

POMONA VALLEY HOSPITAL
M E D I C A L C E N T E R

SLEEP DISORDERS CENTER

| | SCHOOL NIGHTS | WEEKENDS |
|---|---------------|----------|
| What time do you normally get into bed? | | |
| How long does it normally take you to get to sleep? | | |
| What wakes you up? | | |
| How long does it take to return to sleep after awakening? | | |
| What time is your regular morning wake up time? | | |
| Do you wake up spontaneously or by an alarm clock? | | |
| When do you get out of bed? | | |
| What time does school start? | | |
| Hours of Sleep you normally get | | |
| Hours of Sleep you need to feel rested | | |

11. What is your best time of day (when most alert)? _____

12. What is your worst time of day (when most sleepy)? _____

13. How frequently do you take naps? _____

14. Describe time of day and length of nap? _____

15. How do you feel after taking a nap?

VERY REFRESHED

SOMEWHAT REFRESHED

SOMEWHAT TIRED

VERY DROWSY

16. Have you ever had an over-powering, irresistible attack of sleep?

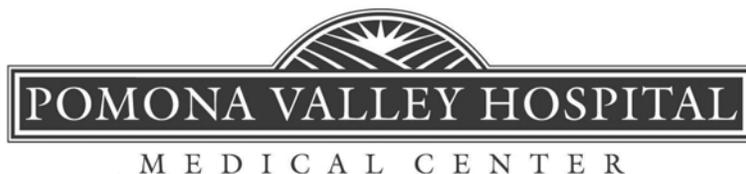
YES NO If yes, describe how frequently this occurs and in what situations. _____

17. Do you ever lose muscle strength when excited, startled, angry, or laughing?

YES NO (for example weakness in knees, sagging facial muscles or total collapse)

18. Do you ever feel paralyzed (can't move) as you go to sleep or as you wake up?

YES NO



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How likely are you to doze off or fall asleep in the following situations, not just feeling tired? Use the following scale to choose the most appropriate number for each situation.

- 0 = would never fall asleep
- 1 = slight chance of falling asleep
- 2 = moderate chance of falling asleep
- 3 = high chance of falling asleep

| <u>SITUATION</u> | <u>Chance of falling asleep</u> |
|--|--|
| Sitting and reading | |
| Watching TV | |
| Sitting in class listening to the teacher | |
| Doing homework | |
| As a passenger in a car for an hour | |
| After meals | |
| During a movie at the theater | |
| In a car, while stopped for a few minutes in traffic | |
| TOTAL | |

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING DURING SLEEP?

| | Times per week | Age began | Last occurrence | Treatment (if any) |
|--|-----------------------|------------------|------------------------|---------------------------|
| Talking during sleep | | | | |
| Sleepwalking | | | | |
| Grinding teeth during sleep | | | | |
| Bedwetting | | | | |
| Recurrent dreams | | | | |
| Disturbing dreams | | | | |
| Waking with acid or sour taste | | | | |
| Waking screaming & fearful in the first 3 hours of night | | | | |
| Chest pain, wheezing, rapid or irregular heart beat during sleep | | | | |
| Unusual movements during sleep | | | | |
| Awakening with headache or excessive perspiration | | | | |

How much sleep do you think you need? _____



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Medications:

Name: _____ Dose: _____ Time of Day _____
