Sleep Diagnostics Questionnaire

The answers you provide to the following questions are *very important.* Check all statements that apply to you. Please respond carefully and completely.

Name: ____ Date: _________________

DOB: ____________________________________

Height (In inches): __________ Weight: _____________ Age: __________ Sex: M / F

Collar size: ______ inches Referred by: ______________________________

Please check all that apply:

___ Depression ___ COPD ___ Nightmares

___ Anxiety ___ Emphysema ___ Deviated septum

___ Nasal Stuffiness ___ Asthma ___ Tonsillectomy

___ Nasal Allergies ___ Irritable bowels ___ Throat surgery

___ Sleep walking ___ Leg cramps ___ Brain surgery

___ Sleep talking ___ Dizziness ___ Scary hallucinations

___ Heart attack ___ High blood pressure ___ Fainting spells

___ Heart Failure ___ Stroke ___ Sensation of paralysis

___ Heart Stent ___ Pain ___ Other

___Coronary Artery Disease ___ Oxygen use ___ Diabetes: Type I or Type II

___Atrial Fibrillation ___Atrial Flutter ___Opiate / Narcotic Use

When you hear bad or good news (laughing, etc.) do you feel weakness in your muscles or sagging in the face? Y / N

Do you take naps? Y / N How long are your naps? ________min

Are your naps refreshing? Y / N

Patient Signature: ______________________________

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Epworth Sleepiness Scale

Name: ______________________________ Date: ________________________

DOB: ______________________________

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling 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 = No chance of dozing
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 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 Score: ________

Patient Signature: ______________________________

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Name: ______________________________________ Date: ___________________

DOB: ______________________________________

1. I was referred for this sleep test because of:
   - ( ) a. Excessive sleepiness / fatigue
   - ( ) b. Loud snoring
   - ( ) c. Pauses in breathing during sleep
   - ( ) d. Insomnia
   - ( ) e. Leg jerks during sleep
   - ( ) f. Other ______________________
2. My sleep problem began when I was _____ years old.
3. My life and daily activities are disrupted by:
   - ( ) a. Dozing when I should be awake
   - ( ) b. Awakening unrefreshed
   - ( ) c. Trouble maintaining attention because of sleepiness
4. My sleep problem is:
   - ( ) a. Serious
   - ( ) b. Moderate
   - ( ) c. Mild
   - ( ) d. Inconsequential
5. I had an evaluation, examination or treatment for a sleep problem on ________________.
   - 5a. My diagnosis was:
     - ( ) i. Periodic limb movements disorder
     - ( ) ii. Obstructive sleep apnea syndrome
     - ( ) iii. Other ____
6. Do you currently use CPAP/BiPAP? ( ) Yes ( ) No
   - a. If so, what is your current pressure? ________________________cm H_2O.
7. a. On work days, I usually try to fall asleep at: _______ AM / PM
   b. On work days, I usually try to wake up at : _______ AM / PM
   c. On work days, I usually get out of bed at: ________ AM / PM
8. a. On non-work days, I usually try to fall asleep at: ________ AM / PM
   b. On non-work days, I usually try to be awake at: ________ AM / PM
   c. On non-work days, I usually get out of bed at: ________ AM / PM
9. a. It takes me more than 30 minutes to fall asleep: ___ days of the week (**fill in how many**)
   b. It takes me more than 60 minutes to fall asleep: ___ days of the week (**fill in how many**)
10. Often, when I am trying to fall asleep, I:
    - ( ) a. Have racing thoughts / worries
    - ( ) b. Feel sad
    - ( ) c. Feel unable to move
    - ( ) d. See vivid dream-like images
    - ( ) e. Feel abnormal sensations (crawling, aching, twitching, etc) in my legs so that I feel that I must move them
    - ( ) f. Have pain in my:1)head 2)back 3)chest 4)belly
    - ( ) g. Sleep with someone in my room
    - ( ) h. Sleep with someone in my bed
    - ( ) i. Get up to attend my children

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11. Often, when I awaken, I:
    - ( ) a. Feel unable to move
    - ( ) b. See vivid dream-like images
    - ( ) c. Suddenly feel very alert
    - ( ) d. Feel my heart pounding
    - ( ) e. Sweat excessively
    - ( ) f. Attend to my children
    - ( ) g. Am confused
    - ( ) i. Am frightened
    - ( ) j. Have dreams
    - ( ) k. Have nightmares
    - ( ) l. Have headaches
    - ( ) m. Am nauseous
    - ( ) n. Have a dry mouth
    - ( ) o. Awaken more than an hour too early

12. On a typical nigh, I sleep _______ hours.

13. It usually takes me (fill in amount of time) ______ hours ______ minutes to fall asleep

14. During the minutes before attempting to sleep, I usually:
    - ( ) a. Watch TV
    - ( ) b. Listen to music
    - ( ) c. Read
    - ( ) d. Speak with my spouse / partner
    - ( ) e. Plan or worry
    - ( ) f. Eat
    - ( ) g. Drink
    - ( ) h. Have sex
    - ( ) i. quarrel
    - ( ) j. Other______________________________

15. During a month, my total sleep per 24 hour days varies from a minimum of _____ hours to a maximum of _____ hours.

16. During a typical night, my longest single period of remaining awake without sleeping is _____ hours ______ minutes.

17. During a typical night, I awaken (how many) ______ times.

18. After falling asleep, I am most likely to awaken:
    - ( ) a. During the first half of the night
    - ( ) b. During the second half of the night
    - ( ) c. At various times
    - ( ) d. I seldom awake during the night

19. Does anyone in your family have a sleep problem? If so, please describe:

Relationship to you	***Problem***
__________________________	____________________________
__________________________	____________________________
__________________________	____________________________

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20. On a typical day, I drink:

	During a typical day	***Within two hours of bedtime***
a. Caffeinated coffee	___ cups	___ cups
b. Caffeinated tea	___ cups	___ cups
c. Caffeinated soda	___ cups	___ cups
d. Beer	___ glasses	___ glasses
e. Wine	___ glasses	___ glasses
f. Other alcohol	___ glasses	___ glasses

21. During a typical 24-hour day, I smoke:
    - ( ) a. Less than one pack of cigarettes
    - ( ) b. ___ pack(s) of cigarettes
    - ( ) c. ___ cigars
    - ( ) d. Pipe bowls
    - ( ) e. I don't smoke any tobacco products

22. How often do you use the following substances?

	Never	***Sometimes***	***Often***
a. Marijuana	( ) 1.	( ) 2.	( ) 3.
b. Narcotics (Cocaine, crack, heroin, morphine, Opium, etc)	( ) 1.	( ) 2.	( ) 3.
c. Hallucinogens (LSD, mescaline, angel dust, Mushrooms, etc)	( ) 1.	( ) 2.	( ) 3.
d. Stimulants (uppers)	( ) 1.	( ) 2.	( ) 3.
e. Depressants (downers)	( ) 1.	( ) 2.	( ) 3.

23. Please print the name and doses (in mg) of all medications you take now or have taken within the last ten days.

Please print clearly and accurately. Print the name of each medication, as shown on each label. Note dosage and frequency. A misspelling can affect your diagnosis.

Name	Dose	Purpose of medication
______________________________	_______	________________________________
______________________________	_______	________________________________
______________________________	_______	________________________________
______________________________	_______	________________________________

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24. I have taken these medications to treat insomnia or to help me stay awake:
Name of medication: ( ) Yes ( ) No

____________________________________ ______ ______

____________________________________ ______ ______

____________________________________ ______ ______

25. I participate in an athletic activity or other exercise:
   - ( ) a. Rarely or never
   - ( ) b. One time per week
   - ( ) c. Two times per week
   - ( ) d. Three times per week
   - ( ) e. Four times per week
   - ( ) f. Five or more times per week

26. My usual working hours are from _________ to _________ .

27. What do you think causes your sleep / wake problem?

____

____

____

28. My weight has ____ increased ____ decreased recently

29. Do you currently use oxygen? ( ) Yes ( ) No
   a. If so, how many liters per minute do you use? _____________lpm.

Name: _________________________________ Date: _____________________

____
SIGNATURE

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