DukeMedicine

EXTRAORDINARY PEOPLE. EXTRAORDINARY CARE.

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 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
___ Arthritis
___Asthma/Bronchitis
___ Arial Fibrillation
___ Cancer
___ CHF (congested heart failure)
___ Chronic pain
___ Chronic sinus disease
___ COPD
(chronic obstructive pulmonary disease)
___ Stroke
___ Depression
___ Restless Legs Syndrome
___ Diabetes
___ Dementia
___ Epilepsy/Seizure
___ Migraine headaches
___Hallucinations/Delusions
___ Heart Attack
___ Hiatal hernia
___ High Blood Pressure
___ High cholesterol
___ Polycystic Ovarian Syndrome (females)
___ Ulcer/heartburn
___ Seizures/Epilepsy
___ Low back pain
___ Migraine headache
___ Multiple Sclerosis
___ Nasal Obstruction
___ Neuropathy
___ Parkinson's disease
___ Problem with alcohol
___ Problem with drugs
___ Sexual Functions
___ Hyper/hypo-thyroidism
___ Pacemaker
___ 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

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 while driving	____

Total score: ____/24