

1960 FP CENTER FOR SLEEP DISORDERS

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 your siblings are deceased, what caused his/her death? _____

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

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

REVIEW OF SYSTEMS CHECK HERE IF YOU HAVE EXPERIENCED NONE OF THE FOLLOWING...

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? _____

ALLERGIC

- Hay Fever
- Frequent sneezing
- Watery eyes
- Seasonal allergies

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)

STOMACH AND BOWELS

- Difficult or painful swallowing
- Acid Reflux ("Heartburn")
- Regurgitation
- Belching
- Hiatal hernia
- Stomach ulcer / Intestinal ulcer
- Nausea or vomiting

PSYCHIATRIC

- Anxiety
- Depression
- Other mood disorder

EARS, NOSE, THROAT, MOUTH

- Ear pain / pressure
- Sinus problems, post nasal drip
- Nasal congestion, runny nose
- Hoarseness
- Frequent need to clear throat

GLANDULAR (LYMPHATIC)

- Swollen lymph nodes anywhere

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

ENDOCRINE

- Increased thirst, hunger
- Sensitive to heat/cold
- Change in skin, body hair
- Diabetes

NEUROLOGIC

- Unusual dizziness, fainting, or loss of consciousness
- Ever had a stroke?
- Ever had a head trauma?
- Ever had a skull fracture?
- Seizures

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? ___Yes ___No. If YES, how often? _____
- Unintended road departures? ___Yes ___No. If YES, how often? _____
- Unintended crossing lights at an intersection? ___Yes ___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

Situation	Chance of Dozing
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.

Patient Signature: _____

Date _____

Physician Signature: _____