Sleep Disorders Questionnaire

NAME:_________________________________ DATE:_______________________
ADDRESS:___________________________________________________________________
_____________________________________________________________________________
DATE OF BIRTH:____________________________ AGE:______ SEX:_______________
HOME PHONE:________________________ WORK PHONE:________________________
CELL PHONE:_________________________

MARITAL STATUS:
SINGLE:____ MARRIED:____ WIDOW(ER):____ DIVORCED:____ SEPARATED:____

REFERRING PHYSICIAN:__________________________________________________________
ADDRESS:_______________________________________________________________________
FAMILY PHYSICIAN:_____________________________________________________________
ADDRESS:_______________________________________________________________________

How did you hear about the Sleep Disorders Center? ____________________________________
_______________________________________________________________________________

Weight: Current _______ lbs.   5 years ago: ________ lbs.   1 year ago: _______ lbs.
Most you ever weighed: _______lbs.
Height: _________ft. ________ inches    Neck size: ________ inches

Please consult your bed partner when answering the following questions. Answer the question as if
you are describing your typical night or sleep pattern. If you use CPAP or BIPAP, answer the
questions based on your use of CPAP or BIPAP.

1. Describe your sleep problem: _____________________________________________________

2. Have you ever had a sleep study performed?    Yes □    No □
   If yes, where did you have the study performed and what were the results: _________________

   ________________________________
3. My bed or sleeping surface is a:
   _____ standard mattress   _____ water bed   _____ futon   _____ other

   If other, please specify:_____________________________________________________

4. Sleep habits:

   Ideal amount of sleep ________ hours.  Do you work in shifts?  □ Yes  □ No

   During the week I:
   Go to bed at ________ (time)  
   Get up at ________ (time)  
   Sleep ________ (hours)  
   A. It usually takes me ________ minutes to fall asleep.
   B. I usually wake up ________ times a night.
   C. Please explain what wakes you up: __________________________________________

   During the weekend I:
   Go to bed at ________ (time)  
   Get up at ________ (time)  
   Sleep ________ (hours)  

   D. If you wake up at night, it usually takes ________ minutes to fall asleep.
   E. I cannot get back to sleep once I wake up:
       Nightly □  Weekly □  Rarely □  Never □
   F. I can sleep 12 hours or more at a time:
       Nightly □  Weekly □  Rarely □  Never □

5. My occupation is:___________________________________________________________

6. I snore:  □ Nightly  □ Weekly  □ Rarely  □ Never

7. My snoring started at age: ______

8. Do you snore:  On your back □  On your sides □  In all positions □

9. My snoring has been described as:  Mild □  Moderate □  Loud □

10. I stop breathing at night:  Yes □  No □

11. How many times do you awaken at night to urinate: ______

12. I have problems with my nose or nasal breathing:  Yes □  No □
    If yes, explain:______________________________________________________________

13. I have had nasal surgery:  Yes □  No □
    If yes, explain:______________________________________________________________
14. I have had a tonsillectomy:  Yes ☐  No ☐

15. I wake up gasping, wheezing, short of breath, or feeling I cannot breathe:  
   Nightly  Weekly  Rarely  Never
   ______  ______  ______  ______

16. I wake up coughing:  
   ______  ______  ______  ______

17. I wake up with my heart beating irregularly:  
   ______  ______  ______  ______

18. I wake up with chest pain:  
   ______  ______  ______  ______

19. I wake up with heartburn or a sour taste in my mouth  
   ______  ______  ______  ______

   I eat my last meal of the day at _________ o’clock

20. I wake up with a headache  
   ______  ______  ______  ______

21. I have/had a bedwetting problem  
   ______  ______  ______  ______

22. I fight sleep or fall asleep uncontrollably while sitting at meetings, watching TV, at the movies, in the car  
   ______  ______  ______  ______

23. I fight sleep at work or school  
   ______  ______  ______  ______

24. I fight sleep while driving  
   ______  ______  ______  ______

25. I have actually fallen asleep while driving a car:  Yes ☐  No ☐

26. It seems that my mood, memory or thought processes have changed:  Yes ☐  No ☐

27. Drowsiness is greatest in the:  Morning ☐  Afternoon ☐  Evening ☐

28. After a typical nights sleep, I feel:  
   Refreshed ☐  Fairly rested ☐  Somewhat tired ☐  Very drowsy ☐

29. I have been told I toss and turn to an Extreme amount  
   Nightly  Weekly  Rarely  Never
   ______  ______  ______  ______

30. I flail or kick while sleeping  
   ______  ______  ______  ______

31. I have the feeling of “restless legs”  
   ______  ______  ______  ______
<table>
<thead>
<tr>
<th></th>
<th>Nightly</th>
<th>Weekly</th>
<th>Rarely</th>
<th>Never</th>
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<tbody>
<tr>
<td>32. I am troubled at night by uncomfortable sensations in my legs</td>
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<td>33. I wake up with muscle or joint aches or pains</td>
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<td>34. Immediately after falling asleep I dream</td>
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<td>35. I dream during naps</td>
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<td>36. I experience vivid dream-like scenes upon waking up or falling asleep</td>
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<td>37. I have episodes where I lose track of time without realizing it</td>
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<td>38. I feel like I cannot move after lying down, before going to sleep, when waking up or going to sleep</td>
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<td>39. I feel sudden weakness in my knees, neck, jaw or arms when angry, sad, laughing or emotional:</td>
<td>Daily □</td>
<td>Weekly □</td>
<td>Rarely □</td>
<td>Never □</td>
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<tr>
<td>40. I have episodes of doing strange things without realizing it at the time or lose a period of time:</td>
<td>Daily □</td>
<td>Weekly □</td>
<td>Rarely □</td>
<td>Never □</td>
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<td>41. I take daytime naps: Yes □ No □</td>
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<td>If yes, how many naps per day: _______</td>
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<td>42. After a nap, I feel: Refreshed □ Fairly rested □ Somewhat tired □ Very drowsy □</td>
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<td>43. I sleepwalk</td>
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<td>44. I talk or scream in my sleep</td>
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<td>45. I am disturbed by nightmares</td>
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<td>46. Do you or your bed partner believe that you move your arms, legs, or body too much during sleep, or have unusual behaviors during sleep?</td>
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</table>
47. Do you have vigorous or violent behaviors during sleep? 
   ______  ______  ______  ______

48. Have you ever hurt yourself or your bed partner during sleep? 
   ______  ______  ______  ______

49. Do you eat or drink without control and without full awareness during the night, after having been asleep? 
   ______  ______  ______  ______

50. I grind my teeth when asleep 
   ______  ______  ______  ______

51. Within the last year depression, anxiety or stress has interfered with my sleep 
   Yes ☐  No ☐

52. At bedtime I have difficulty falling asleep because of worries or thoughts racing through my mind: Yes ☐  No ☐

53. My sleep problem, in addition to those previously mentioned, has resulted in _____________
   ______________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

54. Is there any history in your family of difficulties with sleep or excessive daytime sleepiness or snoring? Yes ☐  No ☐
   If yes, explain: _____________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

55. Please list medicines tried for improving sleep or staying awake:
   DRUG & DOSE  FREQUENCY  STARTED  ENDED
   __________________________  __________  __________  __________
   __________________________  __________  __________  __________
   __________________________  __________  __________  __________
   __________________________  __________  __________  __________
   __________________________  __________  __________  __________
   __________________________  __________  __________  __________

56. What methods have you tried to help you sleep at night or stay awake during the day besides the drugs mentioned above? _____________________________
   _______________________________________________________________________
   _______________________________________________________________________
### ALLERGIES:
- Allergy: ___________________________ Reaction: ___________________________
- Allergy: ___________________________ Reaction: ___________________________
- Allergy: ___________________________ Reaction: ___________________________

### CURRENT MEDICATIONS:

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<tr>
<th>MEDICATION</th>
<th>DOSE/FREQUENCY</th>
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If more space is needed, use the back of this page and check here: ____

### LAST PNEUMONIA VACCINATION: _________________________________

### LAST INFLUENZA VACCINATION: ________________________________

### MEDICAL PROBLEMS

<table>
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<tr>
<th>(Check if you have had any of the following problems):</th>
<th>PAST OPERATIONS</th>
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<tbody>
<tr>
<td>Asthma</td>
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<td>Atrial fibrillation</td>
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<td>Blood clots</td>
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<td>Cancer</td>
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<td>Diabetes</td>
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<td>Emphysema</td>
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<td>Heart Attack</td>
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<td>Heart Failure</td>
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<td>Other:</td>
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|                                                      |                |

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6
Do you use oxygen?  Yes____ No____  If yes, how many liters of oxygen ________

If yes, do you use oxygen  □ All the time  □ With exercise  □ During sleep

Do you smoke cigarettes?  Yes____ Never____ Quit____
If quit, how long ago? __________

For how many years have you smoked cigarettes? ........... ________ years

How many cigarettes per day? .................................. ________ cigarettes

Do you use street drugs now?  Yes____ No____
Have you used street drugs in the past?  Yes____ No____

Do you drink alcohol?  Yes____ No____
How many drinks? __________ per day __________ per week

Do you drink caffeinated beverages?  Yes____ No____
How many caffeinated beverages do you drink per day? (Coffee, tea or soda)_____________

What is your occupation? ___________________________________________________________

Have you been exposed to chemical, toxins, or asbestos in the past?  Yes____ No____
What were the exposures? ___________________________________________________________

Do you exercise?  Yes____ No____
What kind of exercise and how often? _______________________________________________

What health problems have occurred in your family?
Mother: ___________________________________________________________ Deceased □
Father: ___________________________________________________________ Deceased □
Brother(s): ______________________________________________________ Deceased □
Sister(s): ________________________________________________________ Deceased □
Are you currently having any of the following health problems?

**GENERAL:**
- Poor appetite
  - [ ] Yes  [ ] No
- Recent weight loss
  - [ ] Yes  [ ] No
- Fevers, chills or sweats
  - [ ] Yes  [ ] No
- Weight gain
  - [ ] Yes  [ ] No

**CARDIOVASCULAR:**
- Chest pain
  - [ ] Yes  [ ] No
- Irregular or fast heart beat
  - [ ] Yes  [ ] No
- Swelling in the ankles
  - [ ] Yes  [ ] No
- Rheumatic fever
  - [ ] Yes  [ ] No
- Sleep with more than 1 pillow at night
  - [ ] Yes  [ ] No
- Wake up short of breath at night so that you sit up during the night
  - [ ] Yes  [ ] No
- Pain in your legs when walking
  - [ ] Yes  [ ] No
- Elevated cholesterol
  - [ ] Yes  [ ] No
- Have you had a stress test?
  - [ ] Yes  [ ] No

**EYES, EARS, NOSE, THROAT:**
- Blurred vision
  - [ ] Yes  [ ] No
- Double vision
  - [ ] Yes  [ ] No
- Hearing problems
  - [ ] Yes  [ ] No
- Sore throat
  - [ ] Yes  [ ] No
- Sinus disease
  - [ ] Yes  [ ] No

**RESPIRATORY:**
- Asthma
  - [ ] Yes  [ ] No
- Cough with phlegm production
  - [ ] Yes  [ ] No
- Cough with blood
  - [ ] Yes  [ ] No
- Wheezing
  - [ ] Yes  [ ] No
- Shortness of breath with exercise
  - [ ] Yes  [ ] No
- Shortness of breath at rest
  - [ ] Yes  [ ] No
- Dry cough
  - [ ] Yes  [ ] No
- Hay fever
  - [ ] Yes  [ ] No
- Exposure to TB
  - [ ] Yes  [ ] No

**GI:**
- Difficulty swallowing solids
  - [ ] Yes  [ ] No
- Difficulty swallowing liquids
  - [ ] Yes  [ ] No
- Heartburn
  - [ ] Yes  [ ] No
- Ulcers
  - [ ] Yes  [ ] No
- Diarrhea
  - [ ] Yes  [ ] No
- Nausea and vomiting
  - [ ] Yes  [ ] No
- Pain in abdomen
  - [ ] Yes  [ ] No
- Blood in stools
  - [ ] Yes  [ ] No
- Black stools
  - [ ] Yes  [ ] No
- Constipation
  - [ ] Yes  [ ] No
- Change in bowel habits
  - [ ] Yes  [ ] No
- Vomiting blood
  - [ ] Yes  [ ] No
ENDOCRINE:
Thyroid problems........................................Yes ___  No ___
Increased thirst.........................................Yes ___  No ___
Increased urination....................................Yes ___  No ___

NEUROLOGIC:
Headaches...............................................Yes ___  No ___
Seizures..................................................Yes ___  No ___
Weakness in arms or legs..............................Yes ___  No ___
Previous stroke (s)....................................Yes ___  No ___
Numbness or tingling................................Yes ___  No ___
Dizziness................................................Yes ___  No ___

GENITOURINARY:
Frequent urination....................................Yes ___  No ___
Burning with urination...............................Yes ___  No ___
Blood in urine........................................Yes ___  No ___
Difficulty starting to urinate......................Yes ___  No ___
Vaginal discharge......................................Yes ___  No ___
Last menstrual period was: ____________________

HEMATOLOGIC:
Anemia....................................................Yes ___  No ___
Easy bruising..........................................Yes ___  No ___
Nose bleeds.............................................Yes ___  No ___
Frequent infections..................................Yes ___  No ___
Enlarged lymph nodes/lumps.......................Yes ___  No ___

MUSCULOSKELETAL:
Joint pain or swelling................................Yes ___  No ___
Arthritis.................................................Yes ___  No ___
Muscle weakness.....................................Yes ___  No ___
Muscle pain.............................................Yes ___  No ___
Color changes in the fingers when it is cold........Yes ___  No ___
Curvature of the spine...............................Yes ___  No ___

SLEEP:
Snoring at night......................................Yes ___  No ___
Stop breathing during sleep......................Yes ___  No ___
Falling asleep during the day at inappropriate times....Yes ___  No ___
Falling asleep when driving a car or other vehicle....Yes ___  No ___
Restless legs..........................................Yes ___  No ___

SKIN:
Skin cancer.............................................Yes ___  No ___
Skin rash or lumps....................................Yes ___  No ___
BREAST:
Breast lumps.................................................................Yes ___  No ___
Mammograms..............................................................Yes ___  No ___
Nipple discharge.........................................................Yes ___  No ___

PSYCHIATRIC:
Anxiety.................................................................Yes ___  No ___
Depression...............................................................Yes ___  No ___
Problems with excessive use of alcohol or street drugs........ Yes ___  No ___

Please complete the next page (Epworth Sleepiness Scale)

Patient’s signature: ___________________________      Date: ______________

Physician’s signature: ___________________________      Date: ______________
EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual 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

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>CHANCE OF DOZING</th>
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<tbody>
<tr>
<td>1) Sitting and reading</td>
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<tr>
<td>2) Watching TV</td>
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<tr>
<td>3) Sitting inactive in a public place (i.e., a theater or a meeting)</td>
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<tr>
<td>4) As a passenger in a car for an hour without a break</td>
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<td>5) Lying down to rest in the afternoon when circumstances permit</td>
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<td>6) Sitting and talking to someone</td>
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<td>7) Sitting quietly after lunch without alcohol</td>
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<td>8) In a car, while stopping for a few minutes in traffic</td>
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____________________________________________________________________

NAME

DATE