PITTSBURGH PULMONARY ASSOCIATES

Patient Name _____ **Date** _____

HT _____ **WT** _____ **ON SLEEP APNEA EQUPIMENT? YES** ___ **NO** ___ **FOR HOW LONG?** _____

SLEEP DISORDER QUESTIONNAIRE

Please answer the following questions regarding your health:

- Y N I have recently gained weight. If yes, how much _____
- Y N I have high blood pressure.
- Y N I take high blood pressure medications.
- Y N I take anti-depressants.
- Y N I use medications to help me sleep.
- Y N I have been prescribed oxygen to wear at night.
- Y N I use medications to help me breathe.
- Y N I usually have a regular sleep/wake pattern.

Epworth Scale

The following questions help to identity a sleep problem. Chose the most appropriate number for each setting. A score of 6 or more indicates the possibility of a sleep disorder and should be discussed with your physician.

Rather than feeling tired, are you likely to doze or fall asleep in the following situations?

0 = Never 1 = Slight Chance 2 = Moderate Chance 3 = Regularly

- _____ Sitting quietly reading?
- _____ Watching television while in a comfortable position?
- _____ Sitting inactive in a public place (i.e. movie theater)?
- _____ Passenger in a car for an hour with no breaks?
- _____ Lying down to rest sometime in the afternoon?
- _____ Sitting and conversing with someone?
- _____ Sitting quietly after lunch?
- _____ As a passenger in a car while stopped in traffic for a few minutes?

_____ Total Score

1 = Rarely or never 2 = Some of the time 3 = Frequently 4 = Most of the time

Sleepiness

- _____ I am sleepy during the day even though I feel as if I've slept through the night.
- _____ I am tired during the day even though I slept through the night without waking.
- _____ I require a nap to stay awake during the evening.
- _____ I fall asleep watching TV even though I try to stay alert.
- _____ I fall asleep as a passenger in a car.
- _____ I fall asleep or become sleepy during routine situations.

Sleep Apnea / Snoring

- _____ I have been told that I snore even when sleeping on my side.
- _____ My snoring disturbs others.
- _____ I have been told that I snore more when sleeping on my back.
- _____ I am hoarse in the morning on awakening.
- _____ I have been told that I "stop breathing" when sleeping at times.
- _____ I wake up "gasping" or "trying to catch my breath".
- _____ I wake up frequently in the morning with headaches.
- _____ I notice swelling in my ankles and feet at night.
- _____ I sweat at night when asleep.

Narcolepsy

- _____ When angry or surprised, I feel like I am going to pass out.
- _____ I experience vivid, life like scenes when I am overly tired.
- _____ I awaken and cannot move almost as if I am paralyzed.

Other Sleep Behavior

- _____ I kick or twitch my legs at night before I fall asleep.
- _____ I have aching or "crawling" sensations during the night.
- _____ I have been told I kick or twitch my legs or arms when sleeping.
- _____ I grind my teeth when sleeping.
- _____ I lie awake for 30 minutes or more before I fall back to sleep.
- _____ I wake up at night and have difficulty falling back asleep.
- _____ I walk or talk in my sleep at times.

• Scoring Matrix •

	Normal	Mild	Moderate	Severe
Sleepiness	8 or less	8-14	15-19	20-24
Apnea/Snoring	12 or less	13-18	19-26	27-36
Narcolepsy	5 or less	6-7	8-9	10-12
Other	10 or less	11-15	16-21	22-28

Reviewed by _____ Date _____