SLEEP QUESTIONNAIRE

I. ***DEMOGRAPHIC DATA***

Name ______________________________________ Age ___________ Sex ________

Height _______________ Weight ______________ lbs

II. ***PHYSICIAN INFORMATION***

Name of primary physician:

Dr. ___________________________

Address _______________________

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Telephone # ___________________

Specialty _______________________

Name of referring physician:

Dr. ___________________________

Address _______________________

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Telephone # ___________________

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? YES _____ NO _____
If yes, how much? Gained _________lbs or Lost _________lbs

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? YES _____ NO _____
(vacations, visiting family)

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? YES _____ NO _____
(elderly or infant)

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, inappropriate, or unsatisfactory? Please explain: (example: I can't fall asleep intil 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.) YES ____ NO ____

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V. PAST MEDICAL HISTORY

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

Tonsillectomy ______________ Hernia ________________ Apendectomy ___________________

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 ____

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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 sighs 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 of 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 ou 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: ____

Martial 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					

			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?

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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	_______________