Critical Care, Pulmonary & Sleep Associates, LLP
Sleep Questionnaire

Today's Date:_____________

Please complete this questionnaire as accurately as possible. It will us identify and treat your sleep concerns.

Name:____ Date of Birth:________________
Occupation:_____________________Approximate altitude at which you live:______________
Primary care physician:____
Referring physician:____
Physician who ordered sleep study:____
Ear/nose/throat physician:

PHARMACY____

OXYGEN/CPAP/DME COMPANY____

OPTIONAL
This information is used for research on the occurrence of disease in different racial and ethnic groups
Race (circle one) Asian, American Indian or Alaskan native, Black or African American, More than one race, Native Hawaiian, Other Pacific Islander, White/Caucasian, Prefer not to answer
Ethnicity (circle one) Hispanic/Latino or not Hispanic/Latino, Prefer not to answer
Preferred Language________________________________

SLEEP HISTORY
My main sleep complaint (if more than one, list all) Please give duration of the problem.
____
____

Have you been diagnosed with any problem(s) listed below? (Check all that apply)	Yes	No
Obstructive sleep apnea		
Narcolepsy		
Restless leg syndrome		
Insomnia		

SLEEP SCHEDULE	On a workday	On an off day
Usual bedtime:	__________am/pm	__________am/pm
Usual rise time:	__________am/pm	__________am/pm
Total time in bed:	__________hours	__________hours
Average sleep time:	__________hours	__________hours
Average delay in falling asleep:	__________min/hrs	__________min/hrs

Average number of awakenings:	___________per night	___________per night
Time needed to fall back asleep:	___________min/hrs	___________min/hrs

DAYTIME FUNCTION	Yes	No
Are you fatigued?		
Is sleep refreshing to you?		
Are you a restless sleeper?		
Have you fallen asleep driving?		
Have you come close?		
Do you fall asleep at work?		
Do you take any naps?		
How many times per week?	___________	
How long are your usual naps?	___________	
Are they refreshing?		
Do your sleep problems affect you day-to-day life?		
If yes, how? ______________________________ ______________________________		

SLEEP HYGIENE		
Do you do any of the following in bed? (check all that apply)		
Eat:		
Smoke:		
Read:		
Watch TV:		
Do you do any of the following? (check all the apply)		
Eat a big meal immediately before sleep?		
Do vigorous exercise immediately before sleep?		
Take a hot bath of shower immediately before sleep?		
Do you keep the same bedtime each night?	Yes	No
If you can't sleep, do you watch the clock to keep track of time?	Yes	No
Does your sleeping environment promote sleep (quiet, dark)?	Yes	No
Do you feel stressed when going to sleep?	Yes	No

In what position do you sleep? (check all that apply)	Back____	Side____	Stomach____	Sitting up____

If and when you travel, is your sleep better or worse?	Better	Worse
Explain:		

SLEEP PROBLEMS

Please consult your bed partner *as needed* *for help in answering the following questions. Answer as if you are describing a typical night.*

Check the appropriate frequency with which it occurs.	Nightly	Weekly	Rarely	Never
Do you snore?				
Can your snoring be heard in another room?				
Do you stop breathing while you sleep?				
Do you wake up gasping?				
Do you have a sore throat when you wake up?				
Do you have a headache when you wake up?				
When you are awake and either seated or lying down, do you have a creepy, crawly sensation in your legs?				
Do these sensations interfere with falling asleep?				
Do your legs twitch or kick while you are sleeping?				
Do you talk in your sleep?				
Do you eat in your sleep?				
Do you walk in your sleep?				
Do you grind your teeth at night?				
Do you wake up confused at night?				
Do you act out your dreams? If yes, have you hurt yourself or someone else? Yes____ No____				
Do you think you have insomnia?				
Do you have a hard time falling asleep?				
Do you have a hard time staying asleep?				
Does strong emotion cause any part of your body to become weak of limp (temporarily paralyzed)?				
Do you have hallucinations when you fall asleep?				
Do you ever feel a sensation of paralysis when your mind is awake but your body remains asleep?				
Do you have sudden irresistible urges to sleep?				

HABITS

How many caffeine units do you drink per day? (cup of coffee, tea, soda= 1 unit		
Do you consume caffeine in the afternoon?	Yes	No
How many alcoholic units do you drink per week? (1 drink = 1 unit)		

FAMILY HISTORY

Does anyone in your family have any of the following? (check all that apply)		
Narcolepsy	Restless legs	Sleep apnea

MEDICATIONS

NAME AND DOSE	NAME AND DOSE
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

Drug allergy: ____________________________		Drug allergy: ____________________________	
Drug allergy: ____________________________		Drug allergy: ____________________________	
Drug allergy: ____________________________		Drug allergy: ____________________________	
Are you allergic to tape?	Yes____	No____	If yes, what type? _______________
Reaction: ____			

PAST HISTORY

Have you had any ear/nose/throat procedures? (check all that apply and list date occurred)			
Removal of tonsils/adenoids ___________	When? ______________________		
Deviated nasal septum repair __________	When? ______________________		
Uvulo palatal pharyngoplasty (UPPP) ___	When? ______________________		
Laser uvuloplasty (LAUP) ______________	When? ______________________		
Any other surgeries for sleep apnea?		Yes ____	No _____
If yes, describe: ____			
When?			
Have you ever had or been treated for any of the following? (check all that apply)			
Hypertension _____	Stroke (CVA) _____		
Coronary artery disease (heart attack or MI)_	Seizures/epilepsy _____		
Congestive heart failure (CHF) _____	Peripheral neuropathy _____		
Peripheral vascular disease (aorta of leg blood vessels) _____	Diabetes _____		
Atrial fibrillation _____	Fibromyalgia _____		
Other irregular heart rhythms: _____________	Describe: __________________________________		
Chronic pain: ____________	If yes, where? _____________________________		
Thyroid gland disease: _____	Overactive: _______	Underactive: _____	
Depression _____	Bipolar Disorder _____		
Anxiety _____	Memory Loss _____		
Pulmonary hypertension _______	Dementia _____		
COPD _____	Asthma _____		
Parkinson's Disease _____	Restless leg syndrome _____		
Using extra oxygen?	Resting: ____L/min	Exercise: ____L/min	Sleep: ____L/min

REVIEW OF SYSTEMS (check all that apply in both columns)

Nose bleeds	Heartburn or acid reflux _____
Sinus problems _____	Nighttime urination:___How many times per night? _____
Seasonal allergies _____	Impotence _____
Menopause (women only) _____	Arthritis _____
Testsosterone medication (men only) _____	Tempo-mandibular joint problems (TMJ) ____

Please use this space to describe or list any other problems or concerns you think may be relevant to the interpretation of your sleep study:

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____

____

____

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EPWORTH SLEEPINESS SCALE

Patient Name: ____

Age: Weight: Height: BMI: Neck circumference:

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? Even if you have not done some of these things recently, try to work out how they would affect 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

Situation	**Chance of Dozing**
Sitting and Reading	_______________
Watching Television	_______________
Sitting Inactively in a public place for an hour without a break	_______________
As a passenger in a car for an hour without a break	_______________
Lying down to rest in the afternoon	_______________
Sitting and talking to someone	_______________
Sitting quietly after lunch without alcohol	_______________
In a car, while stopping for a few minutes in traffic	_______________