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WOOSTER COMMUNITY HOSPITAL
SLEEP DISORDERS CENTER
SLEEP SCREENING QUESTIONNAIRE
Phone: 330-263-8400 Fax: 330-263-8396

You may print and return the form to your physician or you may E-mail the completed form to:
WCHSleepCenter@WCHOSP.ORG

NAME:_____ **ADDRESS:** _____

PHONE:_____ **DATE OF BIRTH:** _____ **HEIGHT:** _____ **WEIGHT:** _____

FAMILY/PRIMARY CARE PHYSICIAN: _____**ADDRESS:** _____

PHONE OF FAMILY/PRIMARY PHYSICIAN: _____ **DATE:** _____

1)Does your snoring awaken your family or yourself?	YES ☐	NO ☐
2)Has anyone told you that you stop breathing in your sleep?	YES ☐	NO ☐
3)Do you have problems with memory loss?	YES ☐	NO ☐
4)Do you often wake up with morning headaches?	YES ☐	NO ☐
5)Have you experienced a frequent loss of energy ?	YES ☐	NO ☐
6)Do you have a dry mouth upon waking up?	YES ☐	NO ☐
7)Do you feel sleepy often?	YES ☐	NO ☐
8)Have you been diagnosed with high blood pressure?	YES ☐	NO ☐
9)Do you wake up suddenly gasping for air?	YES ☐	NO ☐
10)Are you overweight?	YES ☐	NO ☐
11)Do you have a history of stroke?	YES ☐	NO ☐
12)Do you feel that you're a restless sleeper?	YES ☐	NO ☐
13)Do you have problems with insomnia?	YES ☐	NO ☐
14)Do you have problems with your legs (kicking/twitching)?	YES ☐	NO ☐
15)Do you grind your teeth?	YES ☐	NO ☐
16)Do you have night sweats?	YES ☐	NO ☐
17)Do you use the restroom during the night?	YES ☐	NO ☐
How many times per night _____		
18)Do you have a history of sleep walking?	YES ☐	NO ☐
Pediatric or Adult?_____		
19)Do you have a history of heart problems/heart failure?	YES ☐	NO ☐
20)Have you experienced physical weakness with strong emotion?	YES ☐	NO ☐
21)Do you have sleep attacks while driving?	YES ☐	NO ☐
22)Have you experienced severe tiredness for > 10 years?	YES ☐	NO ☐

TOTAL YES _____

Revised:
1/18/2010

EPWORTH SLEEPINESS SCALE: **Rate yourself in the following situations on a scale of 0-3**

SITUATION	CHANCE OF DOZING
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (i.e. Movies)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when permitted	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

0 = NO CHANCE OF DOZING
1 = SLIGHT CHANCE OF DOZING
2 = MODERATE CHANCE OF DOZING
3 = HIGH CHANCE OF DOZING

9 or above = positive EDS

TOTAL _____

Thank you for your submission! A registered sleep technologist will review your information and it will be forwarded to your physician.

If you have questions and would like to speak to one of our staff members or would like to request informational pamphlets on sleep disorders and sleep testing, please call 330-263-8400.

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