Sleep Screening instructions:

Following are 2 questionnaires: Epworth and Berlin

Epworth: Answer the questions in regards to how tired you, not if you have time to sleep during normal daytime activities.

Berlin: Answer the questions and add in your height and weight.

Both questionnaires will be scored and reported on once returned to Athens Sleep & Wellness Center. You can place package in mail or bring by the lab, when returning pulse ox.

A report will be customized for you and your physician within 3 days, which can be mailed to you or picked up.

Pulse ox instructions:

Place the box with strap around your wrist and place clip on finger (do not use your thumb), as you go to bed. Leave clip on for all of your sleep that night. Remove the next morning and return to Athens Sleep & Wellness Center.

A sleep log is included in your package: The sleep log should be kept and not returned with questionnaires, you continue to fill out nightly log and give to your physician when delivering sleep screen report.

Athens Sleep & Wellness Center

1490 Prince, Ave.
Athens, Ga. 30606
706-613-6990

NAME: _____ MR # _____ DOB: _____

EPWORTH SLEEPINESS SCALE is a recognized questionnaire that helps to determine the extent of daytime sleepiness in everyday type activities.

Please answer the following questions based on how you have behaved or would behave in that situation using the scale listed below.

0 = would never doze off

1 = Slight chance of dozing

2 = some chance of dozing

3 = High chance of dozing

Sitting and reading _____

Watching Television _____

Sitting inactive in a public place (like the movies, etc...) _____

Riding in a car for more than one hour without a break _____

Lying down in the afternoon, if you had the chance _____

Sitting and talking to someone _____

Sitting quietly after lunch without alcohol _____

In a car, driving, while stopped in traffic or a light _____

TOTAL: _____

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE
SLEEP

ACCREDITED
MEMBER CENTER

Berlin questionnaire

Name _____

Address _____

_____

SLEEP EVALUATION

CATEGORY 1

1 Complete the following:

height _____ age _____

weight _____ male/female _____

2 Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3 Your snoring is?

- ☐ slightly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms.

4 How often do you snore?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

5 Has your snoring ever bothered other people?

- ☐ yes
- ☐ no

6 Has anyone noticed that you quit breathing during your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

CATEGORY 2

7 How often do you feel tired or fatigued after your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

8 During your wake time, do you feel tired, fatigued or not wake up to par?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

9 Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ yes
- ☐ no

If yes, how often does it occur?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

CATEGORY 3

10 Do you have high blood pressure?

- ☐ yes
- ☐ no
- ☐ don't know

BMI =

Scoring Questions: Any answer within box outline is a positive response.

Scoring Categories: Category 1 is positive with 2 or more positive responses to questions 2-6 ☐

Category 2 is positive with 2 or more positive responses to questions 7-9 ☐

Category 3 is positive with 1 or more positive responses and/or a BMI>30 ☐

Final Results: 2 or more positive categories indicates a high likelihood of sleep disordered breathing.

FIGURE 2. Adult BMI Chart

Locate the height of interest in the left-most column and read across the row for that height to the weight of interest. Follow the column of the weight up to the top row that lists the BMI. BMI of 18.5–24.9 is the healthy weight range, BMI of 25–29.9 is the overweight range, and BMI of 30 and above is in the obese range.

BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Height	Weight in Pounds																
4'10"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
4'11"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
5'	97	102	107	112	118	123	128	133	138	143	148	153	158	163	158	174	179
5'1"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
5'2"	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
5'3"	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
5'4"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
5'5"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
5'6"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
5'7"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
5'8"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
5'9"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
5'10"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
5'11"	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
6'	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
6'1"	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
6'2'	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
6'3'	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
	Healthy Weight						Overweight					Obese					

Source: Evidence Report of Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, 1998. NIH/National Heart, Lung, and Blood Institute (NHLBI).

Athens Sleep and Wellness
Sleep Questionnaire

How much tobacco do you smoke during a 24-hour period?
A. Packs of Cigarettes?_____ B. Cigars?_____ C. (Pipe) bowls?_____

Please list name and dose (in mg) of all medications you take **NOW** or **WINTHIN THE PAST 30 DAYS**

Medication	Dose	What is it for?
1.		
2.		
3.		
4.		
5.		

Please list the name of any pill for sleeping or to help you stay awake that you have taken in the **PAST**.

Name of Pill	Did it Help?
1._____	Yes ☐ No ☐
2._____	Yes ☐ No ☐
3._____	Yes ☐ No ☐

How many times each week do you participate in sport or partake in some form of exercise?_____

HEALTH HISTORY
Present Height:_____ Present Weight_____ Has you weight changed recently? Yes ☐ No ☐

Please check any problem or illness you have now or have had in the past:

☐ Heart Disease
☐ Low Blood Pressure
☐ Headaches
☐ Black Outs
☐ Hernia
☐ Back Trouble
☐ Asthma
☐ Cancer
☐ Eye Trouble
☐ Meningitis
☐ Depression
☐ Tuberculosis
☐ High Blood Pressure
☐ Fainting
☐ Ringing of the Ears
☐ Hemophilia (Bleeder)
☐ Prostate Trouble
☐ Gout
☐ Allergies
☐ Kidney Trouble
☐ Hearing Trouble
☐ Heartburn
☐ Venereal Disease
☐ Muscle Cramps
☐ Heart Attack
☐ Dizziness
☐ Epilepsy
☐ Ulcers
☐ Mental Problems
☐ Seizures
☐ Bronchitis
☐ Bladder Trouble
☐ Pneumonia
☐ Impotence
☐ Arthritis

SURGERIES & HOSPITALIZATIONS
Please list any prior hospitalizations and/or surgeries. PLEASE THE LATEST FIRST: Include where, what & when.

1._____

2._____

3._____

4._____

What is your personal interpretation of your particular sleep/wake problem?

_____

_____

Have you ever been diagnosed with Narcolepsy in the past or have family history of Narcolepsy? _____

Any signs of sudden muscle weakness or family history of sudden muscle weakness? _____

CPAP usage: # of hours used daily: _____

Athens Sleep & Wellness Center
Sleep Questionnaire

BED PARTNER QUESTIONNAIRE

Name of Patient_____ Date:_____

Name of Person Completing This Form:_____

Check any of the following behaviors that you have observed this person doing while asleep:

- ☐ Light Snoring
- ☐ Choking
- ☐ Grinding Teeth
- ☐ Bed Wetting
- ☐ Crying Out
- ☐ Awakening with Pain
- ☐ Becoming Very Rigid and/or Shaking
- ☐ Loud Snoring
- ☐ Pauses in Breath
- ☐ Sleepwalking
- ☐ Biting Tongue
- ☐ Sitting up in Bed, NOT Awake
- ☐ Head Rocking or Banging
- ☐ Apparently Sleeping even if he/she behaves otherwise
- ☐ Occasional Loud Snores
- ☐ Twitching or Kicking of Legs During Sleep
- ☐ Twitching or Jerking of Arms During Sleep
- ☐ Getting out of Bed NOT Awake
- ☐ Mental Problems
- ☐ Seizures
- ☐ Bronchitis
- ☐ Other: _____

Please describe the sleep behaviors checked in more detail. Include a description of the activity, the time during the night when it occurs, frequency during the night, and whether it occurs every night.

_____

_____

_____

_____

_____

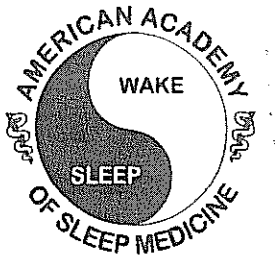
_____

Has this person ever fallen asleep during normal daytime activities or in dangerous situations? Yes ☐ No ☐

If yes, please explain:_____

_____

TWO WEEK SLEEP DIARY



TRUCTIONS:

Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.

Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink ohol. Put "E" when you exercise.

Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.

Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.

Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

MPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 0 PM, fell asleep around Midnight, woke up and couldn't got back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

oday's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C M				

Week 1

Week 2