Sleep Disorders Center
OF PRESCOTT VALLEY, LLC

Robert S. Rosenberg, D.O., F.C.C.P.
Board Certified Pulmonary and Sleep Medicine
Medical Director

SLEEP DIARY

Please fill out page 1 and page 2 each day

Name: _____ DOB: _____

Starting Date: _____ Ending Date: _____

ANSWER IN THE MORNING AFTER WAKING FOR THE DAY						
	At what time did you first go to bed last night?	Approximately, how long did it take to fall asleep?	About how many times, if any, did you awaken during the night?	Overall, about how many hours did you sleep?	At what time did you awaken (for the last time) this morning?	In general, how did you feel when you woke up?
DAY 1						☐ Very refreshed ☐ Somewhat refreshed ☐ Fatigued
DAY 2						☐ Very refreshed ☐ Somewhat refreshed ☐ Fatigued
DAY 3						☐ Very refreshed ☐ Somewhat refreshed ☐ Fatigued
DAY 4						☐ Very refreshed ☐ Somewhat refreshed ☐ Fatigued
DAY 5						☐ Very refreshed ☐ Somewhat refreshed ☐ Fatigued
DAY 6						☐ Very refreshed ☐ Somewhat refreshed ☐ Fatigued
DAY 7						☐ Very refreshed ☐ Somewhat refreshed ☐ Fatigued

AMERICAN ACADEMY OF SLEEP MEDICINE WAKE SLEEP ACCREDITED MEMBER CENTER

Testing and evaluation of sleep-related disorders

3259 N. Windsong Dr. ♦ Prescott Valley, Arizona 86314 ♦ 928-772-6422 ♦Fax 928-772-6425

Patient's name _____ Date of birth _____

Sleep Disorders Center
OF PRESCOTT VALLEY, LLC

Robert S. Rosenberg, D.O., F.C.C.P.
Board Certified Pulmonary and Sleep Medicine
Medical Director

ANSWER AT BEDTIME JUST BEFORE YOU GO TO SLEEP

	How much time, if any, did you spend napping during the day?	Did you consume any of these substances during the day?	On a scale of 1 to 5, how would you rate your overall mood and overall functioning during the day?
DAY 1		☐Caffeine (within 6 hours of bedtime) ☐Alcohol (within 1 hour of bedtime) ☐Medication (type) _____	☐5 - Positive & energetic ☐4 ☐3 ☐2 ☐1 - Depressed & lethargic
DAY 2		☐Caffeine (within 6 hours of bedtime) ☐Alcohol (within 1 hour of bedtime) ☐Medication (type) _____	☐5 - Positive & energetic ☐4 ☐3 ☐2 ☐1 - Depressed & lethargic
DAY 3		☐Caffeine (within 6 hours of bedtime) ☐Alcohol (within 1 hour of bedtime) ☐Medication (type) _____	☐5 - Positive & energetic ☐4 ☐3 ☐2 ☐1 - Depressed & lethargic
DAY 4		☐Caffeine (within 6 hours of bedtime) ☐Alcohol (within 1 hour of bedtime) ☐Medication (type) _____	☐5 - Positive & energetic ☐4 ☐3 ☐2 ☐1 - Depressed & lethargic
DAY 5		☐Caffeine (within 6 hours of bedtime) ☐Alcohol (within 1 hour of bedtime) ☐Medication (type) _____	☐5 - Positive & energetic ☐4 ☐3 ☐2 ☐1 - Depressed & lethargic
DAY 6		☐Caffeine (within 6 hours of bedtime) ☐Alcohol (within 1 hour of bedtime) ☐Medication (type) _____	☐5 - Positive & energetic ☐4 ☐3 ☐2 ☐1 - Depressed & lethargic
DAY 7		☐Caffeine (within 6 hours of bedtime) ☐Alcohol (within 1 hour of bedtime) ☐Medication (type) _____	☐5 - Positive & energetic ☐4 ☐3 ☐2 ☐1 - Depressed & lethargic

Patient's name _____ *Date of birth* _____

SLEEP EVALUATION QUESTIONNAIRE

Please answer each of the following questions:

Name: _____

Height: _____ Weight: _____

Racial/ethnic background:

White/Caucasian _____ Black/African American _____ Asian _____

Native American _____ Latino/Hispanic _____ Multiracial _____

Education:

_____

What are your major concerns about your sleep?

What things have you tried to help your problem?

Do you have a regular bed partner? Yes☐ No☐

Which of the following best describes your sleep problem? Snoring___ Excessive sleeping or fatigue___

Difficulty getting to sleep and/or staying asleep___ Abnormal or unusual behavior during sleep___

Other_____

How long has this problem been present? _____ months/years

Do you have any other problems with you sleep? How long?_____

Have you had a sleep problem diagnosed in the past? Yes☐ No☐ If yes, what was the problem? _____

_____

What treatment(s) were tried? Ambien Halcion Lunesta Melatonin Restoril Rozerem Sonata Trazodone Xanax

Other_____ What helped?_____

What time do you usually go to bed?_____What time do you get up?_____

How many hours of sleep do you think you get? ____hours

Do you keep a regular sleep/wake schedule? Yes☐ No☐

What is the average number of minutes it takes to fall asleep at night? _____minutes

Do you often awaken during the night? Yes☐ No☐

If yes, what is the typical number of times per night you wake up? ____

What awakens you? _____

Do you feel excessively sleepy in the daytime? Yes☐ No☐ If yes, for how long? Months/years____

I can sleep 12 hours or more at a time. Daily☐ Weekly☐ 1-3 times per month☐ Never☐

Do you feel your sleepiness is a result of poor quality of nighttime sleep? Yes☐ No☐

Have you fallen asleep while driving? Yes☐ No☐ If yes, how often?___

How many near miss accidents because of drowsiness or sleepiness have you had in the past 12 months? ____

Patient's name _____ *Date of birth* _____

Check the best answer

After a night's sleep, how often do you feel restored? Daily☐ Weekly☐ 1-3 times/month☐ Never☐

Do you snore? Never☐ Occasionally☐ Frequently☐ Always☐
How loud? (your opinion) _____ Bed partner opinion _____ [1-10, 10 being very loud and disturbing]

Does position affect your snoring? Yes☐ No☐
If yes, what position is loudest? Back____ Stomach____ Right side____ Left side____

Do you wake up coughing? Daily☐ Weekly☐ 1-3 times/month☐ Never☐

Do you wake up choking? Daily☐ Weekly☐ 1-3 times/month☐ Never☐

Do you stop breathing during sleep? Daily☐ Weekly☐ 1-3 times/month☐ Never☐

Do you wake up with dry mouth/sore throat/headache? Daily☐ Weekly☐ 1-3 times per month☐ Never☐

Do you wake up with a stomach acid taste in your mouth? Daily☐ Weekly☐ 1-3 times per month☐ Never☐

Do you wake up confused in the morning? Daily☐ Weekly☐ 1-3 times/month☐ Never☐

Have you experienced excessive weight gain over the past months or years? Yes☐ No☐
If yes, how much weight? ____

Do you feel your sleepiness has to do with your weight gain? Yes☐ No☐

Have you dieted to lose weight? Yes☐ No☐ If yes, how much weight?_____ Have you kept it off? Yes☐ No☐

Do you dream during your naps or sleep? Yes☐ No☐

Have you ever felt sudden muscle weakness when laughing, angry, or surprised? Yes☐ No☐

Have you ever been unable to move your body just as you were falling asleep or waking? Yes☐ No☐

Have you ever had any visual hallucinations or very vivid dreams just as falling asleep or awakening? Yes☐ No☐
If yes, describe_____

MOVEMENT

Are your bedcovers extremely messy when you awaken? Yes☐ No☐

Do you wake yourself by kicking your legs during the night? Yes☐ No☐

Has your bed partner ever complained of your leg kicking during the night? Yes☐ No☐

Do you regularly experience a restless or uncomfortable sensation in your legs that is relieved by movement or walking?
Yes☐ No☐

HABITS

Have you ever smoked cigarettes? Yes☐ No☐

Do you currently smoke? Yes☐ No☐
If yes, give an estimate of average packs of cigarettes per day_____ Years of smoking?_____

On average, I drink 1 cup (8oz)
Caffeinated coffee ____cups per day. Time of day ____a.m. ____p.m.
Caffeinated tea ____cups per day. Time of day ____a.m. ____p.m.
Caffeinated soft drink ____cups per day. Times of day ____a.m. ____p.m.

Do you currently smoke marijuana or take any other mood-altering drugs? Yes☐ No☐
If yes, what and how much?_____

Do you currently drink alcohol? Yes☐ No☐
If yes, on the average, how many drinks? Per day_____ Time of day? _____a.m. _____p.m.

FAMILY HISTORY

Do other members of your family stop breathing at night? Yes☐ No☐
If yes, explain _____

Do other members of your immediate family have daytime sleepiness? Yes☐ No☐
If yes, explain _____

Do other members of your immediate family have any other sleep problems? Yes☐ No☐
If yes, explain _____

Patient's name _____ *Date of birth* _____

PSYCHOLOGICAL HISTORY

Do you feel depressed? Never☐ Occasionally☐ Frequently☐ Always☐

Have you experienced a personality change in the last year? Yes☐ No☐

If yes, describe _____

Have you ever seen a psychiatrist or any type of counselor? Yes☐ No☐

Do you have any other comments regarding your sleep?

SLEEP HYGIENE

Do you nap during the day? Yes☐ No☐

If yes, how many naps per day____ Per week____ Average length of nap _____hours/minutes

Are you refreshed by your nap? Yes☐ No☐

Do you read in bed? Yes☐ No☐

Do you watch TV in bed? Yes☐ No☐

Do you write in bed? Yes☐ No☐

Do you eat in bed? Yes☐ No☐

Do you think or worry in bed? Yes☐ No☐

Do you currently do shift or night work? Yes☐ No☐ If yes, what hours do you work?_____

Have you done shift work or night work in the past? Yes☐ No☐

If yes, did you have trouble sleeping when you did shift work? Yes☐ No☐

If you could set your own schedule, what time would you go to bed? ____a.m. ____p.m.

What time would you get up? ____a.m. ____p.m.

How many times a week do you exercise? _____ What time of day do you exercise? _____a.m. _____p.m.

Do you work on a computer before bed or during the night if unable to sleep? Yes☐ No☐

INSOMNIA ***Answer the following questions assuming "night" means your major sleep time***

Do you often have trouble getting to sleep at night? Yes☐ No☐

Do you go to bed when you are sleepy? Yes☐ No☐

Do you have prolonged periods when you are awake and cannot get back to sleep? Yes☐ No☐

If yes, for how long are you awake altogether during the night? ____minutes per night

Does waking too early and not being able to get back to sleep bother you? Yes☐ No☐

How many nights per week do you have a sleep problem? ____nights per week

Do you frequently check the clock when you are unable to sleep? Yes☐ No☐

Has your mood, memory, or thought process recently changed? Yes☐ No☐

Have you noticed a decrease in sexual interest or function? Yes☐ No☐

Within the last year, has depression, anxiety, or stress interfered with your sleep? Yes☐ No☐

If you had the opportunity, could you nap during the day? Yes☐ No☐

PARASOMNIAS

Do you have episodes of flailing arms/kicking legs/talking/screaming during sleep?

Nightly☐ Weekly☐ 1-3 times per month☐ Never☐

Do you recall a dream or fragment preceding these episodes? Nightly☐ Weekly☐ 1-3 times per month☐ Never☐

Are you confused during these episodes? Yes☐ No☐ Do you remember an episode in the morning? Yes☐ No☐

If yes, describe_____

Do you walk in your sleep? Yes☐ No☐ If yes, how often?_____

Patient's name _____ *Date* _____

Fatigue Severity Scale

During the past week, I found that:	Disagree ⟷ Agree						
My motivation is lower when I am fatigued	1	2	3	4	5	6	7
Exercise brings on my fatigue	1	2	3	4	5	6	7
I am easily fatigued	1	2	3	4	5	6	7
Fatigue interferes with my physical functioning	1	2	3	4	5	6	7
My fatigue prevents sustained physical functioning	1	2	3	4	5	6	7
Fatigue interferes with carrying out certain duties and responsibilities	1	2	3	4	5	6	7
Fatigue is among the three most disabling symptoms	1	2	3	4	5	6	7
Fatigue interferes with my work, family, or social life	1	2	3	4	5	6	7
Total each column							
TOTAL ALL _____							

Epworth Sleepiness Scale

Instructions:

In your current, usual way of life, how likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired: Even if you have not done some of these things recently, try to work out how they would affect you. It is important that you answer each question as best you can.

Using the following scale, choose the most appropriate number for each situation:

Situation	0 Would never nod off	1 Slight chance of nodding off	2 Moderate chance of nodding off	3 High chance of nodding off
Sitting and reading	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)	◯	◯	◯	◯
As a passenger in a car for an hour or more Without stopping for a break	◯	◯	◯	◯
Lying down to rest when circumstances permit	◯	◯	◯	◯
Sitting and talking to someone	◯	◯	◯	◯
Sitting quietly after a meal without alcohol	◯	◯	◯	◯
In a car, while stopped for a few minutes In a traffic or at a light	◯	◯	◯	◯

Patient's name _____ *Date of birth* _____

Insomnia Severity Scale

Check the number that best describes your answer.

Please rate the **current severity** (last two weeks) of your insomnia problem.

Insomnia problem	**None**	**Mild**	**Moderate**	**Severe**	**Very severe**
1. Difficulty falling asleep	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
2. Difficulty staying asleep	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
3. Problem waking up too early	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all Noticeable	A Little	Somewhat	Much	Very Much Noticeable
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

Patient's name _____ *Date of birth* _____

Generalized Anxiety Disorder Assessment (GAD 7) Scale

Over the last two weeks, how often have you been bothered by the following problem?	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
Being so restless that it is hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
Add the score for each column		____ **+** ____	**+** ____	
Total Score (add your column scores) =		_____ **total**		

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐

Somewhat difficult ☐

Very difficult ☐

Extremely difficult ☐

Patient's name _____ *Date of birth* _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or that you have been moving around a lot more than usual	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ☐	1 ☐	2 ☐	3 ☐
Add Columns		_____	+_____	+ _____
TOTAL		_____		

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

STOP – BANG Sleep Apnea Questionnaire

Name: _____ Age: _____ DOB: _____

Snoring

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

Yes ☐ No ☐

Tired

Do you often feel tired, fatigued, or sleepy during daytime?

Yes ☐ No ☐

Observed

Has anyone observed you stop breathing during your sleep?

Yes ☐ No ☐

Pressure

Do you have or are you being treated for high blood pressure?

Yes ☐ No ☐

BMI

Is your BMI more than 35 kg/m_2?

Yes ☐ No ☐

Age

Are you over 50 years old?

Yes ☐ No ☐

Neck Circumference

Is your neck circumference greater than 16 inches?5

Yes ☐ No ☐

Gender

Are you male?

Yes ☐ No ☐