Sleep Problems Assessment Form

Name: ______________________________Date of Birth: _______________

Contact Number: __________________ Email Address: ____________________ Date: ______________

Please indicate your level of agreement with the following statements by circling the appropriate number:

Epworth Sleepiness Scale: The Epworth Sleepiness Scale measures your general level of daytime sleepiness. Please rate your chance of dozing off or falling asleep in the following situations:

0 = No dozing 1 = Slight chance of dozing 2 = Moderate chance of dozing 3 = High chance of dozing

- Sitting and reading: 0 1 2 3
- Watching TV: 0 1 2 3
- Sitting inactive in a public place (e.g., a theater or a meeting): 0 1 2 3
- As a passenger in a car for an hour without a break: 0 1 2 3
- Lying down to rest in the afternoon when circumstances permit: 0 1 2 3
- Sitting and talking to someone: 0 1 2 3
- Sitting quietly after a lunch without alcohol: 0 1 2 3
- In a car, while stopped for a few minutes in traffic: 0 1 2 3

Sleep Problems Assessment: Please indicate the frequency of sleep problems over the past month:

- Difficulty falling asleep: Never Rarely Sometimes Often Always
- Waking up multiple times during the night: Never Rarely Sometimes Often Always
- Waking up early/ unable to go back to sleep: Never Rarely Sometimes Often Always
- Not feeling refreshed upon waking: Never Rarely Sometimes Often Always
- Snoring loudly: Never Rarely Sometimes Often Always
- Pauses in breathing or choking during sleep: Never Rarely Sometimes Often Always
- Restless legs or an urge to move them at night: Never Rarely Sometimes Often Always
- Nightmares or disturbing dreams: Never Rarely Sometimes Often Always
- Using the bathroom alot during the night: Never Rarely Sometimes Often Always

Additional: Please provide any additional details about your sleep patterns, habits, or concerns:

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Medical History: Please list any medical conditions, medications, or treatments that impact your sleep:

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Lifestyle Factors: Please indicate if any of the following factors might contribute to your sleep problems:

- ☐ High caffeine intake ☐ Irregular sleep schedule ☐ High stress levels
- ☐ Excessive alcohol consumption ☐ Sedentary lifestyle ☐ Use of electronic devices before bedtime

Thank you for taking the time to complete this assessment. Our team will review the information provided to better understand your sleep problems and recommend appropriate interventions. If you have any immediate concerns, please feel free to contact us at Midwest Allergy Sinus & Respiratory clinicalstaff@asthma2.com.