



PATIENT SLEEP QUESTIONNAIRE

Today's Date: _____

SECTION I: PATIENT INFORMATION

Patient Name: _____ DOB: _____ Height (inches): _____
Age: _____ Gender: _____ Neck Circumference (inches): _____ Weight (pounds): _____
Referring Physician: _____ Marital Status: Single Married Divorced Widowed

SECTION II: MAJOR SLEEP-RELATED COMPLAINT

- Excessive sleepiness Awaken with headaches Waking too early Snoring
 - Choking sensation during sleep Difficulty falling asleep Stop breathing during sleep Sleep walking
 - Frequent sleep disruptions Difficulty staying asleep Other (please explain): _____
1. How long have you had your symptom(s)? _____ Years _____ Months
2. How did your symptom(s) begin? Suddenly Gradually Other: _____

SECTION IIIa: DAYTIME SYMPTOMS

- 3 Please answer the following questions with the understanding that **FATIGUE** means feeling "worn out" and **SLEEPINESS** means "a need to sleep" or actually dozing off unintentionally.
- 3a.** What word best describes your level of daytime **FATIGUE** in the last month?
 None Mild Moderate Severe Very severe
- 3b.** What word best describes your level of daytime **SLEEPINESS** in the last month?
 None Mild Moderate Severe Very severe
4. How long has daytime sleepiness been a problem for you?
(Check NA if you have no sleepiness.) _____ **years** NA
5. Do you feel rested when you wake up from your usual sleep period? Never Sometimes Most times
6. Do you take naps during the day? Never Sometimes Most times
7. Do you feel refreshed after brief (less than 1 hour) naps? Never Sometimes Most times
8. Do you sleep longer on weekends or holidays than on weekdays? Never Sometimes Most times
9. Do you use medicine to help you stay awake? Never Sometimes Most times
10. During the past month, how much has sleepiness interfered with your normal work performance? Never Rarely Sometimes Frequently Always
11. During the past month, how much has sleepiness interfered with normal social activities with family, friends and other groups? Never Rarely Sometimes Frequently Always
12. Have you had recent accidents or near accidents because of sleepiness? (i.e., car, work, home) Yes No
13. Have you had sudden physical weakness of arms, legs or face when angry, laughing, crying or during other heightened emotional situations? Yes No

- 14. When you fall asleep or just before you awaken do you have bizarre dreams? Yes No
- 15. When you fall asleep or just before you awaken do feel as if you are paralyzed? Yes No
- 16. Have you ever been told that you have Narcolepsy? If yes, when and by whom? Yes No

SECTION IIIb EPWORTH SLEEPINESS SCALE

Please read the questions below and rate the chances that you would doze off or fall asleep (in contrast to just feeling tired) during different routine situations. These situations should refer to your usual way of life in recent times. Please use the scale described below (0 through 3) to rate each question.

0 = Would never doze or sleep 1 = Slight likelihood of dozing or sleeping	2 = Moderate likelihood of dozing or sleeping 3 = High likelihood of dozing or sleeping
Situation	Rating
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting down and talking to someone	
Sitting quietly after a lunch	
In a car, while stopped for a few minutes in traffic	
17. Total Score	

SECTION IV: SLEEP HABITS

- 18. Workday usual bedtime: _____ a.m. p.m.
- 19. Workday usual wake time: _____ a.m. p.m.
- 20. Non-workday usual bedtime: _____ a.m. p.m.
- 21. Non-workday usual wake time: _____ a.m. p.m.
- 22. How many hours of sleep do you feel that you achieve on average during this period? _____ Hours
- 23. How many hours of sleep do you feel you need to feel alert during your waking period? _____ Hours
- 24. How long does it usually take you to fall asleep? _____ Hours _____ Minutes
- 25. How often are you likely to awaken during the night? Rarely 3 times or less Frequently
- 26. Do you currently have a bed partner or sleep observer? (If yes, ask them to complete Section IX.) Yes No
- 27. Have you been told that you snore loudly? (If Yes, how many years has snoring been noted?) Yes No
_____ Years
- 28. Have you been told that you stop breathing during sleep? (If Yes, for how many years?) Yes No
_____ Years
- 29. Have you been told that your arms and legs jerk during sleep? Yes No
- 30. Do you often awaken at night with a sensation in your lower legs that goes away when you walk around? Yes No
- 31. If yes, to #30 above, do the sensations in your lower leg become worse when you get into bed, making it difficult to fall asleep? Yes No

SECTION V: RELATED MEDICAL INFORMATION

32. Do you or have you ever suffered from any of the following? (Check all that apply.)

- | | | |
|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Angina / Heart attack | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chronic nasal / sinus problems | <input type="checkbox"/> Heart failure (CHF) | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chronic lung disease (COPD, Emphysema) | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Treatment for depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Pacemaker / Defibrillator | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Other (please explain): _____ | | |

33. List any major medical problems or illnesses you have had in the past that are not listed.

SECTION VI: MEDICATIONS

34. List all **MEDICATIONS** that you are currently taking. Be sure to list prescription and non-prescription medications, including sleep agents.

<i>Medication Name</i>	<i>Dosage Per Day</i>	<i>For How Long</i>	<i>Purpose</i>
_____	_____	____ Yrs ____ Mos	_____
_____	_____	____ Yrs ____ Mos	_____
_____	_____	____ Yrs ____ Mos	_____
_____	_____	____ Yrs ____ Mos	_____
_____	_____	____ Yrs ____ Mos	_____
_____	_____	____ Yrs ____ Mos	_____
_____	_____	____ Yrs ____ Mos	_____
_____	_____	____ Yrs ____ Mos	_____

35. List all **MEDICATION ALLERGIES** you may have.

36. Do you have any allergies or sensitivities to any tape or bandage?

- Yes No

37. Do you have any allergies or sensitivities to latex?

- Yes No

SECTION VII: PREVIOUS SLEEP APNEA DIAGNOSIS & TREATMENT

38. Have you ever been diagnosed with sleep apnea? If Yes, when? _____

- Yes No

If Yes to above, are you currently being treated with CPAP / BiPAP® therapy?

- Yes No

Do you feel any difference when using CPAP / BiPAP® during sleep?

- Yes No

If currently using positive airway pressure therapy, please indicate the prescribed pressure. _____ cm of water

39. Have you had any surgical treatment(s) for sleep apnea?

- Yes No

40. Have your tonsils been removed? If yes, when? _____

- Yes No

41. Do you use a dental appliance for sleep apnea or teeth grinding?

- Yes No

SECTION VIII: SOCIAL HABITS & FAMILY HISTORY

- 42. Do you drink alcoholic beverages? If yes, please indicate type, quantity and frequency below. Yes No
 If Yes, What type? _____ Number of glasses/cans/bottles? _____ per day week month
- 43. Do you drink caffeinated beverages? If yes, please indicate type, quantity and frequency below. Yes No
 If Yes, What Type? _____ How many glasses/cans/cups? _____ per day week month
- 44. Have you gained any weight over the last year?. Yes No
 If Yes, how much? _____ pounds
- 45. Do other family members have similar sleep problems? Yes No
- 46. What is your occupation? _____
- 47. What are your usual working hours? _____
- 48. Please use the following space to elaborate on other related information about your medical or sleep complaints.

SECTION IX: OBSERVATIONS OF OTHERS

- 49. If you have had opportunities to observe this patient's sleep please check any behaviors that apply and how long they have occurred.
- Snore or Snort ___ Years ___ Months Stop breathing/Gasp for air ___ Years ___ Months
- Leg/arm/body jerks ___ Years ___ Months Violent Behavior/Acting Out Dreams ___ Years ___ Months
- Grind teeth ___ Years ___ Months Screaming/walking in sleep ___ Years ___ Months

50. Use the space provided for additional comments. _____
