how often do you sleep with someone else in your room?	0 _____	1 _____	2 _____	3 _____
36	During the night, how often do you sleep with someone else in your bed?	0 _____	1 _____	2 _____	3 _____
37	During the night, how often do you sleep on a special bed/mattress?	0 _____	1 _____	2 _____	3 _____
38	During the night, how often do you have disturbed, restless sleep?	0 _____	1 _____	2 _____	3 _____
39	During the night, how often do you disturb the sleep of your bed partner?	0 _____	1 _____	2 _____	3 _____

SLEEP QUESTIONNAIRE CONTINUED

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SITUATION					
40	During the night, how often do you provide assistance to someone or something else (child, invalid, pet, etc)?	0 _____	1 _____	2 _____	3 _____
41	During the night, how often do you have nasal congestion?	0 _____	1 _____	2 _____	3 _____
42	During the night, how often do you snore?	0 _____	1 _____	2 _____	3 _____
43	During the night, how often do you hold your breath, or stop breathing?	0 _____	1 _____	2 _____	3 _____
44	During the night, how often do you suddenly wake up gasping for air or unable to breath?	0 _____	1 _____	2 _____	3 _____
45	During the night, how often do you wake up with a choking sensation?	0 _____	1 _____	2 _____	3 _____
46	During the night, how often do you have some other breathing problem?	0 _____	1 _____	2 _____	3 _____
47	During the night, how often do you sweat excessively?	0 _____	1 _____	2 _____	3 _____
48	During the night, how often do you sleepwalk?	0 _____	1 _____	2 _____	3 _____
49	During the night, how often do you sleep talk?	0 _____	1 _____	2 _____	3 _____
50	During the night, how often do you grind your teeth?	0 _____	1 _____	2 _____	3 _____
51	During the night, how often do you have leg twitching or jerking while you are asleep?	0 _____	1 _____	2 _____	3 _____
52	During the night, how often do you have other unusual movement during sleep?	0 _____	1 _____	2 _____	3 _____
53	During the night, how often do you get up to eat after going to sleep?	0 _____	1 _____	2 _____	3 _____
54	During the night, how often is your sleep disturbed because of stomach or abdominal pains?	0 _____	1 _____	2 _____	3 _____
55	During the night, how often is your sleep disturbed because of leg cramps?	0 _____	1 _____	2 _____	3 _____
56	During the night, how often is your sleep disturbed because of paresthesia (pins and needles) in your arms and/or legs?	0 _____	1 _____	2 _____	3 _____
57	During the night, how often is your sleep disturbed because of an itching sensation?	0 _____	1 _____	2 _____	3 _____
58	During the night, how often is your sleep disturbed because of any other kind of pain or intense discomfort?	0 _____	1 _____	2 _____	3 _____

SLEEP QUESTIONNAIRE CONTINUED

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SITUATION					
59	During the night, how often is your sleep disturbed because of being short of breath in a flat position?	0 _____	1 _____	2 _____	3 _____
60	During the night, how often is your sleep disturbed because of "gas" in your stomach, or indigestion?	0 _____	1 _____	2 _____	3 _____
61	During the night, how often is your sleep disturbed because of hunger?	0 _____	1 _____	2 _____	3 _____
62	During the night, how often is your sleep disturbed because of thirst?	0 _____	1 _____	2 _____	3 _____
63	During the night, how often is your sleep disturbed because of awakening with the urgent need to urinate? _____ # times	0 _____	1 _____	2 _____	3 _____
64	During the night, how often is your sleep disturbed because of intense heart pain (angina)?	0 _____	1 _____	2 _____	3 _____
65	During the night, how often is your sleep disturbed because of any other chest pains?				
66	During the night, how often is your sleep disturbed because of asthma?				
67	During the night, how often is your sleep disturbed because of persistent coughing?				
68	During the day, how long does it take you to "get going" in the morning?			HRS	MIN
69	During the day, how often do you feel extremely alert and energetic all day?				



TIM MOORING, M.D. - PATIENT QUESTIONNAIRE - PLEASE PRINT

Full name: _____

Date: _____ Age: _____

CHIEF COMPLAINTS(List the problems about which you came to see the doctor)

1) _____

2) _____

3) _____

Referring Physician _____ Other Physician _____

PAST MEDICAL HISTORY

Medical illness: Please check any of the following medical illnesses that you now have or have ever had, or list any others that are not listed below.

- | | | |
|---|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Any type of heart problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Heart catheterization | <input type="checkbox"/> Treatment for depression | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tension/Anxiety/Nerves | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteo Arthritis | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Stress fractures |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Any type of cancer | <input type="checkbox"/> Colon polyps | |

OPERATIONS OR SURGERIES

Please list all past operations, including cataract surgery, what type of surgery it was and when it was done

Type	Date

Describe any serious accidents or disabling injuries:

Type	Date

IMMUNIZATIONS

Last flu shot _____ Pneumonia shot Yes No When? _____

SOCIAL HISTORY

Current employment status: Disabled Part time Full time Retired Self-employed Other

What type of occupation do you (or did) you have?

Where do you live?

Current marital status? Single Married Separated Divorced Widowed Other

How many children do you have? # _____ # _____ Sons # _____ Daughters

HABITS

Have you ever smoked cigarettes regularly? Yes No If yes, how many packs per day? (avg)
How many years? Are you still smoking? Yes No If no, when did you stop?

Do you use snuff or chewing tobacco? Yes No Do you drink alcohol? Yes No

How many beers daily? How many years?

How many mixed drinks or glasses of wine daily? How many years?

Do you have any drug, nicotine or alcohol habits which concern you? Yes No

Do you regularly use sleeping pills, tranquilizers, or pain killers? Yes No
If yes, which ones?

Do you currently use marijuana, cocaine or other "recreational" drugs? Yes No

FAMILY HISTORY

Please list any diseases which tend to "run in your family" especially high blood pressure, diabetes, heart disease, cancer, gout, asthma, stomach ulcers, arthritis, allergies, epilepsy, tuberculosis, cystic fibrosis, muscle disease, stroke or thyroid disease.

Father's History

Is your Father? Alive – Age _____ Deceased – Age _____
What types of health problems if any did he have?

Mother's History

Is your Mother? Alive – Age _____ Deceased – Age _____
What types of health problems if any did she have?

Do you have any brothers?

How many? Alive – Ages _____ Deceased – Ages _____
What types of health problems do/did they have?

Do you have any sisters?

How many? Alive – Ages _____ Deceased – Ages _____
What types of health problems do/did they have?

If you served in the military:

Were you ill while in the military? Yes No What was the nature of the illness?
Did you serve overseas? Yes No If yes, where & when?

Have you traveled outside of the Amarillo area in the past year? Yes No
If so, please list the places you have been:

Please list all pets or any other animals which you may have been in contact with in the past year:

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

<p>General</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Night sweats</p> <p>Do you eat a special diet? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you exercise regularly? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p>Skin</p> <p><input type="checkbox"/> Recent change in hair distribution</p> <p><input type="checkbox"/> Changes in skin color</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Other _____</p>	<p>Head/Ear/Eyes/Nose/Throat</p> <p><input type="checkbox"/> Diplopia (double vision)</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Other _____</p>
<p>Neck</p> <p><input type="checkbox"/> Neck mass</p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Neck stiffness</p> <p><input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/> Other _____</p>	<p>Respiratory</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> History of Tuberculosis</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Other _____</p>	<p>Breast/GYN</p> <p><input type="checkbox"/> Breast discharge</p> <p><input type="checkbox"/> Breast swelling <input type="checkbox"/> Breast mass</p> <p><input type="checkbox"/> Breast tenderness</p> <p><input type="checkbox"/> Menses: Last one? _____</p> <p><input type="checkbox"/> # Miscarriage _____</p> <p><input type="checkbox"/> Other _____</p>
<p>Cardiovascular</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Edema (swelling) _____</p> <p><input type="checkbox"/> Fast/Irregular heartbeat</p> <p><input type="checkbox"/> Orthopnea (trouble breathing while lying down)</p> <p><input type="checkbox"/> Other _____</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Constipation/Diarrhea</p> <p><input type="checkbox"/> Reflux</p> <p><input type="checkbox"/> Other _____</p>	<p>Genitourinary</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Dysuria (pain with urination)</p> <p><input type="checkbox"/> Frequency of urination</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Nocturia (excessive urination at night)</p> <p><input type="checkbox"/> History of malignancy (cancer)</p> <p><input type="checkbox"/> Other _____</p>
<p>Musculoskeletal</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Other _____</p>	<p>Neurological</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Strokes</p> <p><input type="checkbox"/> Other _____</p>	<p>Psychological</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Other _____</p>
<p>Endocrine</p> <p><input type="checkbox"/> Cold intolerance</p> <p><input type="checkbox"/> Heat intolerance</p> <p><input type="checkbox"/> Thyroid problems</p> <p><input type="checkbox"/> Other _____</p>	<p>Hematological</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Easy bleeding</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Other _____</p>	<p>Other</p>

Patient Signature

Physician Signature

Date

Date