

SLEEP QUESTIONNAIRE

I. DEMOGRAPHIC DATA

Name _____ Age _____ Sex _____

Height _____ Weight _____ lbs

II. PHYSICAIN INFORMATION

Name of primary physician:

Name of referring physician:

Dr. _____

Dr. _____

Address _____

Address _____

Telephone # _____

Telephone # _____

Specialty _____

Specialty _____

III. SLEEP HISTORY

Briefly describe the problem you are experiencing with your sleep (why you need to see the sleep physician), and when this problem began.

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- Have you had problems with excessive daytime sleepiness? YES _____ NO _____
- Have you had problems with excessive fatigue during the day? YES _____ NO _____
- Do you frequently fall asleep while watching television? YES _____ NO _____
- Do you tend to fall asleep during the day when you are quiet and inactive? YES _____ NO _____
- Do you feel distracted and unable to concentrate during the day? YES _____ NO _____
- Have you had any accidents at work due to sleepiness? YES _____ NO _____
- Do you have difficulty staying awake to drive? YES _____ NO _____
- Have you had any near traffic accidents due to sleepiness? YES _____ NO _____
- Have you had an auto accident in the last 5 years? YES _____ NO _____
- Has anyone told you that you snore loudly? YES _____ NO _____
- Do you snore in all sleeping positions? YES _____ NO _____
- Has your family told you that you quit breathing at night? YES _____ NO _____
- Have you ever awakened gasping for breath? YES _____ NO _____
- Have you ever awakened at night with coughing, or choking? YES _____ NO _____
- Do you awaken with a sore throat frequently? YES _____ NO _____
- Do you have morning headaches? YES _____ NO _____
- Has your weight changed in the last five years?
If yes, how much? Gained _____ lbs or Lost _____ lbs YES _____ NO _____
- Have you ever awakened at night with chest tightness or discomfort? YES _____ NO _____
- Have you ever awakened at night with a sour taste in your mouth, or
a burning sensation in your chest? YES _____ NO _____
- Do you have sudden episodes of sleep during the day? YES _____ NO _____
- Have you ever experienced periods in which you feel paralyzed while
going to sleep, or waking up? YES _____ NO _____
- Have you ever had visual hallucinations or dream-like mental images
when falling to sleep? YES _____ NO _____

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- Have you ever experienced sudden physical weakness during strong emotions?
(such as your mouth dropping open or legs going limp, during laughter or anger) YES ____ NO ____
- Did you have childhood sleep problems of any type? YES ____ NO ____
- Were you excessively sleepy as a teenager or young adult? YES ____ NO ____
- Do you take scheduled naps during the day? YES ____ NO ____
- Do you feel better after short naps? YES ____ NO ____
- Are you sleepy even on Vacation? YES ____ NO ____
- Do you kick your legs at night? YES ____ NO ____
- Do you have tingly sensations in your legs and you just have to move them? YES ____ NO ____
- Do you have difficulty initiation sleep at night? YES ____ NO ____
- Do you have frequent awakenings? YES ____ NO ____
- Do you usually have restless sleep? YES ____ NO ____
- Do you sleep better away from your own bed?
(vacations, visiting family) YES ____ NO ____
- Are you sleepy even when you increase your sleep time? YES ____ NO ____
- Do you have pain that bothers you at night? YES ____ NO ____
- Do you grind your teeth in your sleep? YES ____ NO ____
- Have you ever had a severe head trauma? YES ____ NO ____
- Do you sleep walk? YES ____ NO ____
- Do you wet the bed at night? YES ____ NO ____
- Do you talk in your sleep? YES ____ NO ____
- Do you have frequent nightmares? YES ____ NO ____
- Do you ever wake up screaming at night? YES ____ NO ____
- Are you awake at night because of your bed partner? (noise or movement) YES ____ NO ____
- Are you awake at night because some other person needs assistance?
(elderly or infant) YES ____ NO ____

IV. SLEEP SCHEDULE

| | Weekday | Weekend |
|-----------------------------------|---------|---------|
| Time you go to bed | | |
| Time you get up | | |
| Average amount of sleep per night | | |

Do you have rotating or night shift work? YES ____ NO ____

How long does it take you to go to sleep? _____

How do you feel when you wake up? _____

Do you function best in the morning _____ afternoon _____ or evening _____ ?

Do you function worst in the morning _____ afternoon _____ or evening _____ ?

Do you find that your present sleep schedule is inconvenient, YES ____ NO ____ inappropriate, or unsatisfactory? Please explain: (example: I can't fall asleep until late at night and then I can't get up in time for work in the morning, or I fall asleep so early in the evening that I wake up early in the AM well before its time to go to work.)

V. PAST MEDICAL HISTORY

Have you had any surgeries? If yes, what year?

Tonsillectomy _____ Hernia _____ Appendectomy _____

Cardiac Bypass _____ Hysterectomy _____ Cardiac Cath _____

Nasal Surgery _____ Other _____

Do you have any medical problems? If yes, what year?

Diabetes _____ Heart Disease _____ Lung Disease _____ Arthritis _____

Ulcers _____ Thyroid Disease _____ Seizure Disorder _____ High B/P _____

Allergies _____ High Cholesterol _____ Other _____

VI. CURRENT MEDICATIONS

| Medication | Dosage | Taken for How Long? |
|------------|--------|---------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Over the counter medications _____

VII. SYSTEMS REVIEW

- Have you seen an EAR, Nose, and Throat specialist? YES ____ NO ____
- Have you had sinus x-rays? YES ____ NO ____
- Do you have nasal allergies? YES ____ NO ____
- Do you have difficulty breathing through your nose at any time? YES ____ NO ____
- Do you have problems with persistent cough? YES ____ NO ____
- Do you have problems with shortness of breath? YES ____ NO ____
- Do you have problems with coughing at night? YES ____ NO ____
- Do you have problems with wheezing? YES ____ NO ____
- Do you have persistent hoarseness or difficulty swallowing? YES ____ NO ____
- Do you have severe heart fluttering, tightness in or chest or chest pain? YES ____ NO ____
- Have you had stomach burning, or other signs of ulcer? YES ____ NO ____
- Do you take antacids? YES ____ NO ____
- Have you had problems with frequent urination or other urinary problems? YES ____ NO ____
- Have you had swelling of your hands or feet? YES ____ NO ____

Do you have severe difficulties with joint pain, particularly at night? YES ____ NO ____

Have you had seizures or other neurologic problems? YES ____ NO ____

Have you had any problems with depression or anxiety? YES ____ NO ____

Have you ever been hospitalized or treated for depression or anxiety? YES ____ NO ____

In the past six months, have you had constantly low energy levels, constipation or intolerance to cold? YES ____ NO ____

VIII. SOCIAL HISTORY

Occupation: _____

Marital Status: (circle) single married divorced widow

Have you **ever** smoked? YES ____ NO ____
If yes, how long: _____ How many packs per day: _____
When did you quit? _____

Do you drink alcohol of any kind? YES ____ NO ____
If yes, how much and what kind: _____

Do you drink coffee, tea, or soft drinks? YES ____ NO ____
If yes, regular ____ or decaffeinated ____ How much daily? _____

Have you ever used marijuana, cocaine or other drugs? YES ____ NO ____
If yes, which drug and how often: _____

How many meals do you eat daily? _____

Do you exercise regularly? YES ____ NO ____
If yes, what time of the day: _____

IX. FAMILY HISTORY (mother, father, siblings)

| | Living | Age | If Deceased At What Age | Cause of Death | Medical Problems |
|---------|--------|-------|----------------------------|----------------|------------------|
| Father | _____ | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ | _____ |
| Brother | _____ | _____ | _____ | _____ | _____ |

FAMILY HISTORY (mother, father, siblings) continue:

| | Living | Age | If Deceased At What Age | Cause of Death | Medical Problems |
|---------|--------|-------|----------------------------|----------------|------------------|
| Brother | _____ | _____ | _____ | _____ | _____ |
| Brother | _____ | _____ | _____ | _____ | _____ |
| Sister | _____ | _____ | _____ | _____ | _____ |
| Sister | _____ | _____ | _____ | _____ | _____ |
| Sister | _____ | _____ | _____ | _____ | _____ |

| | YES _____ | NO _____ | Person with Disorder _____ |
|---------------------|-----------|----------|-------------------------------|
| Diabetes | YES _____ | NO _____ | _____ |
| High Blood Pressure | YES _____ | NO _____ | _____ |
| Stoke | YES _____ | NO _____ | _____ |
| Obesity | YES _____ | NO _____ | _____ |
| Snoring | YES _____ | NO _____ | _____ |
| Sleep Apnea | YES _____ | NO _____ | _____ |
| Narcolepsy | YES _____ | NO _____ | _____ |
| Daytime Sleepiness | YES _____ | NO _____ | _____ |
| Other | YES _____ | NO _____ | _____ |

Are there any other comments you would like to make that were not covered in this questionnaire?

THE EPWORTH SLEEPINESS SCALE

NAME: _____

DATE : _____ AGE: _____ MALE _____ or FEMALE _____

How likely are you to doze off or fall asleep in the following situations? 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 choose the most appropriate 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 Television | _____ |
| Sitting, inactive in a public place such as 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 the traffic | _____ |
| Total score – add all responses | _____ |