CLEAR

Indiana Sleep Center

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# PATIENT SLEEP QUESTIONNAIRE

Today's Date:_____

## Section I: PATIENT INFORMATION

Patient Name:_____ DOB: _____ Height (inches):_____

Age:_____ Gender:_____ Neck Circumference (inches):_____Weight (pounds)_____

Referring Physician:_____Family Physician:_____

## 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 symptoms?_____years _____months

**2**. How did your symptoms 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 the weekends or holidays than on week days? ☐ Never ☐ Sometimes ☐ Most times

**9**. Do you take medicine to 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 social activities with family, friends and other groups? ☐ Never ☐ Rarely ☐ Sometimes ☐ Frequently ☐ Always

**12**. Have you had accidents or near accidents because of sleepiness? (i.e., car work, home) ☐ Yes ☐ No

**13**. Have you **EVER** experienced **sudden** muscle weakness when you laugh? ☐ Yes ☐ No

**14**. When you fall asleep or just before you awaken do you experience dreams? ☐ Yes ☐ No

**15**. When you fall asleep or just before you awaken do you feel as if you are paralyzed? ☐ Yes ☐ No

**16**. Have you ever been told you have Narcolepsy? If yes, when and by whom? ☐ Yes ☐ No

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## 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. Use the rating scale below.

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 lunch | _____ |
| In a car, while stopped for a few minutes in traffic | _____ |

**17**. Total score: 0

## SECTION IV: SLEEP HABITS

**18**. Workday usual bedtime: _____☐ a.m.☐ p.m.

**20**: Non- workday usual bedtime: _____☐ a.m.☐ p.m.

**19**. Workday usual wake time:_____☐ 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?_____

**25**. How often are you likely to awaken during the night? ☐ Rarely ☐ 3 times or less ☐ More than 3 times, Why?_____

**26**. If you awaken more than 3 times, how long does it take you to fall back asleep?_____and why?_____

**27**. Have you been told that you snore loudly? (If yes, how many years has the snoring been noted____) ☐ Yes ☐ No

**28**. Have you been told that you stop breathing during sleep? (If yes, for how many years_____) ☐ Yes ☐ No

**29**. Have you been told that your arms/legs jerk during sleep? ☐ Yes ☐ No

**30**. Are you often kept from falling asleep by an urge to move your arms, legs or torso? ☐ Yes ☐ No

**31.** If yes to #30 above, is the urge resolved by moving the involved body part? ☐ Yes ☐ No

## SECTION V: RELATED MEDICAL INFORMATION

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

| | | |
|---|---|---|
| ☐ Esophageal Reflux | ☐ Stroke | ☐ Claustrophobia |
| ☐ High Blood pressure | ☐ Angina/heart attack | ☐ Diabetes |
| ☐ Chronic nasal/ Sinus problems | ☐ Heart Failure (CHF) | ☐ Thyroid disease |
| ☐ Chronic lung disease (COPD Emphysema) | ☐ Irregular Heartbeat | ☐ Treatment for depression |
| ☐ Asthma | ☐ Pacemaker/Defibrillator | ☐ Restless leg syndrome |

☐ 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.** Over the last two weeks, have you often had little interest or pleasure in doing things? ☐ Yes ☐ No
If yes, has it been: ☐ Several days? ☐ More than half the days? ☐ Nearly every day?

**35.** Over the last two weeks, have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No
If yes, has it been: ☐ Several days? ☐ More than half the days? ☐ Nearly every day?

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

| **Medication Name** | **Dosage Per day** | **Frequency** | **For How Long** | **Purpose** |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ **Yrs** _____ **Mos** | _____ |
| _____ | _____ | _____ | _____ **Yrs** _____ **Mos** | _____ |
| _____ | _____ | _____ | _____ **Yrs** _____ **Mos** | _____ |
| _____ | _____ | _____ | _____ **Yrs** _____ **Mos** | _____ |
| _____ | _____ | _____ | _____ **Yrs** _____ **Mos** | _____ |
| _____ | _____ | _____ | _____ **Yrs** _____ **Mos** | _____ |

**37**. List all Medication Allergies you may have:_____

**38**. Do have any Allergies or sensitivities to any tape or bandage? ☐ Yes ☐ No OR Latex ☐Yes ☐No

## SECTION VII: PREVIOUS SLEEP APNEA DIAGNOSIS AND TREATMENT

**39**. Have you ever been diagnosed with sleep apnea? If yes, when_____ ☐ Yes ☐ No

If yes to above, are you currently being treated CPAP/Bi-Level therapy? ☐ Yes ☐ No

Do you feel any difference when using CPAP/ Bi-Level during sleep? ☐ Yes ☐ No

If currently using Positive Airway Pressure, please indicate the prescribed pressure _____cm/h20

Have you had problems with Positive Airway Pressure in the past and why?_____

**40**. Have you had any surgical treatment(s) for sleep apnea? ☐ Yes ☐ No

**41**. Have your tonsils been removed? If yes, when_____ ☐ Yes ☐ No

**42**. Do you use a dental appliance for sleep apnea or teeth grinding? ☐ Yes ☐ No

## SECTION VIII: SOCIAL HABITS AND FAMILY HISTORY

**43**. Do you drink alcoholic beverages, If yes, indicate the type, quantity and frequency below ☐ Yes ☐ No

If yes, what type?_____Number of glasses/cans/ bottles:_____per ☐ Day ☐ Week ☐ Month

**44**. Do you drink caffeinated beverages? If yes, indicate type, quantity and frequency below. ☐ Yes ☐ No

If Yes, what type?_____ Number of glasses/cans/ bottles:_____per ☐ Day ☐ Week ☐ Month

**45**. Have you gained any weight over the last year? ☐ Yes ☐ No

If Yes, how much_____Pounds

**46**. Do other family members have similar sleep problems? ☐ Yes ☐ No

**47**. What is your occupation?_____

**48**. What are your usual working hours?_____

**49**. Please use the following space to elaborate on other related information about your medical or sleep complaints.

_____

_____

## SECTION IX: OBSERVATIONS BY OTHERS

**50**. If you have had the opportunity to observe this patient's sleep please check any of the behaviors that apply and how long they have occurred.

☐ Snore or snort: _____years _____Months ☐ Stops breathing/Gasps 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

**U**se the space below for additional comments._____

_____

_____

AASM ACCREDITED Facility Member™