Georgia Pulmonary Group
Georgia Sleep Specialists
Pulmonary Disease, Sleep Disorders & Critical Care Medicine
1800 Tree Lane, Suite 200, Snellville, GA 30078 • 770-979-0367
500 Medical Center Blvd., Suite 160, Lawrenceville, GA 30045 • 770-237-2480

(TO BE COMPLETED BY PATIENT)

Name: _____ D.O.B.: _____ Date: _____

ATTENTION PATIENTS:

The physicians of Georgia Pulmonary Group specialize in both pulmonary medicine and sleep medicine. This questionnaire asks general questions relating to your sleep and will help us determine if you may have some kind of sleep disorder. The symptoms of some sleep disorders are obvious, like snoring, while others may be more subtle. We appreciate your assistance in helping us to provide you with the best and most complete care possible by filling out this form completely and honestly.

SYMPTOMS DURING SLEEP

Indicate by PLACING A CHECK MARK if you experience any of the following symptoms when sleeping or trying to sleep:

____ Loud snoring
____ Breathing or snoring stops in my sleep
____ Awaken gasping for breath
____ Become sleepy during the day
____ Difficulty falling asleep
____ Difficulty remaining asleep
____ Fatigue
____ Awaken with a dry mouth
____ Morning headaches
____ Irritability/Depression
____ Memory impairment or Inability to concentrate
____ Irresistible urge to move legs or arms
____ Legs or arms jerking during sleep
____ Frequent urination disrupting sleep
____ Sleep talking or Sleep walking

Have you previously been diagnosed with a sleep disorder? _____

If yes, when and what disorder? _____

_____

_____

SLEEP HABITS

1) At what time do you usually get in the bed? _____ AM/PM
2) How long does it take you to fall asleep after you have turned out the lights? _____ minutes/hours.
3) How often do you awaken each night? _____
4) Total time I spend awake in bed _____ minutes/hours.
5) I usually wake up from sleep at _____ AM/PM
6) What time do you get out of bed from sleep? _____ AM/PM
7) Indicate total length of naps daily _____
8) If you do rotating shift work, or have other work schedule changes and need more space to describe:

_____

EPWORTH SLEEPINESS SCALE

Always Tired? How Likely Are You To Fall Asleep In The Following Situations?

Even if you haven't experienced some of these situations recently, consider how you might be affected. Use the fol1owing scoring guide to rate your response - Be honest!

0 = I would never fall asleep.
1 = Slight chance of falling asleep.
2 = Moderate chance of falling asleep.
3 = High chance of falling asleep.

Your Score	
	Sitting and reading
	Watching TV
	Sitting, Inactive in a public place (e.g. in a theatre or meeting)
	As a passenger in a car for an hour without a break
	Lying down to rest in the afternoon when circumstances permit
	Sitting and talking to someone
	Sitting quietly after a lunch without alcohol
	In a car, while stopped for a few minutes in the traffic
	Total Score

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