

Sleep Questionnaire

| Name: | | Date: | | | | |
|--|--|-------------------|-----------|------|--|--|
| Date of Birth:// Ago | e: Gender: | Height: | _ Weight: | lbs. | | |
| Referring Physician: | Occupation | i | | | | |
| Please give a brief description of | | | | | | |
| Please describe any events that o | occur while falling asle | | | | | |
| List all current and past health p | roblems 🗆 None | | | | | |
| | | | | | | |
| List Current Medications (Include 1 | 3 | | | | | |
| Check if you use any of the follow | wina devices □ None | | | | | |
| Oxygen Flow rate L/min Wh CPAP or BiPAP (mask worn when sometimes of the policy of | hen do you use it? leeping) Type of CPAP/BiF Heated humidifica _YesNo | PAP unit tion? | _ | | | |
| List All Over-the-counter Medica | | | | | | |
| 1 2 | 3 4 | | | | | |
| | | | | | | |
| List any Allergies to Medications 1. | | | | | | |
| 2 | | | | | | |
| List All of Your Lifetime Surgerie | s and Major Injuries \Box | None | | | | |

| 2 | _ 4 | | |
|---|---|--|--|
| | | | |
| Social History | | | |
| Highest education level? ☐ High School ☐ Vocational | _ | | |
| Marital Status? □ Married □ Single □ Divorced □ | | | |
| Do you or did you ever smoke? \Box Yes \Box NoPacks | / day How Many Years? | | |
| Have you ever quit? ☐ Yes ☐ No | | | |
| If yes, for how long did you quit? How o | | | |
| If yes, when did you quit? How o | did you quit? | | |
| Do you use tobacco products other than cigarettes? | Yes □ No If yes, which ones? | | |
| Does anyone smoke in your household? \square Yes $\ \square$ No | oHave you ever used illegal substances?□ Yes □ No | | |
| Have you ever had trouble with alcohol, drug, or otl | her substance use? ☐ Yes ☐ No | | |
| Do you have an Advanced Medical Directive / Living | ן Will? □ Yes □ No | | |
| Family History (blood valated kin) | | | |
| Family History (blood related kin) | | | |
| □ Adopted or do not know family history | | | |
| If your mother or father is deceased, what caused h | his/her death? | | |
| If any of your siblings are deceased, what caused h | is/her death? | | |
| Diana list any slave discurdant or other significant | andical puchlams in value familie | | |
| Please list any sleep disorders or other significant m | ledical problems in your family. | | |
| | | | |
| REVIEW OF SYSTEMS CHECK HERE IF YOU H | IAVE EXPERIENCED NONE OF THE FOLLOWING | | |
| Do you CURRENTLY or FREQUENTLY suffer from | | | |
| CONSTITUTIONAL | EARS, NOSE, THROAT, MOUTH | | |
| □ Unusual fatigue | ☐ Ear pain / pressure | | |
| ☐ Weight gain. How much? lbs | ☐ Sinus problems, post nasal drip | | |
| Over what time frame? | Nasal congestion, runny nose | | |
| ALLERGIC | ☐ Hoarseness | | |
| □ Hay Fever | ☐ Frequent need to clear throat | | |
| □ Frequent sneezing | GLANDULAR (LYMPHATIC) | | |
| □ Watery eyes | □ Swollen lymph nodes anywhere | | |
| □ Seasonal allergies | Swoller lymph flodes anywhere | | |
| CARDIOVASCULAR | | | |
| ☐ High blood pressure | LUNGS (RESPIRATORY) | | |
| □ Abnormally low blood pressure□ Chest pain on exercise (angina) | ☐ Asthma, wheezing | | |
| ☐ Criest pair on exercise (angina) ☐ Irregular beat or palpitation of heart | ☐ Cough for more than 3 weeks | | |
| egular beat or palpitation of neart art murmur Ever had collapsed lung? | | | |
| Swelling or edema of ankles Ever had bullous lung disease? | | | |
| ☐ History of heart attack | ☐ Recurrent bronchitis | | |

☐ Shortness of breath

☐ History of enlarged heart / heart failure (CHF)

| STOMACH AND BOWELS | |
|---|--|
| □ Difficult or painful swallowing □ Acid Reflux ("Heartburn") □ Regurgitation □ Belching □ Hiatal hernia □ Stomach ulcer / Intestinal ulcer □ Nausea or vomiting | ENDOCRINE☐ Increased thirst, hunger☐ Sensitive to heat/cold☐ Change in skin, body hair☐ Diabetes |
| PSYCHIATRIC | NEUROLOGIC |
| □ Anxiety | Unusual dizziness, fainting, or loss of consciousness |
| □ Depression | ☐ Ever had a stroke? |
| □ Other mood disorder | □ Ever had a head trauma?□ Ever had a skull fracture? |
| General: | □ Seizures |
| Do you feel that you suffer from insomnia? | |
| Do you feel that you get too little sleep at night? | Yes;No |
| Sleep Hygiene: What time do you: -go to bed on weekdays? am pm -on weekends -wake up on weekdays? am pm -on weekends When you go to bed, how long does it usually take you to fall a On the average, how long are you awake in the morning before Do you take naps during the day? Yes; No If yes, at Do you routinely exercise each day? Yes; No - If yes On the average, how many ounces of alcoholic beverages do y On the average, how many ounces of caffeinated beverages do Do you usually have a drink containing caffeine or alcohol withi Yes; No Have you ever worked shift work ? Yes; No If ye | am pm asleep? minutes e you actually get out of bed ? minutes what time: How long ? minutes , at what time: ou consume:-per day? per week? b you consume:-per day? per week? in 2-3 hours of the time you go to bed? |
| How much difficulty do you have with: - waking up during the night? - getting back to sleep after waking up during the night? - waking up in the morning? - getting out of bed after waking up in the morning? - waking up with headaches? | mild moderate severe |
| On the average, how long are you awake during the night ? | minutes |
| Hypersomnolence (Excessive Sleepiness): Do you wake up feeling tired or wanting more sleep regardless Do you struggle to stay awake during the day?Yes; Do you fall asleep at meetings/lectures?Yes; | of how much sleep you get?Yes;No _No _No |



| Have you ever dozed off at a traffic light or to Have you ever had an accident operating an fatigue? Yes; No. If yes, please des | automobile | or other | machinery | | eepiness | or |
|---|------------------------------|----------------------------|---|--------------------|------------|--------|
| Besides actual traffic accidents have you ever - Unintended lane shifts?Ye - Unintended road departures?Ye - Unintended crossing lights at an inters Do you use caffeine or other stimulants to stiff you feel that you have excessive daytime sthat reflect severe sleepiness. | YesNo.esNo.ection? ay alert? | If YES, If YES, hYesYes; _ | how often now often? No. If N No | ? /ES, how ofte | en? | |
| Sleep Behavior: If you answer yes to the f Do your legs or arms bother you when restin | | | | | ce provide | d. |
| Do you have any unusual movements (leg je | rks, head m | novements | s, etc.) duri | ng sleep? | Yes; | No. |
| Do you have any unusual sleep behavior (sle | ep walking, | sleep tal | king, etc.)? | Yes; | _No. | |
| Do you experience dreams?Yes; Have you noticed a change in your dreams? Do you experience nightmares?Yes; | (i.e. increas | | | | No | |
| Breathing Disorders: Do you experience any breathing problems d | uring sleep | ?Yes | ;No. | If yes, please | describe: | |
| Do you or have you been told that: -you snore? -have pauses in breathing during sleep? -difficulty breathing in a flat position? -waking up short of breath? -waking up choking or gasping for air? | Yes | No | | | | |
| Narcolepsy: Have you ever been diagnosed as having nar Has anyone in your family been diagnosed w | | osv? | Yes; _ Yes; | No No | | |

| How much difficulty do you have with: | mild | madarata | 201070 |
|--|--------------------|----------|----------------------|
| - feeling sleepy, fatigued, or weak after an emotional experience? - not being able to move when first waking up? - hallucinations when falling asleep or waking up? - sleep attacks (falling asleep despite not wanting to)? | | moderate | Severe |
| Epworth Sleepiness Scale How likely are you to doze off or fall asleep in the following situations, in refers to your usual way of life in recent times. Even if you have not done to work out how they would have affected you. Please use the following state of the following s | e some o scale: | f these | things recently, try |
| 0 = would <u>never</u> doze 1 = <u>slight</u> chance of dozing 2 = <u>moderate</u> chance of dozing Situation | ozing Chance | _ | _ |
| Sitting and reading | | | |
| Watching TV | | | |
| Sitting, inactive in a public place (e.g. theater or a meeting) | | | |
| As a passenger in a car for an hour without a break | | | |
| Lying down to rest in the afternoon when circumstances permit | | | |
| Sitting and talking to someone | | | |
| Sitting quietly after a lunch without alcohol | | | |
| In a car, while stopped for a few minutes in the traffic | | | |
| TOTAL | | | |
| Thank you for your cooperation. | | | |
| FOR PHYSICIAN (only) "I have personally reviewed and confirmed the above information | on." | | |
| Signature Date | | | |