Questionnaire

Patient Name: _____ Sex: _____ Age: _____ Date:_____

Occupation: _____

Referring Physician: _____ Family physician (PCP): _____

Marital status: {} Single {} Married {} Divorced {} Widowed

Please complete the following questionnaire.

Sleep Complaints:

{} Trouble sleeping at night For how long? _____

{} Being sleepy all day For how long? _____

{} Snoring For how long? _____

{} Other, explain _____

Sleep Pattern

Typical Bedtime: _____

Typical amount of time it takes to fall asleep: _____

Typical amount of time it takes to back to sleep after an awakening: _____

Typical number of awakenings per night: _____

Typical wake up time: weekday _____ weekend _____

Typical time you get out of bed: weekday _____ weekend _____

Total amount of sleep per night: _____

Number of naps per day: _____

Please check all of the following statements that are true about your sleep:

Sleep Habits

{} I usually watch TV or read in bed prior to sleep

{} I often travel across 2 or more time zones

{} I drink alcohol prior to bedtime

{} I smoke prior to bedtime or when I awaken during the night

{} I eat a snack at bedtime

{} I eat if I wake up during the night

{} I typically wake up from sleep to go to the bathroom

{} I have trouble falling to sleep

{} I often wake up during the night

{} I am unable to fall back to sleep easily if I wake up during the night

{} I think a lot when I am trying to fall asleep

{} I have nightmares as an adult

{} I experience a tingling sensation in my legs when I try to fall asleep

{} I sweat a great deal during sleep

{} I cannot sleep on my back

Breathing

{} I have been told I stop breathing while I sleep

{} I wake up at night choking, or gasping for air

{} I have been told I snore

{} I have been told I only snore when I am sleeping on my back

{} I have been awakened by my own snoring

Restlessness

{} My legs and arms are uncomfortable when I lie down

{} I have to move my legs or walk to relieve the uncomfortable feelings in my legs

{} I am a restless sleeper

{} I have been told that I kick or jerk my legs and/or arms during sleep

{} I have a hard time falling asleep because of my leg movements

{} I have talked in my sleep as an adult

{} I have walked in my sleep as an adult

{} I grind my teeth in my sleep

Daytime Sleepiness

{} I take daytime naps

{} I have a tendency to fall asleep during the day

{} I have fallen asleep while driving

{} I have been in auto accidents because I have fallen asleep while driving

{} I fall asleep while watch TV

{} I fall asleep during conversations

{} I have had injuries because of my sleepiness

{} I have had hallucinations when falling asleep or waking up.

{} I have had an inability to move while falling asleep or waking up

Habits

Do you smoke? {} Yes {} No

If yes: How much? _____ For how long? _____

Do you drink alcohol? {} Yes {} No

If yes: How often? _____ For how long? _____

Social History

{} Sleep Alone

{} Share a bed with someone

{} Share a bedroom, but have separate beds

{} Share a home, but have separate rooms

Employment Status: {} Employed {} Unemployed {} Retired

{} My job requires that I drive me vehicle

{} I work with dangerous equipment

{} I am a shift worker

{} I am currently a student

Medical History

Vital statistics

What is your: Height? ____ feet _____ inches Weight? _____ pounds Neck Size: _____

What was your weight one year ago? _____ pounds Five years ago? _____pounds

Current Medications

Medication	Dose	# Times Per Day

Allergies: _____

Past Sleep Evaluation and Treatment

{} I have had a previous sleep disorder evaluation

{} I have had a previous overnight study

{} I have had a daytime nap study

{} I have been prescribed a CPAP or BIPAP machine for home use

{} I have had surgical treatment for a sleep disorder

{} I have been prescribed medication for a sleep disorder

{} I have been treated for a sleep disorder

Past Medical History

{} Hypertension (high blood pressure)

{} Heart Disease

{} Diabetes

{} Stomach or colon problems

{} Lung problems/COPD/asthma

{} Reflux

{} Fibromyalgia

{} Stroke

{} TIA "Light Stroke"

{} Blackouts

{} Seizures

{} Back or joint problems

{} Cancer

{} Thyroid cancer

{} Hepatitis/jaundice

{} Hearing Impairment

{} Depression or severe anxiety

{} Alcoholism

{} Chemical dependency or abuse

Female

{} Premenstrual syndrome

{} Menopause

Male

{} Prostate problems

{} Erectile dysfunction/impotence

List all other past medical problems and dates:

List Surgeries and the year

Check any of the following symptoms you have had in the past 12 months

Yes	No		Yes	No	
{}	{}	Frequent headaches	{}	{}	Frequent heartburn/Indigestion
{}	{}	Fainting or passing out	{}	{}	Abdominal pain
{}	{}	Sudden loss of vision	{}	{}	Frequent constipation
{}	{}	Inability to speak	{}	{}	Frequent diarrhea
{}	{}	Hearing loss	{}	{}	Rectal bleeding/black stools
{}	{}	Hoarseness	{}	{}	Difficulty urinating/incontinence
{}	{}	Nosebleeds	{}	{}	Blood in urine

{}	{}	Cough for more than 2 weeks	{}	{}	Urinating more than 2 times per night
{}	{}	Coughing up blood	{}	{}	Pain in joints or bones
{}	{}	Shortness of breath	{}	{}	Unusual bruising or bleeding
{}	{}	Swelling in feet or ankles	{}	{}	Epilepsy/seizures
{}	{}	Chest pain, pressure	{}	{}	Change in wart, mole or skin growth
{}	{}	Irregular heartbeat	{}	{}	Weight loss of more than 5-10 pounds
{}	{}	Difficulty swallowing food			

Family History

Has an immediate relative had any of the following?

Yes	No		Relation	Yes	No		Relation
{}	{}	Cancer	_____	{}	{}	Stroke	_____
{}	{}	Diabetes	_____	{}	{}	Anxiety/Depression	_____
{}	{}	Hypertension	_____	{}	{}	Sleep apnea	_____
{}	{}	Heart Disease	_____	{}	{}	Narcolepsy	_____
{}	{}	Thyroid Disease	_____	{}	{}	Other _____	_____

Using the Answer Key below, please circle the number that best applies to your life over the past 6 months

Answer Key **1- Never** **2- Rarely** **3- Sometimes** **4- Usually** **5- Always**

I have trouble falling asleep	1	2	3	4	5
I wake up often during the night	1	2	3	4	5
At bedtime, thoughts race through my head	1	2	3	4	5
At bedtime, I feel sad and depressed	1	2	3	4	5
When falling asleep, I feel paralyzed (unable to move)	1	2	3	4	5
When falling asleep, I have restless legs	1	2	3	4	5
I wake up suddenly gasping for breath, unable to breath	1	2	3	4	5
At night my heart pounds, beats fast, irregularly	1	2	3	4	5

I sweat a great deal at night	1	2	3	4	5
I have a lot of nightmares	1	2	3	4	5
I am unable to move after a nap	1	2	3	4	5
I have hallucinations as I wake up in the morning	1	2	3	4	5
I have slept for several days at a time	1	2	3	4	5
I have been unable to sleep for several days	1	2	3	4	5
I think I have insomnia	1	2	3	4	5
I am sleepy during the day and struggle to stay awake	1	2	3	4	5
I have fallen asleep talking to someone, or eating	1	2	3	4	5
I have trouble doing my job due to fatigue	1	2	3	4	5
I often let someone else drive due to my fatigue	1	2	3	4	5
I have high blood pressure	1	2	3	4	5
I have less desire or interest in sex	1	2	3	4	5
I have considered or attempted suicide	1	2	3	4	5
I smoke tobacco within two hours before bed	1	2	3	4	5
I feel my nose is blocked up when I am trying to sleep	1	2	3	4	5
My snoring is worse while I am on my back	1	2	3	4	5

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations?

Rate each description according to your normal way of live in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best 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	_____
Watching TV	_____
Sitting inactive in a public place	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
Sitting in a car, while stopped for a few minutes in traffic	_____
	Total: _____