Health
Benefits
Employee Services
HBE

HBE Preventive Health – Sleep Assessment Form

Please bring your completed assessment form to your appointment.
To schedule an appointment please call 505 844-HBES (4237).

Name:	**Employee ID#:**	**Date:**

☐**Male** ☐**Female**	**Age:**	**Phone:**	**Email:**

Sleep and Health History

In general, would you describe your sleep as: ☐Refreshing ☐Not Refreshing

What is the QUALITY of your sleep?

☐Extremely Good
☐Very Good
☐Good
☐Adequate
☐Fair
☐Poor
☐Very Poor
☐Extremely Poor

On a scale of 0 to 10, how SLEEPY are you during the day?
Not Sleepy ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extremely Sleepy

On a scale of 0 to 10, how TIRED are you during the day?
Not Tired ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extremely Tired

On average, how long does it usually take you to fall asleep?

On average, how many hours in bed do you usually spend in a night?

On average, how many hours of sleep do you usually get in a night?

Do you wake up a lot during your sleep?

If yes, how many times per night on average?

If awakened, do you have trouble returning to sleep?

If awakened, how much time awake do you spend at night trying to get back to sleep?

Would you or others say you snore loudly? ☐YES ☐NO ☐ Don't Know

Have you or others moved from the bed because of your snoring? ☐YES ☐NO ☐ N/A

Would you or others say that you have other trouble breathing while you sleep – do you stop breathing, choke, gasp, or struggle for breath? ☐YES ☐NO ☐ Don't Know

While lying still in bed, do you have uncomfortable sensations in your legs that prevent you from sleeping? ☐YES ☐NO

If yes, do these sensations go away when you move your legs? ☐YES ☐NO

Would you or others say that you twitch or jerk your legs while you sleep? ☐YES ☐NO

Have you or others ever moved from your bed because of your twitches/leg jerks?
☐YES ☐NO ☐ N/A

Indicate which, if any, symptoms you've been having at least weekly during the past month:

☐Wake up with dry mouth
☐Problems controlling your blood pressure
☐Morning headaches
☐Difficulty concentrating
☐Difficulty with memory
☐Feeling anxious
☐Feeling depressed
☐Disturbing dreams or nightmares

Indicate which, if any, of the items listed below wake you up or keep you from sleeping:

☐Restless legs or leg jerks
☐Trouble breathing
☐Indigestion/ Reflux
☐Needing to use the bathroom
☐Other:
☐Pain
☐Racing thoughts/ Can't turn off your mind
☐Anxiety or fear about something
☐Needing a drink of water

Sleep Problem (indicate all that apply)	Duration of problem	
Insomnia	Months	Years
Nightmares	Months	Years
Poor Sleep Quality	Months	Years
Sleep Breathing Problem	Months	Years
Sleep Movement Problem	Months	Years
Other:	Months	Years

Please list any medications, supplements or vitamins, prescribed or over the counter, you are currently using on a regular basis for any condition:

Please list any medications, supplements, vitamins, oxygen, CPAP, nasal strips, dental devices etc. that you use to improve your sleep:

On average how many beverages containing caffeine do you consume a day?
Count an 8oz. serving as one beverage. For example: a can of soda is 12oz. = 1 ½ beverages.

When was your last complete physical exam?

Have you had an overnight sleep study or visited a sleep medicine doctor? ☐YES ☐NO

Have your tonsils and/ or adenoids been removed? ☐YES ☐NO

Have you had any sinus surgeries? ☐YES ☐NO

Have you had problems with allergies and/ or sinuses? ☐YES ☐NO

Have you had any sinus infections in the past three years? ☐YES ☐NO

Do you have asthma or other lung disease? ☐YES ☐NO

Do you have any chronic disease(s)? ☐YES ☐NO
If yes, please list:

Do you have a family history of any of the following? (Please indicate)

☐ Diabetes	☐ Heart disease	☐ High blood pressure
☐ Stroke	☐ Sleep apnea	☐ Restless leg syndrome
☐ Insomnia	☐ Depression	☐ Other:

Insomnia Severity Index

Please answer each of the questions below by indicating the response that best describes your sleep patterns in the past week. Please answer all questions.

Please rate the current (past week's) SEVERITY of your insomnia problem(s):	0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Difficulty falling asleep:	☐	☐	☐	☐	☐
Difficulty staying asleep:	☐	☐	☐	☐	☐
Problem waking up too early:	☐	☐	☐	☐	☐

How SATISFIED/DISSATISFIED are you with your current sleep pattern?	Very Satisfied ☐	A Little ☐	Some What ☐	Much ☐	Very Dissatisfied ☐
To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?	Not at all Interfering ☐	A Little ☐	Some What ☐	Much ☐	Very Much Interfering ☐
How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?	Not at all Noticeable ☐	A Little ☐	Some What ☐	Much ☐	Very Much Noticeable ☐
How WORRIED/DISTRESSED are you about your current sleep problem?	Not at all ☐	A Little ☐	Some What ☐	Much ☐	Very Much ☐

Total: _____

Epworth Sleepiness Scale

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

Situation:	**Chance of dozing:**			
	0 would never dose	1 slight chance of dozing	2 moderate chance of dozing	3 high chance of dozing
Sitting & Reading	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐
Sitting inactive in a public place (e.g. a theater or movie)	☐	☐	☐	☐
As a passenger in a car for an hour without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting & talking with someone	☐	☐	☐	☐
Sitting quietly after lunch without alcohol	☐	☐	☐	☐
In a car, while stopped for a few minutes in traffic	☐	☐	☐	☐

Total: _____

Sleep Hygiene

Do you awaken at the same time each day? If no, usual workday wake up time: usual wake up time on day off:	YES ☐	NO ☐	
Do you participate in regular exercise at least 3 days a week?	YES ☐	NO ☐	
If you exercise, do you exercise at least 4 hours prior to going to bed?	YES ☐	NO ☐	Don't exercise
If you nap, do you nap only early in the day for no more than 20 minutes?	YES ☐	NO ☐	Don't nap
Do you have a comfortable sleep environment? This means an environment that includes; a comfortable bed, comfortable bedroom temperature, a clean, quiet and darkened bedroom.	YES ☐	NO ☐	
Do you have techniques or rituals to help you relax at bedtime? Such as: taking a warm bath, listening to relaxing music, deep breathing, or imagery.	YES ☐	NO ☐	
Do you expose yourself to sunlight each morning?	YES ☐	NO ☐	
Do you smoke less than 2 hours before going to bed?	YES ☐	NO ☐	Don't smoke
Do you check the time if you awaken at night?	YES ☐	NO ☐	Don't wake up @ night
Do you drink more than 2 cups of coffee or other caffeine containing beverages per day?	YES ☐	NO ☐	Don't drink caffeine
Do you drink alcohol within 2 hours of going to bed?	YES ☐	NO ☐	Don't drink alcohol
Do you eat large meals within 3 hours of going to bed?	YES ☐	NO ☐	
Do you go to bed when you are not "sleepy"? In other words, do you go to bed based on the time, boredom, or because you think you should?	YES ☐	NO ☐	
Do you use your bedroom for activities other than sleep or sex? Such as: watching TV, paying bills, discussing the problems of the day, studying or work activities or do you have an office in your bedroom?	YES ☐	NO ☐	

Please describe your bedtime routine (what do you do in the hour before you go to bed):

Work/ Life Balance

Do you travel much for work? ☐YES ☐NO
If yes, how often?

How many hours, if any, do you work over your normal work schedule each week?

Do you take at least a 30 minute break away from your work each day? ☐YES ☐NO

Do you take time to relax each day? ☐YES ☐NO

What, if any, specific activities or techniques do you use to relax or manage your stressors? Please list:

How much time do you spend watching TV/ playing computer games / or other non work related computer activities? per day per week

Do you have regular opportunities to socialize with friends/ peers/ family? ☐YES ☐NO

Do you have any special interests or hobbies (exclude work related activities)? ☐YES ☐NO

If yes, are you satisfied with the amount of time you get to pursue these interests? ☐YES ☐NO

On a scale of 0 to 10, how satisfied are you with your job?

Not Satisfied ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extremely Satisfied

On a scale of 0 to 10, how well do you feel that you balance your work and your life?

Not Balanced ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Extremely Balanced