SLEEP RITE
EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best 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 meeting)	________
Sitting as a passenger in a car, for an hour without a break	________
Lying down to rest in the afternoon when your schedule permits it	________
Sitting and talking to someone	________
Sitting quietly after a lunch without alcohol	________
Sitting in a car, while stopped for a few minutes in the traffic	________
TOTAL	____________

Name: ___________________________ **DOB** _____________

SLEEP RITE
BEDTIME QUESTIONNAIRE

Patient Name: __________________________ **Date:**___________________________

How long did you sleep last night? _____________ hours

Did you take a nap today? _________ What time? _________ How long? __________________

Prior to coming to the sleep center, has today been unusual in any way?

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Did you have any of the following today?

- ❑ Alcohol What time? ____________ How much?_______________________
- ❑ Coffee What time?____________ How much?_______________________
- ❑ Tea What time?____________ How much?_______________________

What medications have you taken today?

Medication	**Amount**	**Time Taken**
___________________________	___________	__________________________
___________________________	___________	__________________________
___________________________	___________	__________________________
___________________________	___________	__________________________
___________________________	___________	__________________________
___________________________	___________	__________________________
___________________________	___________	__________________________
___________________________	___________	__________________________
___________________________	___________	__________________________

Do you have any physical complaints right now? If yes, please explain:

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Usual bedtime: __________a.m./p.m. Usual wake time: _____________a.m./p.m.

SLEEP RITE
SLEEP QUESTIONNAIRE

Patient Name: ______________________ DOB: _______Sex: **M / F** Age: ___Date:_________

Occupation: _________________________ Usual Work Hours/Days: _________________

Referring Physician: ____________________ Family Physician (PCP): __________________

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Please complete the following questionnaire by filling in the blanks and placing a check in appropriate areas.

My Main Sleep Complaint(s) Is:

❑ Trouble sleeping at night How many months/years? ______________________________

❑ Being sleepy all day How many months/years? ______________________________

❑ Snoring How many months/years? ______________________________

❑ Unwanted behaviors during sleep, explain _______________________________________

❑ Other, explain ____

Sleep Pattern	Work Days (Weekday)	Off Days(Weekends)
Typical bedtime:	_________ a.m./p.m.	_________a.m./p.m.
Typical amount of time it takes to fall asleep:	_______________	_______________
Typical number of awakenings per night:	_______________	_______________
List any activities that you normally do during nighttime awakening(s), i.e., restroom, eat, watch TV:	_______________	_______________
Typical amount of time to fall back asleep after an awakening:	_______________	_______________
Typical wake up time:	_________ a.m./p.m.	_________a.m./p.m.
Desired wake up time:	_________ a.m./p.m.	_________a.m./p.m.
How do you usually awaken, i.e., alarm clock?:	_______________	_______________
Typical time you get out of bed:	_________ a.m./p.m.	_________a.m./p.m.
Total amount of sleep per night:	_______________	_______________
Number of naps per day:	_______________	_______________