Sleep Medicine Services of Western Massachusetts, LLC

Sleep Inventory

Name ______________________________

I usually go to bed around _______ pm and awaken for the day at _________ am

It takes me approximately ______ minutes to fall asleep I will usually awaken _______ times per night

I awaken at night due to: □ need to go to bathroom □ snoring/stop breathing
□ worrying/anxiety □ leg movements

If I wake up during the night it will usually take me _______ minutes to fall back asleep

My bed partner tells me that during the night I: □ snore/stop breathing □ move my legs

How many years of snoring? _________ Stopping breathing in sleep?_________

When I am falling asleep or waking up I □ *have* □ *have not* experienced hearing or seeing someone in the room who was not there

I □ *have* □ *have not* experienced being paralyzed in the morning when I am waking up

During episodes when I am emotionally excited my body has gone limp □ *yes* □ *no*

I □ *do* □ *do not* regularly experience symptoms of restlessness in my legs before sleep

I will usually take _______ naps per day I drink _______ caffeinated beverages per day

My last caffeinated beverage is at _______ □ *am* □ *pm* I average_______ alcoholic beverages per day

My last alcoholic beverage is usually at _______ pm Height: _______feet______inches Weight:__________

During the past _______ years I have □ *gained* □ *lost* _______ pounds

Please list any medicines you are taking with doses and frequency:

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Drug Allergies:

________________________________ ________________________________
________________________________ ________________________________

Prior Surgeries:

____
____
____

Current Medical Problems/Diseases:

____
____
____

Marital Status ☐Single ☐Married/Partnered ☐Divorced/Separated ☐Widowed
Number of Children______________ Your Occupation: ____________________

Tobacco Use ______ None ______ Packs/day ______ Quit ______ years ago

Family History

Mother: ☐Living ☐Deceased Medical Problems________________________

Father: ☐Living ☐Deceased Medical Problems________________________

Please estimate how likely you would be to nod off or fall asleep in each of the following scenarios.
Rate each scenario from 0 - 3 using the following scale:

0	1	2	3
Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

SITUATION: During the day	CHANCE OF DOZING
Sitting and reading	
Sitting, inactive, in a public place (theater, meeting, etc)	
Lying down in the afternoon when circumstances permit	
Passenger in a car for an hour without a break	
Sitting and talking to someone	
Sitting quietly after lunch (assume no alcohol with lunch)	
In a car, while stopped for a few minutes in traffic	
Watching TV	
TOTAL	/24

Please check any symptoms that you may have had *recently*.

fever
chills
weight loss
fatigue

worsening of eyesight
temporary visual loss
double vision
visual distortion
pain in or behind the eyes
excessive tearing
dryness of the eyes

problems hearing
ringing in the ears
pain or fullness in the ears
persistent blockage of the nasal passages
persistent sore throat
drainage of clear fluid from an ear or the nose

chest pain
irregular heart beats
rapid heart beating
inability to exercise
pain in the legs while walking
shortness of breath at rest or with mild exertion
persistent cough
dark or bloody phlegm

difficulty chewing or swallowing
pain on swallowing
abdominal pain
diarrhea
constipation

recent change in bowel habits
loss of bowel control
black or bloody stool

excessive urination
loss of urinary control
recurrent urination at night
pain with urination
change in sexual function

headache/morning headache
head injury
seizures or fainting
numbness or tingling
speech disturbance
forgetfulness or memory loss
pain in muscles or joints
tremor or involuntary movement
weakness or shrinkage of muscles
balance problems
neck or back pain
persistent itching
change in skin color
unusual hair loss
discharge from the nipples
lump in breast

feelings of depression or anxiety
hearing voices or seeing images
thoughts of harming yourself or other people

intolerance of hot or cold temperatures
change in appetite
difficulty controlling weight
growth of hands or feet
unusual thirst
increased consumption of liquids

unusual bruising
bleeding of the gums
swelling of limbs
excessive bleeding from cuts
lumps in the neck, armpits or groins
unusual sensitivity to certain foods or substances
hives
swelling of the lips or tongue

WOMEN
change in menstruation

MEN
lump in testicle