

SLEEP MEDICINE QUESTIONNAIRE

Please fill out all 4 pages of this form as completely as possible. Thank you.

Name _____ Date _____ Age _____ Gender _____ What is your occupation? _____

Highest level of education _____ Marital status _____ Number of children (with ages) _____

In your own words, please list your main sleep problems and estimate how long you had each problem.

1. _____

2. _____

Previous sleep diagnosis (please list all) _____ Year(s) diagnosed _____

Name and address of diagnosing doctor _____

Have you had a sleep study before? Yes _____ No _____ Year(s) _____

Name and address of center where study was done _____

Please check any/all treatments you currently use for your sleep problems.

CPAP _____ **BiPAP** _____ Setting _____ When did you first start using CPAP/BiPAP? _____

Name and address of CPAP/BiPAP supplier _____

How many nights a week do you use CPAP/BiPAP? _____ How many hours each night? _____

Problems with CPAP/BiPAP _____ Is CPAP/BiPAP effective? _____

Oral appliance _____ When did you first start using an oral appliance? _____

Name and address of person who made your oral appliance _____

How many nights a week do you use your oral appliance? _____ How many hours each night? _____

Problems with oral appliance _____ Is the oral appliance effective? _____

Oxygen _____ Setting _____ When did you first start using oxygen? _____

Name and address of prescribing doctor _____

Name and address of oxygen supplier _____

How many nights a week do you use oxygen? _____ How many hours each night? _____

Problems with oxygen _____ Is oxygen effective? _____

Surgery for sleep apnea _____ Year(s) of surgery _____

Name and address of surgeon(s) _____

Problems with surgery _____ Is surgery effective? _____

Medications for sleep problems (name and dose): _____

Date(s) medications started _____ how many times a week used _____

Name and address of prescribing doctor(s) _____

Problems with medications _____ Are medications effective? _____

What medications have you tried in the past for sleep problems? _____

Why did you stop taking these medications? _____

Please answer the following questions about your sleep habits.

Workdays (example Monday-Friday) _____ Work hours _____

Workdays: Bed time _____ How long to fall asleep _____ Final wake time _____

Number of times awake in the night _____ Reason for awakening _____ Average time awake each time _____

Naps per day (include times dozing off) _____ Average length of naps _____

Non-workdays: Bed time _____ How long to fall asleep _____ Final wake time _____

Number of times awake in the night _____ Reason for awakening _____ Average time awake each time _____

Naps per day (include times dozing off) _____ Average length of naps _____

Ideal bedtime _____ Ideal wake time _____

How long have you had this sleep schedule? _____

Do you have a bed partner? Yes ___ No ___ Is the head of your bed elevated? Yes ___ No ___ If so, how much? _____

Do you sleep out of your bed? Yes ___ No ___ If so, where? _____ How many times a week? _____

Have any of your blood relatives (parents, children, siblings, cousins, grandparents, uncles/aunts) had any of the following conditions?

Obstructive sleep apnea _____ Insomnia _____ Parkinson's disease _____

Loud snoring _____ Restless legs _____ Depression _____

Excessive sleepiness _____ Heart disease _____ Anxiety _____

Narcolepsy _____ Epilepsy or seizures _____ Attention deficit/hyperactivity _____

Other (please list) _____

Current medical problems (diabetes, high blood pressure, heart disease, COPD, depression, etc)

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

Are you pregnant? Yes ___ No ___ N/A _____

Past medical problems and year of occurrence (surgeries, accidents, head injury, depression, etc)

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

Current medications, vitamins and supplements (please list doses)

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

Name _____ Date _____ Page 2/4

Medication and food allergies

1 _____
 3 _____
 5 _____

2 _____
 4 _____
 6 _____

Personal habits/information

Do you smoke or use chew tobacco? Yes ___ No ___ If so, how much PER DAY? _____ How long have you used tobacco? _____

Do you drink alcohol? Yes ___ No ___ If so, how many drinks PER WEEK? _____ Have you had treatment for alcohol dependence? Yes ___ No ___ Year _____

Do you drink caffeinated beverages (soda, coffee, tea, energy drinks)? Yes ___ No ___ If so, how much PER DAY? _____

Do you use recreational drugs (marijuana, etc) Yes ___ No ___ If so, what do you use and how much? _____

Have you had treatment for drug dependence? Yes ___ No ___ Year _____

Weight (pounds) _____ Height (feet/inches) _____ Neck/collar size (inches) _____

Weight loss or gain in the past year (pounds) _____ Weight loss or gain the in past 5 years (pounds) _____

Please estimate the likelihood of nodding off or falling asleep in the following scenarios using a 0 – 3 scale.

0	1	2	3
Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing

Situation	Chance of dozing
Sitting and reading	
Sitting, inactive, in a public place (theater, meeting, etc)	
Passenger in a car for an hour without a break	
Lying down in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch (assume no alcohol with lunch)	
In a car, while stopped for a few minutes in traffic	
Watching TV	

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Please indicate how often you have experienced the following symptoms recently using the scale below. Please ask your bed partner to help.

0	1	2	3	4
Never	Rarely (less than once a month)	Occasionally (1-3 times a month)	Frequently (1-3 times a week)	Daily or almost daily

- | | |
|---|---|
| <p>1.</p> <p>Snoring 0 1 2 3 4</p> <p>Breathing stops while asleep 0 1 2 3 4</p> <p>Breathing alternates between shallow and deep while asleep 0 1 2 3 4</p> <p>Awakened by gasping or choking 0 1 2 3 4</p> <p>Night sweats 0 1 2 3 4</p> <p>Wake up with heartburn without medication 0 1 2 3 4</p> <p>Wake up with a dry mouth 0 1 2 3 4</p> <p>Urinating more than once per night 0 1 2 3 4</p> <p>Headaches in the morning when you wake up 0 1 2 3 4</p> | <p>2.</p> <p>Restless/uncomfortable feelings in legs or arms 0 1 2 3 4</p> <p>Urge to move arms or legs while staying still 0 1 2 3 4</p> <p>Urge to move interferes with getting to sleep 0 1 2 3 4</p> <p>Twitching or jerking of limbs while asleep 0 1 2 3 4</p> <p>3.</p> <p>Sudden temporary muscle weakness brought on by emotion 0 1 2 3 4</p> <p>Unable to move body while waking up or falling asleep 0 1 2 3 4</p> <p>Hallucinations or dreamlike images falling asleep or awakening 0 1 2 3 4</p> <p>Fall asleep while holding a conversation or engaged in an activity 0 1 2 3 4</p> |
|---|---|

- 4.**
- Waking up to eat or drink at night, more than just a sip of water 0 1 2 3 4
 - Walking around in sleep without remembering 0 1 2 3 4
 - Acting out dreams while asleep 0 1 2 3 4
 - Making angry or frightened sounds while sleeping 0 1 2 3 4
 - Making angry or frightened movements while sleeping 0 1 2 3 4
 - Talking, yelling or groaning while asleep 0 1 2 3 4

- 5.**
- Not feeling rested in the morning when you wake up 0 1 2 3 4
 - Sleepiness interferes with work or school 0 1 2 3 4
 - Sleepiness makes it difficult to drive 0 1 2 3 4
 - Sleepiness interferes at home or social life 0 1 2 3 4
 - Fall asleep watching TV 0 1 2 3 4
 - Fall asleep on couch or recliner 0 1 2 3 4

- 6.**
- Difficulty learning new things 0 1 2 3 4
 - Difficulty getting organized 0 1 2 3 4
 - Overwhelmed by complicated tasks 0 1 2 3 4
 - Difficulty staying focused at work or school 0 1 2 3 4

- 7.**
- Feeling down or blue much of the day 0 1 2 3 4
 - Decreased interest in social activities 0 1 2 3 4
 - Feelings of guilt or remorse 0 1 2 3 4
 - Changes in appetite 0 1 2 3 4
 - Irritable much of the day 0 1 2 3 4
 - Easily upset 0 1 2 3 4
 - Impatient with others 0 1 2 3 4
 - Loss of temper/anger outbursts 0 1 2 3 4

- 8.**
- Anxious, nervous or edgy much of the day 0 1 2 3 4
 - Easily startled 0 1 2 3 4
 - Fear of being in tight/enclosed spaces 0 1 2 3 4
 - Nightmares or disturbing dreams 0 1 2 3 4
 - Recurrent obsessive thoughts 0 1 2 3 4
 - Panic attacks in the middle of the night 0 1 2 3 4

- 9.**
- Thoughts won't quiet down at bedtime 0 1 2 3 4
 - Takes longer than an hour to get to sleep without medication 0 1 2 3 4
 - Wake three or more times per night 0 1 2 3 4
 - Can't get back to sleep if awakened 0 1 2 3 4
 - Frustrated because of inability to sleep 0 1 2 3 4

- 10. Men only**
- Problem obtaining or maintaining erections 0 1 2 3 4
 - Awakening with painful erections 0 1 2 3 4

- 11. Women only**
- Awakened by painful menstrual cramps 0 1 2 3 4
 - Sleep problems related to menstrual cycle 0 1 2 3 4
 - Sleep problems related to menopause 0 1 2 3 4

- 12.**
- Stuffy or runny nose 0 1 2 3 4
 - Sinus fullness or pain 0 1 2 3 4
 - Tooth grinding or clenching 0 1 2 3 4
 - TMJ/jaw joint pain 0 1 2 3 4
 - Sore throat/hoarseness 0 1 2 3 4

- 13.**
- Wheezing 0 1 2 3 4
 - Coughing 0 1 2 3 4
 - Shortness of breath 0 1 2 3 4
 - Rapid or irregular heartbeat 0 1 2 3 4
 - Swelling of limb (edema) 0 1 2 3 4
 - Chest pain or heaviness 0 1 2 3 4

- 14.**
- Abdominal pain or cramping 0 1 2 3 4
 - Diarrhea 0 1 2 3 4
 - Bloating or Belching 0 1 2 3 4

- 15.**
- Achy joints 0 1 2 3 4
 - Achy or tender muscles 0 1 2 3 4
 - Awakened by pain 0 1 2 3 4
 - Pain interferes with going to sleep 0 1 2 3 4