

## **Mt. Hood ENT & Allergy**

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### **Sleep Disorder Packet**

Dear Sleep Disorder Patient:

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](http://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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## 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:

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

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 house work 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:

**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.

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.

6/29/15

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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<br>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 bed 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                |       |       |       |       |       |       |       |

6/29/15