Western Washington Medical Group

SDS-CL-25 (V4)

Date: ___/___/___ ID/Initials ____ Age: ___ Sex: __ Height _____ Weight _____
Work Shift: __ n/a __ First (9-5pm) __ Second (4-12am) __ Third (12to 8am)
Work Hours: __ 0 __ 10-20 __ 20-40 or ___ > 40 Hours per week
Do you regularly have a bed partner? (3 or more days/week) ___ (Yes/No)
How much sleep do you typically get per night? ____ hours (e.g., 8.5 hours)
How much time to you typically spend in bed per night? ___ hours (e.g., 9.5 hours)

Answer all questions for what has been typical for you for the last 3 months.

	NEVER	ONCE A MONTH	1-3 TIMES A WEEK	3-5 TIMES A WEEK	>5 TIMES A WEEK
1. My work or other activities prevent me from getting at least 6hrs of sleep					
2. My bedtime or waketime varies by more than 3 hours					
3. It takes me 30 minutes or more to fall asleep					
4. I am awake for 30 minutes or more during the night					
5. I wake up 30 or more minutes before I have to and can't fall back asleep					
6. I am tired, fatigued, or sleepy during the day					
7. I sleep better if I go to bed before 9pm and wake up before 430am					
8. I sleep better if I go to bed late (after 1am) and wakeup late (after 9am)					
9. I am prone to fall asleep at inappropriate times or places					
10. I snore					
11. I wake up with a dry mouth in the morning (cotton mouth)					
12. My snoring is so loud, that my bed partner complains					
13. I have been told that that I stop breathing in my sleep					
14. I wake up choking or gasping for air					
15. I feel uncomfortable sensations in my legs, especially when sitting or lying down, that are relieved by moving them					
16. I have an urge to move my legs that is worse in the evenings and nights					
17. I wake up frequently during the night for no reason					
18. When angered, humored, frightened, I experience sudden muscle weakness					
19. When falling asleep or waking up, I experience scary dream like images					
20. When I am first awakening, I feel like I can't move					
21. I have nightmares					
22. For no reason, I awaken suddenly, feeling startled and afraid					
23. I have been told that I walk, talk, eat, act strangely or violently while asleep					
24. I grind my teeth or clench my jaw while I sleep					
25. My sleep difficulties interfere with my daily activities					

PLEASE MARK THE COLUMN YOU FEEL MOST ACCURATELY DESCRIBES THE FOLLOWING SITUATIONS

	ALWAYS	OFTEN	SOMETIMES	NEVER
I wake up gasping, wheezing, short of breath or feeling like I can't breathe.				
I have been told that I toss and turn a lot in my sleep				
I wake up with stomach acid in my mouth.				
I am troubled by sensations in my legs (restlessness etc)				
I fall asleep unexpectedly for short periods of time while sedentary(i.e. at meetings, watching tv, at the movies, or while riding in a car)				
I fight sleep while driving.				

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of the things recently, try to work out how they would have affected you. Use the following scale to choose the *most appropriate number* for each situation.

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

SITUATION	CHANCE OF DOZING			
Sitting and reading.	0	1	2	3
Watching Television	0	1	2	3
Sitting inactive in a public place (eg. Theater or in a meeting)	0	1	2	3
As a passenger in a car for an hour without 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 being stopped in traffic for a few minutes	0	1	2	3
Total/Out of 24				
PATIENT NAME	DATE			

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