Mt. Hood ENT & Allergy

Sleep Disorder Packet

Welcome to Mt. Hood ENT & Allergy. We look forward to helping you with your sleep problems.

In order to facilitate your sleep disorder evaluation, please complete the enclosed forms. Though some of the information may seem redundant or unnecessary, we want to assure you that it is important in making the appropriate diagnosis. Please ask your bed partner to help you with these questions. Often patients are not aware of the severity of their symptoms. Be honest and thorough in answering each of the questions.

1. The Sleep Questionnaire: This form is self-explanatory. Your answers should reflect the events of the last 6-12 months, unless requested otherwise. Feel free to use the back of any of the pages if needed.

2. Sleep Observation: In order to best identify your sleep disorder, please ask your bed partner (or a friend) to observe your sleep. We would like a short written statement of your sleep habits from the hours of 1:00 am till 2:00 am on one night and from 4:00 am till 5:00 am on another night. If your sleep hours do not allow this schedule please observe your sleep during the fourth and sixth hours of your usual sleep time. Please record sleeping position, snoring, and apneas (stopping breathing). If possible record the number of apneas during each hour.

3. The Sleep Diary: This form should be filled out to reflect your usual sleep habits for a one week period. This form should be filled out in the morning and evening. DO not interrupt your sleep time to fill out any awakenings in the middle of the night. Your best memory of the previous night will suffice.

4. Patient Registration and Medication Summary Forms

5. The Review of Systems / Past Medical History Forms

You can download our forms from: www.mthoodent.com

This packet will take one full week to complete.

It should be completed prior to your appointment.

Please bring all of this information with you to your appointment.

We look forward to discussing these problems with you in detail.

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10202 E. Burnside St. Portland, OR 97216 T: 503.257.3204 F: 503.255.7208
Otolaryngology / Head & Neck Surgery ENT Related Allergy Sleep Disorders
Audiology & Hearing Instruments Nasal & Sinus Disease Facial Plastic Surgery

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Sleep History and Questionnaire

Date: _____

Name: _____ Age:_____

Occupation: _____

Describe your problem: Please check all that apply.

□ Difficulty falling asleep
□ Walk or talk in your sleep
□ Difficulty maintaining sleep
□ Feel sleepy during the day
□ Snoring
□ Fall asleep unexpectedly during the day
□ Stop breathing at night (apnea)
□ Have legs that ache or move a lot at night
□ Please describe your sleep symptoms or problems:

_____
_____
_____
_____
_____
_____

Have you ever consulted a medical professional for this problem? □ Yes □ No

If yes, whom and where: _____

What treatment did you receive for this problem?

_____
_____
_____
_____
_____

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Your Sleep Environment: Check all that apply and estimate the number of times per week.

□ I can see light in my bedroom during my sleep time,
e.g. from windows, electronic devices or lights _____
□ Pets in the bedroom _____
□ Excessive heat or cold causing me to awaken _____
□ Noise that awakens me, e.g. road noise, noise from neighbors or from within your home _____
□ Bed partner's snoring, movement or schedule awakens me _____
□ I have an uncomfortable bed that causes me to awaken _____

Your Sleep Hygiene: Check all that apply

□ I watch TV in the bedroom
□ I watch TV until bedtime
□ I work on my computer in the bedroom
□ I work on my computer until bedtime
□ I do housework until bedtime
□ I do work for my job until bedtime
□ I exercise within 3 hours of bedtime
□ My mind races when I go to bed
□ I am on call at night (either for family or work)
□ I read novels until bedtime

Your Sleep Schedule -- Please also, fill out the **sleep diary**

How many hours sleep do you usually get per night? _____

Work shift: □ Day □ Swing □ Graveyard □ Rotating □ Split
What are your work hours? _____
What is your usual bedtime? _____

Do you nap during the day? _____

Dietary factors affecting your sleep
I drink _____ ounces of caffeinated coffee before 10:00 AM. After 10:00 AM _____
I drink _____ ounces of caffeinated colas before 10:00 AM. After 10:00 AM _____
I drink _____ ounces of caffeinated tea before 10:00 AM. After 10:00 AM _____
I smoke _____ packs of cigarettes daily.
I drink _____ ounces of beer or _____ ounces of wine or _____ ounces of alcohol daily.

I use street drugs or medications □ Yes □ No. If yes, please list:

_____

I have used the following medications to improve my sleep:

_____

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About my feelings -- Please check all words that express how you feel about yourself.

□ Feel tense
□ Depressed
□ Confident
□ Full of regrets
□ Considerate
□ Hostile
□ Anxious
□ Financial problems
□ Inadequate
□ Sympathetic
□ Sexual problems
□ Can't make friends
□ Restless
□ In conflict
□ Bored
□ Intelligent

My Epworth Sleepiness Score

How likely are you to "doze off" or fall asleep in the situations described below?

Use the following scale to select the number that is most appropriate for you. 3
0 = Never
1 = Rarely
2 = Occasionally
3 = Regularly

Write the number in the space after each situation:
Sitting and reading _____
Watching television _____
Sitting inactive in a public place like a meeting or classroom _____
As a passenger in a car for one hour _____
Lying down to rest in the afternoon _____
Sitting quietly after lunch (without alcohol) _____
In a car while stopped for a few minutes in traffic _____

Total _____

Score results:
1-6 Good, you appear to be getting sufficient sleep.
7-8 Average, but more or better sleep may be needed.
9-24 Excessively sleepy, an evaluation by a sleep specialist is recommended.

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Date: _____

Patient Name: _____

Instructions: When filling out this sleep diary, estimate, to the best of your ability, the answers to the questions about your sleep for the night before.

For example: If you begin this diary on Monday, on Tuesday morning estimate the answers for Monday and Monday night and record them in the column labeled "Day 1".

Use the example column to help you format your answers.

	Example	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Prior to going to bed I napped from ___ to ___. (Note times of all naps.)	1:30 TO 2:30 pm							
I took ___ mg. of medication and/or ___ oz. of alcohol before going to bed to help me sleep.	Ambien 10 mg.							
I went to bed and turned the lights off at ___ o'clock.	11:15 pm							
After turning off the lights, I fell asleep in ___ minutes.	35 min.							
My sleep was interrupted ___ times during the night. Specify number of awakenings.	3							
My sleep was interrupted for ___ minutes with each of the interruptions listed above.	10,5,20							
This morning I awakened at ___ o'clock. (Time of last awakening)	6:15 am							
This morning I got out of bet at ___ o'clock.	6:40 am							
When I got up this morning I felt ___ (1 = exhausted to 5 = very refreshed)	2							
Overall, my sleep last night was ___ (1 = very restless to 5 = very sound and restful)	3							

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