advocare | Pulmonary and Sleep Physicians of South Jersey

Sleep Disorders Questionnaire

NAME:_____ DATE:_____
ADDRESS:_____
_____

DATE OF BIRTH:_____ AGE:_____ SEX:_____

HOME PHONE:_____ WORK PHONE:_____

CELL PHONE:_____

MARITAL STATUS:
SINGLE:____ MARRIED:____ WIDOW(ER):____ DIVORCED:____ SEPARATED:____

REFERRING PHYSICIAN:_____
ADDRESS:_____

FAMILY PHYSICIAN:_____
ADDRESS:_____

How did you hear about the Sleep Disorders Center? _____

_____

Weight: Current _____ lbs. 5 years ago: _____ lbs. 1 year ago: _____ lbs.

Most you ever weighed: _____lbs.

Height: _____ft. _____ inches Neck size: _____ inches

Please consult your bed partner when answering the following questions. Answer the question as if you are describing your typical night or sleep pattern. If you use CPAP or BIPAP, answer the questions based on your use of CPAP or BIPAP.

1. Describe your sleep problem: _____

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2. Have you ever had a sleep study performed? Yes □ No □
   If yes, where did you have the study performed and what were the results: _____

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3. My bed or sleeping surface is a:
_____ standard mattress _____ water bed _____ futon _____ other

If other, please specify:_____

4. Sleep habits:

Ideal amount of sleep _____ hours. Do you work in shifts? □ Yes □No

During the week I:	During the weekend I:
Go to bed at _____ (time)	Go to bed at _____ (time)
Get up at _____ (time)	Get up at _____ (time)
Sleep _____ (hours)	Sleep _____ (hours)

A. It usually takes me _____minutes to fall asleep.
B. I usually wake up _____ times a night.
C. Please explain what wakes you up: _____

_____

_____

_____

D. If you wake up at night, it usually takes _____ minutes to fall asleep.
E. I cannot get back to sleep once I wake up:
Nightly □ Weekly □ Rarely □ Never □
F. I can sleep 12 hours or more at a time:
Nightly □ Weekly □ Rarely □ Never □

5. My occupation is:_____

6. I snore: Nightly □ Weekly □ Rarely □ Never □

7. My snoring started at age: _____

8. Do you snore: On your back □ On your sides □ In all positions □

9. My snoring has been described as: Mild □ Moderate □ Loud □

10. I stop breathing at night: Yes □ No □

11. How many times do you awaken at night to urinate: _____

12. I have problems with my nose or nasal breathing: Yes □ No □
If yes, explain: _____
_____

13. I have had nasal surgery: Yes □ No □
If yes, explain:_____

_____

14. I have had a tonsillectomy: Yes □ No □

	Nightly	Weekly	Rarely	Never
15. I wake up gasping, wheezing, short of breath, or feeling I cannot breathe:	_____	_____	_____	_____
16. I wake up coughing:	_____	_____	_____	_____
17. I wake up with my heart beating irregularly:	_____	_____	_____	_____
18. I wake up with chest pain:	_____	_____	_____	_____
19. I wake up with heartburn or a sour taste in my mouth	_____	_____	_____	_____

I eat my last meal of the day at _____ o'clock

20. I wake up with a headache	_____	_____	_____	_____
21. I have/had a bedwetting problem	_____	_____	_____	_____
22. I fight sleep or fall asleep uncontrollably while sitting at meetings, watching TV, at the movies, in the car	_____	_____	_____	_____
23. I fight sleep at work or school	_____	_____	_____	_____
24. I fight sleep while driving	_____	_____	_____	_____

25. I have actually fallen asleep while driving a car: Yes □ No □

26. It seems that my mood, memory or thought processes have changed: Yes □ No □

27. Drowsiness is greatest in the: Morning □ Afternoon □ Evening □

28. After a typical nights sleep, I feel:
Refreshed □ Fairly rested □ Somewhat tired □ Very drowsy □

	Nightly	Weekly	Rarely	Never
29. I have been told I toss and turn to an Extreme amount	_____	_____	_____	_____
30. I flail or kick while sleeping	_____	_____	_____	_____
31. I have the feeling of "restless legs	_____	_____	_____	_____

	Nightly	Weekly	Rarely	Never
32. I am troubled at night by uncomfortable sensations in my legs	_____	_____	_____	_____
33. I wake up with muscle or joint aches or pains	_____	_____	_____	_____
34. Immediately after falling asleep I dream	_____	_____	_____	_____
35. I dream during naps	_____	_____	_____	_____
36. I experience vivid dream-like scenes upon waking up or falling asleep	_____	_____	_____	_____
37. I have episodes where I lose track of time without realizing it	_____	_____	_____	_____
38. I feel like I cannot move after lying down, before going to sleep, when waking up or going to sleep	_____	_____	_____	_____

39. I feel sudden weakness in my knees, neck, jaw or arms when angry, sad, laughing or emotional:
Daily □ Weekly □ Rarely □ Never □

40. I have episodes of doing strange things without realizing it at the time or lose a period of time:

Daily □ Weekly □ Rarely □ Never □

41. I take daytime naps: Yes □ No □
If yes, how many naps per day: _____

42. After a nap, I feel: Refreshed □ Fairly rested □ Somewhat tired □ Very drowsy □

	Nightly	Weekly	Rarely	Never
43. I sleepwalk	_____	_____	_____	_____
44. I talk or scream in my sleep	_____	_____	_____	_____
45. I am disturbed by nightmares	_____	_____	_____	_____
46. Do you or your bed partner believe that you move your arms, legs, or body too much during sleep, or have unusual behaviors during sleep?	_____	_____	_____	_____

	Nightly	**Weekly**	**Rarely**	**Never**
47. Do you have vigorous or violent behaviors during sleep?	_____	_____	_____	_____
48. Have you ever hurt yourself or your bed partner during sleep?	_____	_____	_____	_____
49. Do you eat or drink without control and without full awareness during the night, after having been asleep?	_____	_____	_____	_____
50. I grind my teeth when asleep	_____	_____	_____	_____

51. Within the last year depression, anxiety or stress has interfered with my sleep
Yes □ No □

52. At bedtime I have difficulty falling asleep because of worries or thoughts racing through my mind: Yes □ No □

53. My sleep problem, in addition to those previously mentioned, has resulted in _____
_____
_____

54. Is there any history in your family of difficulties with sleep or excessive daytime sleepiness or snoring? Yes □ No □
If yes, explain: _____
_____

55. Please list medicines tried for improving sleep or staying awake:

DRUG & DOSE	FREQUENCY	STARTED	ENDED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

56. What methods have you tried to help you sleep at night or stay awake during the day besides the drugs mentioned above? _____
_____
_____

ALLERGIES:

Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____
Allergy:_____ Reaction:_____

CURRENT MEDICATIONS:

MEDICATION DOSE/FREQUENCY

_____
_____
_____
_____
_____
_____
_____
_____

If more space is needed, use the back of this page and check here:____

LAST PNEUMONIA VACCINATION:_____
LAST INFLUENZA VACCINATION:_____

MEDICAL PROBLEMS

(Check if you have had any of the following problems):

Asthma	☐	High blood pressure	☐
Atrial fibrillation	☐	Kidney disease	☐
Blood clots	☐	Pulmonary hypertension	☐
Cancer	☐	Sleep disorders	☐
Diabetes	☐	Stroke	☐
Emphysema	☐	Thyroid disease	☐
Heart Attack	☐	Valvular heart disease	☐
Heart Failure	☐		

Other: _____
_____
_____

PAST OPERATIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you use oxygen? Yes____ No____ If yes, how many liters of oxygen _____

If yes, do you use oxygen □ All the time □ With exercise □ During sleep

Do you smoke cigarettes? Yes____ Never____ Quit____
If quit, how long ago?_____

For how many years have you smoked cigarettes?..... _____ years

How many cigarettes per day? ..... _____ cigarettes

Do you use street drugs now? Yes____ No____
Have you used street drugs in the past? Yes____ No____

Do you drink alcohol? Yes____ No____

How many drinks? _____ per day _____ per week

Do you drink caffeinated beverages? Yes____ No____

How many caffeinated beverages do you drink per day? (Coffee, tea or soda)_____

What is your occupation?_____

Have you been exposed to chemical, toxins, or asbestos in the past? Yes____ No____

What were the exposures?_____

Do you exercise? Yes____ No ____

What kind of exercise and how often?_____

What health problems have occurred in your family?

Mother:_____ Deceased □

Father:_____ Deceased □

Brother(s):_____ Deceased □

Sister(s):_____ Deceased □

Are you currently having any of the following health problems?

GENERAL:

Poor appetite…….. Yes ____ No ____
Recent weight loss……. Yes ____ No ____
Fevers, chills or sweats…….. Yes ____ No ____
Weight gain…….Yes ____ No ____

CARDIOVASCULAR:

Chest pain……...Yes ____ No ____
Irregular or fast heart beat…….. Yes ____ No ____
Swelling in the ankles…… Yes ____ No ____
Rheumatic fever……Yes ____ No ____
Sleep with more than 1 pillow at night…….. Yes ____ No ____
Wake up short of breath at night so that you
sit up during the night…….. Yes ____ No ____
Pain in your legs when walking……Yes ____ No ____
Elevated cholesterol……... Yes ____ No ____
Have you had a stress test?…… Yes ____ No ____

EYES, EARS, NOSE, THROAT:

Blurred vision……Yes ____ No ____
Double vision……Yes ____ No ____
Hearing problems……... Yes ____ No ____
Sore throat…….. Yes ____ No ____
Sinus disease…….. Yes ____ No ____

RESPIRATORY:

Asthma……... Yes ____ No ____
Cough with phlegm production……. Yes ____ No ____
Cough with blood……...Yes ____ No ____
Wheezing……... Yes ____ No ____
Shortness of breath with exercise…….. Yes ____ No ____
Shortness of breath at rest…… Yes ____ No ____
Dry cough……...Yes ____ No ____
Hay fever……Yes ____ No ____
Exposure to TB…….. Yes ____ No ____

GI:

Difficulty swallowing solids ……Yes ____ No ____
Difficulty swallowing liquids…….... Yes ____ No ____
Heartburn……... Yes ____ No ____
Ulcers……. Yes ____ No ____
Diarrhea…… Yes ____ No ____
Nausea and vomiting……. Yes ____ No ____
Pain in abdomen…… Yes ____ No ____
Blood in stools……... Yes ____ No ____
Black stools……Yes ____ No ____
Constipation……... Yes ____ No ____
Change in bowel habits…….. Yes ____ No ____
Vomiting blood…….. Yes ____ No ____

ENDOCRINE:

Thyroid problems……...Yes ____ No ____
Increased thirst……...Yes ____ No ____
Increased urination……Yes ____ No ____

NEUROLOGIC:

Headaches…….. Yes ____ No ____
Seizures……..Yes ____ No ____
Weakness in arms or legs……...Yes ____ No ____
Previous stroke (s)……..Yes ____ No ____
Numbness or tingling……Yes ____ No ____
Dizziness…… Yes ____ No ____

GENITOURINARY:

Frequent urination……..Yes ____ No ____
Burning with urination……...Yes ____ No ____
Blood in urine…… Yes ____ No ____
Difficulty starting to urinate…….. Yes ____ No ____
Vaginal discharge……...Yes ____ No ____
Last menstrual period was: _____

HEMATOLOGIC:

Anemia……...Yes ____ No ____
Easy bruising…… Yes ____ No ____
Nose bleeds…… Yes ____ No ____
Frequent infections……Yes ____ No ____
Enlarged lymph nodes/lumps……Yes ____ No ____

MUSCULOSKELETAL:

Joint pain or swelling……Yes ____ No ____
Arthritis……..Yes ____ No ____
Muscle weakness……... Yes ____ No ____
Muscle pain……Yes ____ No ____
Color changes in the fingers when it is cold…… Yes ____ No ____
Curvature of the spine……Yes ____ No ____

SLEEP:

Snoring at night……..Yes ____ No ____
Stop breathing during sleep……... Yes ____ No ____
Falling asleep during the day at inappropriate times……Yes ____ No ____
Falling asleep when driving a car or other vehicle…… Yes ____ No ____
Restless legs……... Yes ____ No ____

SKIN:

Skin cancer……Yes ____ No ____
Skin rash or lumps…… Yes ____ No ____

BREAST:

Breast lumps……...Yes ____ No ____
Mammograms…… Yes ____ No ____
Nipple discharge…… Yes ____ No ____

PSYCHIATRIC:

Anxiety……...Yes ____ No ____
Depression……..Yes ____ No ____
Problems with excessive use of alcohol or street drugs…… Yes ____ No ____

Please complete the next page (Epworth Sleepiness Scale)

Patient's signature: _____ Date: _____

Physician's signature: _____ Date: _____

EPWORTH SLEEPINESS SCALE

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? (This refers to your usual 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
1) Sitting and reading	
2) Watching TV	
3) Sitting inactive in a public place (i.e., a theater or a meeting)	
4) As a passenger in a car for an hour without a break	
5) Lying down to rest in the afternoon when circumstances permit	
6) Sitting and talking to someone	
7) Sitting quietly after lunch without alcohol	
8) In a car, while stopping for a few minutes in traffic	

_____ _____

NAME DATE