Respiratory & Sleep Disorders Specialists

SLEEP QUESTIONNAIRE

Patient Name:_____ Date of Birth _____/_____/_____

Marital Status: _____Married _____Single _____Widow _____Divorced

Bed Partner: _____Yes _____No Height:_____ Weight:_____

1. Main sleep complaints, check all that apply:

- Loud or disturbing snoring
- I've been told I stop breathing when I sleep
- I am tired and sleepy during the day
- I wake up gasping for air
- I fall asleep unintentionally
- I can't fall asleep or stay asleep
- My limbs jerk or kick at night
- I have unwanted behavior during sleep.
  Explain:_____
- Other:_____

2. How long have you had a sleep problem?_____

3. Have you ever had a sleep study? If so, when?_____

4. Are you currently on CPAP of BIPAP therapy? If yes, what is the current pressure and mask type?

_____

5. Have you gained or lost weight recently? How much?_____

6. What time do you usually:

	Weekday	Weekend
Go to bed?	_____	_____
Wake up?	_____	_____

7. Do you take naps during the day? _____Yes _____No If yes, how many? _____

How long do you nap?_____

8. Do you work rotating shifts? **_____Yes _____No**

9. Do you have trouble falling asleep? **_____Yes _____No**

10. Do you have trouble staying asleep? **_____Yes _____No**

11. Do you have trouble falling back to sleep once awakened? **_____Yes _____No**

12. Do you lie in bed with racing/repetitive thoughts? **_____Yes _____No**

13. Do you take medications to help you fall asleep? _____Yes _____No
14. Do you take stimulants during the day to help you stay awake? _____Yes _____No
15. Do you suffer from pain that interferes with your sleep? _____Yes _____No

16. Have you ever been told that you snore? _____Yes _____No
17. Have you ever been told that you stop breathing in your sleep? _____Yes _____No
18. Do you wake yourself from snoring, or from choking/gasping for air? _____Yes _____No
19. Do you suffer from indigestion/heartburn/reflux disease? _____Yes _____No
20. Do you ever awaken suddenly feeling short of breath? _____Yes _____No
21. Do you wake up with a dry mouth or sore throat? _____Yes _____No
22. Do you suffer from morning headaches? _____Yes _____No
23. Do you sweat at night? _____Yes _____No
24. Do you feel refreshed and well rested upon wakening? _____Yes _____No

25. Do you experience leg discomfort such as a creepy-crawly or achy sensation that compels you to move your legs or get up and walk? _____Yes _____No
26. Do your arms or legs jerk/kick in your sleep? _____Yes _____No
27. Do you grind your teeth while you sleep? _____Yes _____No
28. Do you have frequent nightmares? _____Yes _____No
29. Have you ever walked or talked in your sleep? _____Yes _____No
30. Have you ever injured yourself or a bed-partner acting out your dreams while sleep? _____Yes _____No

31. Do you experience vivid-like dreams soon after falling asleep or close to waking up? _____Yes _____No
32. Have you ever found yourself unable to move or paralyzed for a short time upon falling asleep or awakening? _____Yes _____No
33. Have you ever experienced sudden muscle weakness during vigorous laughter when angry? _____Yes _____No
34. Have you ever experience sleep attacks, or sudden onset of severe drowsiness? _____Yes _____No

35. Do you smoke? If yes, how much? _____
36. How many alcoholic beverages do you consume in a week on average? _____
37. How many caffeinated beverages do you consume in a day on average? _____
38. Do you suffer from allergies? _____Yes _____No
39. Do you suffer from chronic nasal congestion? _____Yes _____No
40. Have you ever had nasal or sinus surgery? If yes, when? _____

Epworth Sleepiness Scale:

41. How likely are you to fall asleep in the following situations?

	(0)	(1)	(2)	(3)
-Sitting and reading:	_____Never	_____Slight	_____Moderate	_____High
-Watching television:	_____Never	_____Slight	_____Moderate	_____High
-Sitting inactive in a public place:	_____Never	_____Slight	_____Moderate	_____High
-As a passenger in a car for 1 hour or more:	_____Never	_____Slight	_____Moderate	_____High
-Lying down to rest in the afternoon:	_____Never	_____Slight	_____Moderate	_____High
-Sitting and talking to someone:	_____Never	_____Slight	_____Moderate	_____High
-Sitting quietly after lunch:	_____Never	_____Slight	_____Moderate	_____High
-In a car stopped at a traffic light:	_____Never	_____Slight	_____Moderate	_____High

42. Do you have or are you currently being treated for:

_____High blood pressure	_____Asthma	_____Angina	_____Emphysema/COPD
_____Thyroid disease	_____Heart attack	_____Stroke	_____Seizures
_____Congestive heart failure	_____Frequent urination	_____Diabetes	_____Depression
_____Anxiety	_____Drug/alcohol problems	_____Chronic pain	
_____Bipolar disorder	_____Acid reflux/heartburn	_____Chronic nasal congestion	
_____Irregular heart rhythm			

43. Please list any other medical problems:

_____
_____
_____
_____
_____
_____
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_____
_____
_____

Sign:_____ **Date:**_____