EPWORTH SLEEPINESS SCALE	
How likely are you to nod 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 haven't done some of these 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 = no chance of dozing** **1 = slight chance of dozing** **2 = moderate chance of dozing** **3 = high chance of dozing**	
Sitting and reading	
Watching TV	
Sitting inactive in a public place (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
ADD UP THE TOTAL	

INSOMNIA SEVERITY INDEX					
Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem					
Insomnia problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How SATISFIED / DISSATISFIED are you with your CURRENT sleep pattern?				
Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?				
Not at all noticeable	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?				
Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?				
Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

NAME:	DATE OF BIRTH:	PHONE:

SLEEP SCHEDULE	WEEKDAYS	WEEKENDS
What time do you get into bed?		
What time do you get out of bed to start your day?		
Estimated number of hours you sleep per night		
Number and length of naps		
How long does it take you to fall asleep in the beginning of the night?		
Number of awakenings per night		
How long does it take you to fall back asleep?		

WHICH OF THE FOLLOWING INTERFERE WITH YOUR SLEEP (Check all that apply)				
☐ Pain	☐ Difficulty breathing	☐ Nightmares	☐ Need to urinate	☐ Stress
☐ Anxiety	☐ Restless legs	☐ Heartburn	☐ CPAP	☐ Other

Current military status: ☐ Active duty ☐ Dependent ☐ Retiree
In the next 12 months, will you: ☐ Deploy ☐ PCS ☐ ETS ☐ Retire ☐ In a Medical Board (MEB)
How many alcohol drinks do you consume per week?
Number of caffeine beverages / day?
What tobacco products do you use?

CPAP USERS
Mask style: ☐ Nasal pillows or prongs ☐ Nasal cradle (under nose) ☐ Nasal (over the nose) ☐ Full face mask (over nose and mouth) ☐ Hybrid full face mask (under nose and over mouth)
Mask problems: ☐ Leaking ☐ Skin redness ☐ Skin breakdown ☐ Skin discomfort ☐ Other
Air pressure problems: ☐ Too much air ☐ Not enough air ☐ Difficulty exhaling ☐ Feeling smothered ☐ Stomach bloating ☐ Gas in the morning
Usage problems: ☐ Removal in sleep ☐ Fall asleep without mask ☐ Other
Other problems: ☐ Nose or mouth dryness ☐ Throat pain ☐ Ear pain
When using CPAP, do you: ☐ Snore ☐ Cough ☐ Gasp ☐ Choke ☐ Sneeze