



Sleep Patient Questionnaire Form

Today's Date: ____/____/____

Name: _____

(The sleep technician can complete the section below with you at your appointment if you're unsure of the measurements):

Sleep History:

1. Please briefly describe your sleep problem from **your** perspective:

2. How long have you had this problem (weeks, months, years)? _____

3. Has anyone else told you that you snore loudly: Yes ____ No ____

If yes, has your snoring caused people to refuse to sleep in the same room?
Yes ____ No ____

4. Has anyone noticed you to stop breathing in your sleep? Yes ____ No ____
If yes, how frequently (if you can estimate)?: _____

5. Please indicate if you have noticed (or someone has told you) that you:

a) Suddenly wake up gasping for breath or short of breath? Yes ____ No ____

b) Have had witnessed apnea (stop breathing)? Yes ____ No ____

c) Wake with a headache? Yes ____ No ____

d) Snort yourself awake? Yes ____ No ____

e) Notice your legs jerking or twitching during the night? Yes ____ No ____

f) Are unable to move when falling asleep or immediately upon waking up? Yes ____ No ____

g) Have vivid or life like visual images while falling asleep or upon awakening? Yes ____ No ____

h) Have episodes of sudden muscular weakness (paralysis or inability to move) when laughing, angry or in other extreme emotional situations? Yes ____ No ____

g) Wake up confused and wander during the night? Yes ____ No ____

Sleep Apnea History (complete this section *only* if you are already diagnosed with obstructive sleep apnea and are being treated using a CPAP or BiPAP machine; otherwise, continue on to “Sleep Hygiene”):

When were you diagnosed with sleep apnea? _____
What are the settings on your machine? _____
What company provided your machine? _____
What company provides supplies for you? _____
How old is the current machine you are using? _____
What type of mask are you using? _____
Do you use humidification? _____
Do you have any problems tolerating treatment?
(*please explain if you are having problems*): _____

Sleep Hygiene:

6. Do you regularly participate in an exercise program? Yes ____ No ____
If yes, please describe your routine and the time that you exercise:

7. Do you take a hot shower or bath 2 hours or less prior to bed? Yes ____ No ____

8. Do you eat 3 hours prior to bed? Yes ____ No ____
If so, how much/what do you eat?:

9. Does any noise or problem interfere with your sleep (noise, temperature in the house or bed partner)? Yes ____ No ____

10. Please list any activities that you engage in while in the bedroom--aside from sex and sleep (for example, work, TV, reading, etc.):

11. Do you have any problems with thoughts running through your mind at night? Yes ____ No ____

If yes, please describe: _____

Restless Legs Syndrome Screen:

12. Do you have the urge to move your legs usually accompanied or caused by leg sensations that are uncomfortable? Yes ____ No ____

13. Does the onset or worsening of leg symptoms occur in the evening or at night? Yes ____ No ____

14. Is the onset or worsening of symptoms at rest or inactivity when you are lying down? or sitting? Yes ____ No ____

15. Is there any relief of the uncomfortable sensations with movement temporarily (either partial or total relief from the discomfort) by walking or stretching? Yes ____ No ____

Sleep Habits:

16. On average, what is your normal bedtime:
During the week?: _____
On the weekends?: _____

17. On average, what time do you get out of the bed in the morning:
During the week?: _____
Weekends?: _____

18. Estimate how many hours of sleep you get:

A. On the average night for you? _____ hrs. B. On a bad night for you? _____ hrs.

19. How long does it take you to fall asleep?

A. On the average night for you? _____ hrs. B. On a bad night for you? _____ hrs.

Parasomnia Screen:

20. Has anyone ever told you that you:
a. You grind your teeth at night? Yes ____ No ____
If yes, do you wear a mouthguard? Yes ____ No ____
b. You walk in your sleep? Yes ____ No ____
c. Act out your dreams? Yes ____ No ____
d. Perform repetitive or seemingly purposeless acts at night? Yes ____ No ____

Daytime Functioning:

21. Do you find that during the day you have a problem with severe sleepiness (feeling very sleepy and struggling to stay awake) during the daytime? Yes ____ No ____

22. Are there performance issues because of your sleepiness at work? Yes _____ No _____

23. Do you ever fall asleep during the day without meaning to? Yes _____ No _____
If yes, how many times on average a week _____

24. Do you take naps during the day? Yes _____ No _____
If yes, what is the average number of naps per week? _____

25. What time of the day do you feel the sleepest/fatigue? _____

26. Have you ever had a car accident while you were driving caused by your fatigue or sleepiness (not due to drug or alcohol usage)? Yes _____ No _____

27. Have you ever had a near collision (for example, driving off the road) as a result of your sleepiness (*not due to alcohol or drug usage*)? Yes _____ No _____

28. Does your job require shift work? Yes _____ No _____
If yes, please describe your shifts and how they rotate: _____

Social History:

29. How much of the following do you consume **during the average day**?

Alcohol: _____

Coffee (with caffeine): _____

Tea (with caffeine): _____

Soft drinks (with caffeine): _____

Cigarettes: _____

Other tobacco products: _____

30. Do you have a bed partner currently? Yes _____ No _____
If yes, do they have any concerns about your sleep?

31. Does your bed partner disturb your sleep in any way? If so, how? Yes _____ No _____

32. Do you have pets sleeping in the bedroom/bed with you? Yes _____ No _____

33. Do you feel your home sleep environment is optimal for you sleep? Yes _____ No _____
If no, why not? _____

Medical History:

Please check if you have ever had/have any of the following conditions:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anxiety +/- panic attacks | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low back pain |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dementia | <input type="checkbox"/> Migraine headache |
| <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Nasal Obstruction |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hallucinations/Delusions | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> CHF (congested heart failure) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hiatal hernia | <input type="checkbox"/> Problem with alcohol |
| <input type="checkbox"/> Chronic sinus disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Problem with drugs |
| <input type="checkbox"/> COPD
(chronic obstructive pulmonary disease) | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Sexual Functions |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Polycystic Ovarian Syndrome (females) | <input type="checkbox"/> Hyper/hypo-thyroidism |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Ulcer/heartburn | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Restless Legs Syndrome | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Obstructive sleep apnea (on CPAP) | | |
| <input type="checkbox"/> Obstructive sleep apnea (tried but could not tolerate CPAP for some reason) | | |
| <input type="checkbox"/> Insomnia (if yes, what treatments do you use now? _____
What treatments have you tried before? _____) | | |

Other medical conditions you would like to mention/feel may be relevant:

Surgical History:

- | | |
|-------------------------------|-------|
| Tonsillectomy | _____ |
| UPPP | _____ |
| Septal deviation repair | _____ |
| Turbinates reduction | _____ |
| Sinus surgery | _____ |
| Thyroidectomy | _____ |
| Bariatric/Weight Loss Surgery | _____ |
| Other | _____ |

Family Medical History:

Does anyone in your family have any of the following conditions, and; if so, please list their relationship to you:

- | | |
|--|-------|
| <input type="checkbox"/> Obstructive Sleep Apnea-Hypopnea Syndrome | _____ |
| <input type="checkbox"/> Restless legs syndrome (RLS) | _____ |
| <input type="checkbox"/> Insomnia | _____ |
| <input type="checkbox"/> Narcolepsy | _____ |
| <input type="checkbox"/> Other (please explain): | _____ |

Neurological: ___ *No problems*

___ Memory loss

___ Limb jerking

___ Trouble thinking

Psychiatric: ___ *No problems*

___ Depressed

___ Mood changes

___ Anxious/Anxiety

___ Panic attacks

___ Hallucinations

___ Acting out dreams while asleep

Epworth Sleepiness Scale:

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.

1 = *slight* chance of dozing or sleeping

2 = *moderate* chance of dozing or sleeping

3 = *high* chance of dozing or sleeping

SITUATION

CHANCE of DOZING

Sitting and reading

Watching TV

Sitting inactive in a public place

Being a passenger in a motor vehicle for an hour or more

Lying down in the afternoon

Sitting and talking to someone

Sitting quietly after lunch (no alcohol)

Stopped for a few minutes in traffic while driving

Total score:

_____/24