Patient Sleep Questionnaire

Occupation: _____ **Race:** _____ **Marital Status:** _____

Primary Care Physician: _____ **Referring Physician:** _____

1 Your Symptoms/Chief Complaint:

a What is your major sleep problem? _____

b How long has it occurred? _____

c Have you ever had any problems with your sleep? ☐ yes ☐ no
If "yes", briefly describe the evaluation, treatment and results. _____

d If you are tested for your sleep problem, what do you hope that treatment will accomplish? _____

2 Sleep Hygiene

a What time do you usually go to bed and get up on week days or work nights?
Got to bed: _____ AM/PM Get up: _____ AM/PM

b What time do you usually go to bed and get up on weekends or non-working nights?
Got to bed: _____ AM/PM Get up: _____ AM/PM

c How many hours do you sleep at night? _____

d What do you usually do prior to turning out the bedroom light and attempting to go to sleep? _____

e How long does it usually take you to fall asleep? _____

f. How many times do you usually awaken during the night? _____

g. How many times do you urinate during the night? _____

h. What wakes you up during the night? _____

i. Upon awakening, how do you feel? _____ Tired _____ Rested

j. Do you ever nap or return to bed after arising? ☐ yes ☐ no

i. If so, how often do you nap during the day? _____

ii. How long do you usually nap during the day? _____

iii. Do you feel rested or refreshed after you nap? ☐ yes ☐ no

3 Snoring/Apnea/Sleepiness

a Have you ever been told or do you know that you snore when you sleep?

i. ☐ yes ☐ no ☐ don't know
If yes, who hears you? _____ Bed partner _____ Someone in the same room _____ Someone in the next room

ii. How are you usually sleeping when you snore?
_____ On you back _____ On your side _____ On your stomach _____ In a sitting position

iii. Do you snore every night? ☐ yes ☐ no ☐ don't know

b Has anyone ever told you that you seem to stop breathing at night when you are sleeping? ☐ yes ☐ no

c Do you ever awaken with an increase in your heart rate? ☐ yes ☐ no

d Do you ever wake up gasping for air? ☐ yes ☐ no

e Do you usually feel tired during the day? ☐ yes ☐ no

4 Insomnia

a Do you have trouble falling asleep? ☐ yes ☐ no

b If "yes", how long have you had trouble falling asleep? _____

c Was there some event which occurred at the onset of your insomnia (i.e. loss of job, family, stress, etc)? _____

d How frequently do you have trouble sleeping? _____

e When you cannot get to sleep while in bed, do you get out of bed? ☐ yes ☐ no

f When you finally return to bed, how long does it take before you fall asleep again? _____

g If you slept poorly at night, how does it affect you the next day? _____

5 Miscellaneous Symptoms

a When driving, have you ever run off the road or had an accident because of sleepiness? ☐ yes ☐ no
b Do you grind your teeth while sleeping? ☐ yes ☐ no
c Do you ever wake up with a headache? ☐ yes ☐ no
d Do you have heartburn or reflux (acid taste in your mouth)? ☐ yes ☐ no
e Do you act out your dreams? ☐ yes ☐ no
f Do you have nightmares? ☐ yes ☐ no
g Do you wet the bed? ☐ yes ☐ no
h Do you walk in your sleep? ☐ yes ☐ no
i Do you ever have an unpleasant, restless feeling in your legs or arms, such as when relaxing in the evening? ☐ yes ☐ no
j If "yes", is the restless feeling relieved by walking or movement? ☐ yes ☐ no
k Is the restless feeling worse when still? ☐ yes ☐ no
l Is the restless feeling accompanied by increased leg movements or twitches? ☐ yes ☐ no
m Do you usually have abnormal feelings of sadness or depression? ☐ yes ☐ no
n Do you awaken early and have trouble getting back to sleep? ☐ yes ☐ no
o Have you had a loss of sexual drive or urge? ☐ yes ☐ no
p Have you had recent difficulty with your memory? ☐ yes ☐ no
q Have you had a change in weight? ☐ yes ☐ no

6 Narcolepsy/Cataplexy

a Do you ever feel like you cannot move?
  i Soon after lying down to sleep? ☐ yes ☐ no
  ii When awakening from sleep? ☐ yes ☐ no
  iii. If yes, how often does this occur? _____
b Do you dream?
c Do you dream soon after you lie down?
d Have you ever experienced seeing things or hearing voices that weren't real?
  i When going to sleep? ☐ yes ☐ no
  ii During the night? ☐ yes ☐ no
  iii Upon waking from sleep? ☐ yes ☐ no
  iv During the day? ☐ yes ☐ no

7 Medications

a Do you use prescribed medications or over-the-counter medications either regularly or occasionally? ☐ yes ☐ no
If "yes", please list below or attach a list:

Medication Name	Dosage	How long used

b Do you have any specific drug allergies? ☐ yes ☐ no
If "yes", be specific: _____

8 Medical History

a Do you have the following medical problems:

			When:
i High blood pressure	☐ yes	☐ no	
ii Diabetes	☐ yes	☐ no	
iii Heart Disease	☐ yes	☐ no	
iv Asthma	☐ yes	☐ no	
v Ulcer	☐ yes	☐ no	
vi Other	☐ yes	☐ no	

9 Surgery

a Have you had the following types of surgery? When:

i Tonsillectomy ☐ yes ☐ no
ii Adenoidectomy ☐ yes ☐ no
iii Nasal or Sinus ☐ yes ☐ no
iv Head or Neck ☐ yes ☐ no
v Other ☐ yes ☐ no
vi
vii

10 Family History (Medical Problems)

Mother
Father
Brothers
Sisters
Does anyone in your family have sleep apnea? ☐ yes ☐ no

11 Daily Activities/Social History

a Are you employed outside the home? ☐ yes ☐ no
i If "yes", what days do you usually work?
ii What are your usual working hours? Start _____ AM/PM End _____ AM/PM
iii Do you ever change shifts? _____ Regularly _____ Infrequently _____ Never

b Do you smoke cigarettes? ☐ yes ☐ no
i If "yes", how long have you been a smoker? _____ years
ii How much do you smoke a day?
iii If "no", have you ever been a smoker? ☐ yes ☐ no
iv How many years did you smoke?
v When did you stop smoking?

c Do you consume caffeine in your beverages? ☐ yes ☐ no
i If "yes", how much caffeine do you usually consume?

d Do you drink alcohol? ☐ yes ☐ no
i If "yes", what kind?
ii How much?

e Have you ever used any illegal drugs? ☐ yes ☐ no ☐ don't know
f Pets?
g Hobbies you are currently involved in:
h Number of children:

12 Review of Systems:

Current Weight: _____ Maximum weight ever: _____ Desired weight: _____
Within the last 6 months, have you been: _____ Gaining weight _____ Losing weight _____ No change

Do you have any of the following problems:

_____ Eye problems: Require glasses, glaucoma, cataracts, other
_____ Ear, nose, or throat problems: Hearing, congestion, soreness, swallowing, other
_____ Hormone: Diabetes, thyroid problems, heat or cold intolerance, hot flashes, other
Cancer: what kind? Treatment?
_____ Respiratory or breathing problems: Asthma, shortness of breath, cough, other
Blood pressure problems: Since when (year)?
_____ Heart: Chest pain, skipped beats, racing heart, other
_____ Vascular problems:
Urinary problems: Difficulty urinating, bladder infection, sexual/erectile dysfunction, other
_____ Musculoskeletal: Aches or pains, arthritis, other

___ Neurological: Fainting, dizziness, stroke, numbness, seizures, unconsciousness, other _____

___ Skin: Rashes, itching, other _____

___ Allergies: Pollen, dust, other (list drug allergies on previous page) _____

___ Mood/Psychological: Sadness, down in the dumps feelings, depression, irritability, feelings of hopelessness, crying episodes, memory problems, problems with concentration, loss of usual interest, impatience, loss of appetite, inability to wait or sit still, considered suicide, made plans for suicide, suicidal attempt, other _____

___ _____

___ Trauma: (Physical or psychological) _____

___ Gastrointestinal: Ulcers, vomiting, bleeding, nausea, heartburn, other _____

___ Other: _____

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 chose 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 or Sleeping			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place	0	1	2	3
Being a passenger in a motor vehicle for an hour or more	0	1	2	3
Lying down in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (no alcohol)	0	1	2	3
Stopped for a few minutes in traffic while driving	0	1	2	3
Add Columns			+	+
Total				