

Sleep Questionnaire

Name: _____ Date: _____
Date of Birth: ___/___/___ Age: _____ Gender: _____ Height: _____ Weight: _____ lbs.
Referring Physician: _____ Occupation: _____

Please give a brief description of your sleep problem and its duration:

Please describe any events that occur while falling asleep, during sleep, or while waking up that you consider unusual:

List all current and past health problems: None

1. _____ 3. _____
2. _____ 4. _____

List Current Medications (Include inhalers, birth control) (List name, dose, frequency): None

1. _____ 3. _____
2. _____ 4. _____

Check if you use any of the following devices: None

- Oxygen Flow rate _____ L/min When do you use it? _____
 CPAP or BiPAP (mask worn when sleeping) Type of CPAP/BiPAP unit _____ CPAP pressure _____
Date you started using CPAP _____ Heated humidification? _____
Do you use an oral appliance? _____ Yes _____ No
If Yes: Type of oral appliance _____ Date you started using oral appliance _____

List All Over-the-counter Medications or Supplements (Vitamins, natural herbs, etc.): None

1. _____ 3. _____
2. _____ 4. _____

List any Allergies to Medications (include IV contrast) or Foods and the Reaction: None

1. _____ 3. _____
2. _____ 4. _____

List All of Your Lifetime Surgeries and Major Injuries: None

1. _____ 3. _____
2. _____ 4. _____

Social History

- Highest education level? High School Vocational School College Graduate School
Marital Status? Married Single Divorced Widow/Widower Co-Habitant
Do you or did you ever smoke? Yes No Packs / day _____ How Many Years? _____
Have you ever quit? Yes No
If yes, for how long did you quit? _____ How did you quit? _____
If yes, when did you quit? _____ How did you quit? _____
Do you use tobacco products other than cigarettes? Yes No If yes, which ones? _____

Does anyone smoke in your household? Yes No

Have you ever used illegal substances? Yes No

Have you ever had trouble with alcohol, drug, or other substance use? Yes No

Do you have an Advanced Medical Directive / Living Will? Yes No

Family History (blood related kin)

Adopted or do not know family history

If your mother or father is deceased, what caused his/her death? _____

If any of you siblings are deceased, what caused his/her death? _____

Please list any sleep disorders or other significant medical problems in your family:

REVIEW OF SYSTEMS: Do you **CURRENTLY** or **FREQUENTLY** suffer from or have difficulty with any of the below?

CONSTITUTIONAL

- Unusual fatigue
- Weight gain.
How much? _____ lbs
Over what time frame? _____
- None of the above**

ALLERGIC

- Hay Fever
- Frequent sneezing
- Watery eyes
- Seasonal allergies
- None of the above**

CARDIOVASCULAR

- High blood pressure
- Abnormally low blood pressure
- Chest pain on exercise (angina)
- Irregular beat or palpitation of heart
- Heart murmur
- Swelling or edema of ankles
- History of heart attack
- History of enlarged heart/ heart failure (CHF)
- None of the above**

GLANDULAR (LYMPHATIC)

- Swollen lymph nodes anywhere
- None of the above**

STOMACH AND BOWELS

- Difficult or painful swallowing
- Acid Reflux (“Heartburn”)
- Regurgitation
- Belching
- Hiatal hernia
- Stomach ulcer/
Intestinal ulcer
- Nausea or vomiting
- None of the above**

PSYCHIATRIC

- Anxiety
- Depression
- Other mood disorder
- None of the above**

**EARS, NOSE,
THROAT, MOUTH**

- Ear pain / pressure
- Sinus problems,
post nasal drip
- Nasal congestion,
runny nose
- Hoarseness
- Frequent need to clear throat
- None of the above**

LUNGS (RESPIRATORY)

- Asthma, wheezing
- Cough for more than 3 weeks
- COPD / emphysema
- Ever had collapsed lung?
- Ever had bullous lung disease?
- Recurrent bronchitis
- Shortness of breath
- None of the above**

ENDOCRINE

- Increased thirst, hunger
- Sensitive to heat/cold
- Change in skin, body hair
- Diabetes
- None of the above**

NEUROLOGIC

- Unusual dizziness, fainting, or
loss of consciousness
- Ever had a stroke?
- Ever had a head trauma?
- Ever had a skull fracture?
- Seizures
- None of the above**

SLEEP HISTORY

General:

- Do you feel that you suffer from insomnia? Yes; No
Do you feel that you get too little sleep at night? Yes; No
Do you feel that you get too much sleep at night? Yes; No

Sleep Hygiene:

What time do you:

- go to bed on weekdays? am pm -on weekends? am pm
-wake up on weekdays? am pm -on weekends? am pm

When you go to bed, how long does it usually take you to fall asleep? _____ minutes

On the average, how long are you awake in the morning before you actually get out of bed? _____ minutes

Do you take naps during the day? Yes; No. - If yes, at what time: _____ How long? _____ minutes

Do you routinely exercise each day? Yes; No - If yes, at what time: _____

On the average, how many ounces of alcoholic beverages do you consume:

-per day? per week?

On the average, how many ounces of caffeinated beverages do you consume:

-per day? per week?

Do you usually have a drink containing caffeine or alcohol within 2-3 hours of the time you go to bed?

Yes; No

Have you ever worked shift work? Yes; No. - If yes, please describe: _____

How much difficulty do you have with:

never mild moderate severe

- | | | | | |
|--|-------|-------|-------|-------|
| - waking up during the night ? | _____ | _____ | _____ | _____ |
| - getting back to sleep after waking up during the night ? | _____ | _____ | _____ | _____ |
| - waking up in the morning ? | _____ | _____ | _____ | _____ |
| - getting out of bed after waking up in the morning ? | _____ | _____ | _____ | _____ |
| - waking up with headaches ? | _____ | _____ | _____ | _____ |

On the average, how long are you awake during the night? _____ minutes

Hypersomnolence (Excessive Sleepiness):

Do you wake up feeling tired or wanting more sleep regardless of how much sleep you get? Yes; No

Do you struggle to stay awake during the day? Yes; No

Do you fall asleep at meetings/lectures? Yes; No

Have you ever dozed off at a traffic light or toll booth? Yes; No

Have you ever had an accident operating an automobile or other machinery because of sleepiness or fatigue?

Yes; No If yes, please describe: _____

Besides actual traffic accidents have you ever experienced any of the following while driving?

- | | | | |
|--|------------------------------|------------------------------|--------------------------|
| - Unintended lane shifts? | <input type="checkbox"/> Yes | <input type="checkbox"/> No. | If YES, how often? _____ |
| - Unintended road departures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No. | If YES, how often? _____ |
| - Unintended crossing lights at an intersection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If YES, how often? _____ |

Do you use caffeine or other stimulants to stay alert? Yes; No

If you feel that you have excessive daytime sleepiness, please describe a few experiences that you have had that reflect severe sleepiness.

Sleep Behavior: If you answer yes to the following question, please describe in the space provided.

Do your legs or arms bother you when resting or falling asleep? Yes; No

Do you have any unusual movements (leg jerks, head movements, etc.) during sleep? ___Yes; ___No.

Do you have any unusual sleep behavior (sleep walking, sleep talking, etc.)? ___Yes; ___No.

Do you experience dreams? ___Yes; ___No

Have you noticed a change in your dreams? (i.e. increased, decreased, etc)? ___Yes; ___No

Do you experience nightmares? ___Yes; ___No If yes, please describe: _____

Breathing Disorders:

Do you experience any breathing problems during sleep ? ___Yes; ___No. If yes, please describe:

Do you or have you been told that:	Yes	No
-you snore?	_____	_____
-have pauses in breathing during sleep?	_____	_____
-difficulty breathing in a flat position?	_____	_____
-waking up short of breath?	_____	_____
-waking up choking or gasping for air?	_____	_____

Narcolepsy:

Have you ever been diagnosed as having narcolepsy?	_____	Yes;	_____	No
Has anyone in your family been diagnosed with narcolepsy?	_____	Yes;	_____	No
How much difficulty do you have with:	never	mild	moderate	severe
- feeling sleepy, fatigued, or weak after an emotional experience?	_____	_____	_____	_____
- not being able to move when first waking up?	_____	_____	_____	_____
- hallucinations when falling asleep or waking up?	_____	_____	_____	_____
- sleep attacks (falling asleep despite not wanting to)?	_____	_____	_____	_____

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. Please use the following scale:

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

<u>Situation</u>	<u>Chance of Dozing</u>
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g. 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 the traffic	_____
TOTAL	_____

Thank you for your cooperation.

FOR PHYSICIAN (only) "I have personally reviewed and confirmed the above information."

Signature _____

Date _____