

**PULMONARY & CRITICAL CARE
MEDICINE CONSULTANTS, PC**

SLEEP QUESTIONNAIRE

Your answers to the following questions will help us to obtain a better understanding of your sleep problems. Please answer every question to the best of your ability. It is helpful to discuss the answers with someone who has witnessed your problems, such as a spouse or bed partner.

BACKGROUND INFORMATION

Date: _____

Name: _____ DOB: _____

Occupation: _____ Referral Source: _____

Physician: _____ Phone: _____

Your Height: _____ Weight: _____

Has Your Weight Changed: Yes No

If yes: How much? _____ How long: _____

Please describe your sleep or sleep problem: _____

When did your sleep problem begin? _____

Have you seen any other doctors for your sleep problem? Yes No

If yes, who?

Have you ever had a sleep study? Yes No

If yes, where? _____

Have you ever been treated for snoring, sleep apnea, sleeplessness or insomnia?

SLEEP SYMPTOMS

1. Do you snore?..... Yes/No
2. Does your snoring or kicking prevent someone from sleeping in the same bed with you?..... Yes/No
3. Do you wake up gasping or feeling like you cannot breathe?..... Yes/No
4. Has your bed partner ever told you that you stop breathing during sleep?..... Yes/No
5. Do you awaken with a headache?..... Yes/No
6. Do you have a restless or creepy feeling in your legs that is decreased by moving your legs or walking or prevents you from sleeping?..... Yes/No
7. Has your bed partner ever noticed leg movements while you were sleeping?..... Yes/No
8. Does your bed partner complain that you kick them during the night?.. Yes/No
9. Do you toss and turn?..... Yes/No
10. Do you awaken feeling refreshed?..... Yes/No
11. Do you have a problem with sleepiness while driving?..... Yes/No
12. Have you ever had an automobile accident related to sleepiness?..... Yes/No
13. Does sleepiness interfere with work or school?..... Yes/No
14. Have you ever had accidents at work related to sleepiness?..... Yes/No
15. Do you ever find yourself somewhere and do not know how you got there?..... Yes/No
16. Do you have vivid dreams shortly after falling asleep at night?..... Yes/No
17. Do you ever feel that you cannot move after lying down or just after you awaken?..... Yes/No
18. Do you ever feel sudden weakness in your limbs when laughing emotionally?..... Yes/No
19. When you are awaken, are you short of breath or wheezing?..... Yes/No

20. Do you grind your teeth at night?.....Yes/No
21. Do you have trouble going to sleep?.....Yes/No
22. Do you have frequent arousals during the night?.....Yes/No
23. Do you awaken during the night and have trouble going back to sleep?.....Yes/No
24. Do you awaken early in the morning and cannot go back to sleep?.....Yes/No
25. Do you awaken at night with thoughts racing through your mind?.....Yes/No
26. Do you get up more than once a night to urinate?.....Yes/No
27. Do you have difficulty falling asleep or awaken frequently through the night because of pain?.....Yes/No
28. Do you watch T.V., read, eat, etc. in bed?.....Yes/No
29. Do you fall asleep more easily on the couch than in bed?.....Yes/No
30. Are you easily awakened by noise or light?.....Yes/No
31. Do you feel frustrated or tense when seeing your bed or bedroom?.....Yes/No
32. Have you felt depressed recently?.....Yes/No
33. Have you been having any marital conflict lately?.....Yes/No
34. Do you have job stress?.....Yes/No
35. Do you find it difficult to get out of bed in the morning?.....Yes/No
36. Is your job or school performance affected by your sleep problem?.....Yes/No
37. Do you and your bed partner have similar bedtimes?.....Yes/No
38. If you have a regular bed partner, do they sleep better or worse than you?

39. How do you sleep away from home (e.g., on vacation)? _____
40. What do you do after awakening in the night? _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected 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 TV.....	_____
Sitting inactive in a public place (e.g., a 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 traffic.....	_____
	Total _____

SLEEP HABITS

	<u>Work Days</u>	<u>Weekends</u>
What time do you go to bed?	_____ am/pm	_____ am/pm
What time do you get up?	_____ am/pm	_____ am/pm
How long does it take you to fall asleep?	_____ hrs	_____ min
On average, how many hours of actual sleep do you get nightly?	_____ hrs	_____ min
On average how many times do you wake up during the night?	_____ hrs	_____ min
Do you return to bed after rising?	Yes/No	Yes/No
What time do you go to work or school?	_____ am/pm	_____ am/pm
What time do you return home?	_____ am/pm	_____ am/pm
Does your job require working different shifts?	Yes/No	Yes/No
If yes, which shifts?	_____	_____
How many naps do you take?		
during the day?	_____	_____
during the evening?	_____	_____

MEDICAL HISTORY

Have you ever been told by a doctor that you have:

(Check all that Apply)

- | | |
|---|---|
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Thyroid gland problems | <input type="checkbox"/> Emphysema or Chronic Bronchitis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Depression or other psychiatric disorder |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn/Reflux disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Kidney disease | |

Do you have any other medical problems? If so, please list them here:

Have you ever had:

(Check all that Apply)

- | | |
|--|--|
| <input type="checkbox"/> Tonsillectomy (tonsils taken out) | |
| <input type="checkbox"/> History of trauma | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy (gallbladder) |
| <input type="checkbox"/> other surgeries: _____ | |

Do you ever use sleep pills, tranquilizer or sedatives?

Yes/No

If yes, please list.

NAME

DOSE

Allergies

Please list all drugs that you are allergic to:

FAMILY HISTORY

Does anyone in your family snore or been diagnosed with sleep apnea, narcolepsy, insomnia or other sleep disorders? If yes, please list _____

Has anyone in your family been diagnosed with one of the disorders listed under the medical history? If yes, please list _____

SOCIAL HISTORY

Children: _____

Please list with whom you live: _____

HABITS

Do you smoke? Present Past Never

If present smoker: packs/day _____ years _____
If past smoker: packs/day _____ years _____ when quit? _____

How much of the following do you use:

	<u>Weekdays</u>	<u>Weekend days</u>
Coffee	_____	_____
Tea	_____	_____
Chocolate	_____	_____
Caffeinated soda (pop)	_____	_____
Alcohol	_____	_____
Recreational drugs	_____	_____

SYSTEM REVIEW

In the last month, have you ever had:

General	Yes	No	Cardiac	Yes	No
Loss of energy	[]	[]	Heart problems	[]	[]
Fever/Chills	[]	[]	Chest pain	[]	[]
Night Sweats	[]	[]	Heart murmurs	[]	[]
			Heart attacks	[]	[]
			Fainting	[]	[]
Skin					
Rashes	[]	[]			
Change in skin color	[]	[]	Gastrointestinal		
Unhealed sores	[]	[]	Abdominal pain	[]	[]
			Heartburn	[]	[]
			Nausea/Vomiting	[]	[]
Blood			Diarrhea	[]	[]
Unusual bleeding	[]	[]	Constipation	[]	[]
Easy bruising	[]	[]	Blood in stool	[]	[]
Anemia	[]	[]			
Enlarged glands	[]	[]	Urinary		
			Burning in urine	[]	[]
Endocrine			Blood in urine	[]	[]
Heat/Cold intolerance	[]	[]	Increased urine	[]	[]
Hair growth/loss	[]	[]	Flank pain	[]	[]
Increased thirst	[]	[]	Trouble in start/stop	[]	[]
Increased hunger	[]	[]			
			Muscles/Skeleton		
Eyes/Ears/Mouth			Joint pain	[]	[]
Vision trouble	[]	[]	Morning stiffness	[]	[]
Double vision	[]	[]	Back problems	[]	[]
Eye pain	[]	[]			
Hearing trouble	[]	[]	Neurological		
Ringing in ears	[]	[]	Blackouts	[]	[]
Dizziness	[]	[]	Seizures	[]	[]
Dental problems	[]	[]	Frequent headaches	[]	[]
Difficulty swallowing	[]	[]	Muscle weakness	[]	[]
Mouth sores	[]	[]	Trouble talking	[]	[]
Hoarseness	[]	[]	Balance problems	[]	[]
			Memory changes	[]	[]
Lung/Nose					
Nose bleeds	[]	[]	Emotion		
Cough	[]	[]	Mood swings	[]	[]
Runny nose	[]	[]	Crying spells	[]	[]
Shortness of breath	[]	[]	Depression	[]	[]
Wheezing	[]	[]	Psychiatric treatment	[]	[]
Cold	[]	[]			

