E LINE ORTHODONTICS, PLLC
YOON H. CHANG, DDS, MS

SLEEP SURVEY

Patient Name: _____ Date: _____/_____/_____

How many hours of sleep are you now getting in a typical night? _____ hours

How long does it take you to fall asleep once you are in bed? _____ minutes

Check off any of the following behaviors occurring during your sleep that either you or someone else has noted in the past year.

_____ Walking in your sleep
_____ Talking in your sleep
_____ Bed-wetting
_____ Grinding your teeth
_____ Twitching of the legs or arms
_____ Large body jerks
_____ Restless sleep
_____ Rolling or rocking movement
_____ Falling out of bed
_____ Shouting, screaming or swearing
_____ Violent movements
_____ Excessive sweating
_____ Frequent coughing

_____ Asthma
_____ Loud snoring
_____ Heart palpitations
_____ Waking up gasping or choking
_____ Waking up with heartburn
_____ Waking up with chest pain
_____ Waking up with painful penile erections
_____ Waking up with air hunger
_____ Waking up with frequent urge to urinate
_____ Waking up with the feeling of weight on chest
_____ Waking up with frightening images
_____ Waking up with terror
_____ Waking up with anxiety or tension

_____ Sleep paralysis (i.e., being awake in bed not able to move or speak)
_____ Apnea (i.e., lapses in breathing, periods of no breathing)
_____ Waking up with "pins and needles" or restlessness in legs
_____ Other. Please describe: _____

Do you feel very drowsy or sleepy at any point during the day? Yes No

Do you ever have strange hallucinations-like dream while napping? Yes No

Do you ever have "sleep attacks" during the day (i.e., periods when you cannot prevent yourself from falling asleep)? Yes No

Do you ever have "cataleptic attacks" (i.e., episodes when something is triggered and you suddenly feel weak in the legs and/or collapse)? Yes No

Have you ever had a NEAR ACCIDENT or ACCIDENT (circle one) due to excessive drowsiness? Yes No

What is your main concern regarding your sleep? (Why did your doctor order a sleep study?):
_____
_____
_____

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What is the most you have ever weighed? _____

What did you weigh 5 years ago? _____
What did you weigh 1 year ago? _____

When did your sleep problem begin? (Month and/or year) _____

My ideal amount of sleep is _____ hours per night.

During the week, I usually:
go to bed at _____ (TIME)
get up at _____ (TIME)
sleep a total of _____ (HOURS)

During the weekend, I usually:
go to bed at _____ (TIME)
get up at _____ (TIME)
sleep a total of _____ (HOURS)

My job requires shift work: Yes No If yes, my hours are _____.

I usually wake up _____ times during the night. Please explain what wakes you up:
_____
_____

I have difficulty going back to sleep once I wake up:
Always Frequently Occasionally Never

I snore:
Always Frequently Occasionally Never

My snoring started at age: _____

I snore in all sleeping positions: Yes No

I have problems with my nose or nasal breathing: Yes No If yes, please explain:
_____
_____

I have been told that I toss and turn to an extreme amount:
Always Frequently Occasionally Never

I have been told that I talk or scream in my sleep:
Always Frequently Occasionally Never

I have been told that I grind my teeth while I sleep:
Always Frequently Occasionally Never

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I wake up with a sour or stomach acid taste in my mouth:
Always Frequently Occasionally Never

Last meal is eaten at what time? _____ AM/PM

I wake up with my heart beating irregularly:
Always Frequently Occasionally Never

I wake up at night with muscle or joint aches and pains:
Always Frequently Occasionally Never

I see or hear things that are not real when lying in bed, but not asleep:
Always Frequently Occasionally Never

Type of sound or visualization: _____

After a typical night's sleep, I feel stiff or achy:
Always Frequently Occasionally Never

After a typical night's sleep, I feel:
Refreshed Fairly rested Somewhat rested Very drowsy

I take naps: Yes No If yes, how many hours per day? _____
If no, is there a reason why you do not take naps? No Need Situation Does Not Permit

I dream during my naps:
Always Frequently Occasionally Never

After my naps, I feel:
Refreshed Fairly rested Somewhat rested Very drowsy

I have episodes of doing strange things without realizing it or losing a period of time:
Always Frequently Occasionally Never

Drowsiness is greatest in the: Morning Afternoon Evening

Within the last year, depression, anxiety or stress has interfered with my sleep: Yes No
If yes, please explain: _____

I have lost interest in sex or have trouble functioning sexually?
Always Frequently Occasionally Never

My spouse or bed partner has noticed that I quit breathing at night:
Always Frequently Occasionally Never

I have headaches in the morning:
Always Frequently Occasionally Never

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Do you smoke or have you smoked? Yes No
If yes, how many years have (did) you smoked? _____
How many cigarettes (cigars) per day? _____
If you quit, how long ago? _____

Do you drink caffeinated beverages? Yes No
If yes, how many cups or cans per day? _____
My usual beverage is: Coffee Tea Soda

I consume alcohol. Yes No
If yes, how often? Daily Weekly Monthly
I usually drink in the: Morning Afternoon Evening
My usual beverage is: _____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations in contras 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	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____