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?  
      If yes, do you wear a mouthguard?  
      Yes ____ No ____  
      Yes ____ No ____
   b. You walk in your sleep?  
      Yes ____ No ____  
      Yes ____ No ____
   c. Act out your dreams?  
      Yes ____ No ____  
      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 sleepiest/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:

___ Anxiety +/- panic attacks  ___ Diabetes  ___ Low back pain
___ Arthritis  ___ Dementia  ___ Migraine headache
___ Asthma/Bronchitis  ___ Epilepsy/Seizure  ___ Multiple Sclerosis
___ Atrial Fibrillation  ___ Migraine headaches  ___ Nasal Obstruction
___ Cancer  ___ Hallucinations/Delusions  ___ Neuropathy
___ CHF (congested heart failure)  ___ Heart Attack  ___ Parkinson’s disease
___ Chronic pain  ___ Hiatal hernia  ___ Problem with alcohol
___ Chronic sinus disease  ___ High Blood Pressure  ___ Problem with drugs
___ COPD  ___ High cholesterol  ___ Sexual Functions
(chronic obstructive pulmonary disease)
___ Stroke  ___ Polycystic Ovarian Syndrome (females)
___ Depression  ___ Ulcer/heartburn  ___ Pacemaker
___ Restless Legs Syndrome  ___ Seizures/Epilepsy  ___ Concussion
___ Obstructive sleep apnea (on CPAP)
___ Obstructive sleep apnea (tried but could not tolerate CPAP for some reason)
___ 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
Turbinate 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:

___ Obstructive Sleep Apnea-Hypopnea Syndrome ____________________________
___ Restless legs syndrome (RLS) ____________________________
___ Insomnia ____________________________
___ Narcolepsy ____________________________
___ Other (please explain): ____________________________
Review of Systems: Check any of the following that you feel apply to you currently:

Constitutional: ___ No problems
___ Poor energy ___ Fever ___ Fatigue ___ Sweating while asleep at night

Eyes: ___ No problems
___ Wear corrective lenses (glass/contacts)

Ears/Nose/Mouth/Throat: ___ No problems
___ Hoarse voice ___ Hearing Impaired, if yes: ___ Hearing Aid
___ Difficulty swallowing ___ Sinus discharge

Hematological/Lymphatic: ___ No problems
___ Enlarged lymph nodes ___ Increased bruising
___ Increased bleeding ___ Limb swelling

Heart/Cardiovascular: ___ No problems
___ Passing out/fainting ___ Blood clots/phlebitis (DVT)

Lungs/Respiratory: ___ No problems
___ Hyperventilation ___ Shortness of breath ___ Wheezing

Allergy/Immunology: ___ No problems
___ Adhesive tape ___ Milk ___ Pollen ___ Latex ___ Medication(s):

Gastrointestinal Stomach/Intestine/Liver: ___ No problems
___ Reflux/heartburn

Genitourinary: ___ No problems
___ Increased urge to urinate ___ Increased frequency of urination
___ Difficulty with sexual dysfunction

Skin: ___ No problems
___ Rashes

Endocrine: ___ No problems
___ Recent weight gain ___ Recent weight loss
___ Irregular menses ___ Heat and/or sold intolerance
___ Thyroid disease (list type of disease and if your treated):

Bones/Joints/Muscles: ___ No problems
___ Joint pain ___ Joint swelling
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

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE of DOZING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting inactive in a public place</td>
<td></td>
</tr>
<tr>
<td>Being a passenger in a motor vehicle for an hour or more</td>
<td></td>
</tr>
<tr>
<td>Lying down in the afternoon</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch (no alcohol)</td>
<td></td>
</tr>
<tr>
<td>Stopped for a few minutes in traffic while driving</td>
<td></td>
</tr>
</tbody>
</table>

**Total score:**  

\[
\text{Total score: } \frac{\text{Sum of scores}}{24} \]