# Sleep Questionnaire

Your answers will provide the ASC staff with a better understanding of you and your sleep patterns and related health issues. The information provided will be held in strict confidence and will be used to provide you with better care**.** Please answer the best that you can and sign.

Patient's Name: ________________________ DOB: _____________ Age: ________

Height: ____________Weight: ____________Sex: MALE ____________ FEMALE_________

**PHYSICIAN INFORMATION**:

Primary Physician: _____________________ Address: ______________________________

Phone: ______(______)__________________

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Requesting Physician (if different from Primary): ___________________________

Address: _______________________________________Phone: ___(______)_________________

Specialty: _____________________________

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**SLEEP HISTORY**:

**Give a short description of the sleep issues you are experiencing and when it began:**

______________________________________________________________________________

______________________________________________________________________________

□YES □NO Are you a restless sleeper?
□YES □NO Has anyone told you that you snore? For how long? ______
□YES □NO Do you snore sleeping in all positions? For how long? ______
□YES □NO Has your family told you that you quit breathing at night? For how long? ______
□YES □NO Have you ever awakened gasping for breath? For how long? ______
□YES □NO Do you awaken with mouth dryness? For how long? ______
□YES □NO Do you have morning headaches? For how long? ______
□YES □NO Has your weight changed in the last 5yrs? Gained____ Lost____
□YES □NO Do you have “tingly” legs and feel as if you have to move them?
For how long?______

□YES □NO Do you kick your legs at night? For how long? _____
□YES □NO Do you sleep better away from your own bed? (ie: vacation)For how long? _____
□YES □NO Do you have pain that bothers you at night? For how long? ______
□YES □NO Do you grind your teeth in your sleep? For how long? ______
□YES □NO Do you sleep walk? For how long? ______
□YES □NO Do you talk in your sleep? For how long? ______
□YES □NO Have you ever experienced periods in which you feel paralyzed while you are going to sleep or waking up? For how long? ______
□YES □NO Have you ever had a visual hallucination or dream-like mental images when falling asleep? For how long? ______
□YES □NO Have you ever experienced sudden physical weakness during strong emotions? (i.e.: legs going limp while laughing or when angry) For how long? ______
□YES □NO Do you have difficulty staying awake to drive? For how long? ______
□YES □NO Have you ever had an automobile accident due to sleepiness?
(if yes) Date of Accident ___/___/_____

**SLEEP SCHEDULE:**

| | Bedtime | Wake time | Average amount of sleep per night |
|---|---|---|---|
| Weekday: | am/pm | am/pm | hours |
| Weekends: | am/pm | am/pm | hours |

Do you wake feeling rested? YES________ NO_________

Do you currently use CPAP treatment at night? YES________ NO_________

Pressure: ___________

Do you have rotating or night shift work? YES ________NO_________

How long does it take you to go to sleep?________________ hours ________________ minutes

How many times do you wake up from sleep? _______Do you fall back to sleep easily? _______

Do you nap? _______ If so, how often and when? ____________________

**MEDICAL HISTORY:**

*Please check all that apply…*

□ Tonsillectomy □ Hernia repair □ Appendectomy □ Cardiac Bypass

□ Hysterectomy □ Orthopedic surgery □ Cardiac Cath □ Nasal surgery
□ Emphysema □ Asthma □ Diabetes □ Heart Disease □ Lung Disease □ Arthritis □ Ulcers □ Thyroid Disease □ Seizure Disorder
□ High blood pressure □ High Cholesterol □ Allergies □ GERD / Reflux
□ Other: ______________________________________________________________

******If you answered "yes" to allergies, please list all______________________**

__________________________________________________________________

**MEDICATIONS:** Please list all the medications that you are currently taking

(Name / dose) (Name / dose)

| | | | |
|---|---|---|---|
| ______________ | __________ | ______________ | __________ |
| ______________ | __________ | ______________ | __________ |
| ______________ | __________ | ______________ | __________ |
| ______________ | __________ | ______________ | __________ |
| ______________ | __________ | ______________ | __________ |

Over the counter medications: ____________________________________________

**Medication Allergies**: __________________________________________________

Are you currently using supplemental oxygen □ YES □ NO If yes, _______ LPM

**SOCIAL HISTORY:**

**Caffeine**:
How much caffeine do you consume on a daily basis?
↑ Caffeinated beverage (cola, Mt. Dew, etc.
How many cans per day?____
↑ Tea
↑ Coffee
How many cups per day?____

**Tobacco**:
↑ Never
↑ Quit
Currently Smoke
Currently Chew
How many packs per day?____
How many years? ____

**Home:**
↑ married
↑ divorced
↑ widowed
↑ single
children
How many children?

**Alcohol:** Never
↑ Quit
↑ Occasionally
↑ Daily
↑ Beer
↑ Liquor
↑ Cocktails

**Illicit Drugs:** Never
Quit
↑ Occasionally
↑ Daily
What are you using?

**Work:** retired
↑ disabled
↑ student
↑ currently employed
↑ work day
↑ work nights
↑ shift work

**What is (was) your occupation?** ______________________________

**FAMILY HISTORY**:
*Family History including father, mother, and* siblings*:*

| | | | Person with disorder | | | | Person with disorder |
|---|---|---|---|---|---|---|---|
| Diabetes | □YES | □NO | ____________ | Obesity | □YES | □NO | ____________ |
| High B/P | □YES | □NO | ____________ | Snoring | □YES | □NO | ____________ |
| Stroke | □YES | □NO | ____________ | Sleep Apnea | □YES | □NO | ____________ |
| Narcolepsy | □YES | □NO | ____________ | Daytime Fatigue | □YES | □NO | ____________ |
| Depression | □YES | □NO | ____________ | Anxiety | □YES | □NO | ____________ |

**YOUR SYMPTOMS: DO YOU EXPERIENCE ANY OF THE FOLLOWING:**

□Yes □No Fever
□Yes □No Night Sweats
□Yes □No Unexplained weight loss/gain

□Yes □No Hearing Loss
□Yes □No Hoarseness
□Yes □No Sore Throat
□Yes □No Nasal Congestion

□Yes □No Coughing
□Yes □No Shortness of breath
□Yes □No Difficulty breathing lying flat
□Yes □No Difficulty breathing at night
□Yes □No Wheezing
□Yes □No Coughing up blood
□Yes □No History of positive TB skin test

□Yes □No Muscle aching
□Yes □No Joint Pain

□Yes □No Excessive thirst
□Yes □No Skin moistness or dryness
□Yes □No Heat intolerance
□Yes □No Cold intolerance

□Yes □No I am or could now be pregnant
□Yes □No Post-menopausal

□Yes □No Chest Pain
□Yes □No Ankle Swelling
□Yes □No Heart Murmur

□Yes □No Black Stools or bleeding from bowels
□Yes □No Nausea/Vomiting
□Yes □No Trouble Swallowing
□Yes □No Abdominal Pain

□Yes □No Frequent Bladder infections
□Yes □No Painful urination
□Yes □No Frequent urination
□Yes □No Blood in urine
□Yes □No Night time urination
□Yes □No Loss of bladder control
□Yes □No Difficulty starting stream of urine

□Yes □No Skin Rash
□Yes □No Easy bruising

□Yes □No Loss of appetite
□Yes □No Feeling depressed
□Yes □No Anxiety
□Yes □No Agitation
□Yes □No Increased stress/trouble at work

□Yes □No Paralysis
□Yes □No Numbness/Weakness in hands, feet, or legs
□Yes □No Trouble with balance

□Yes □No History of stroke
□Yes □No Difficulty with concentration
□Yes □No Seizures
□Yes □No Headaches

**OTHER SYMPTOMS NOT LISTED:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

# EPWORTH SLEEPINESS SCALE

**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.

**Scale:** 0 = would **never** doze 1 = **slight** chance of dozing 2 = **moderate** chance of dozing 3 = **high** chance of dozing

| SITUATION | CHANCE OF DOZING |
|---|---|
| Sitting & reading | ____________ |
| Watching television | ____________ |
| Sitting inactive in a public place such as a theatre 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 & talking to someone | ____________ |
| Sitting quietly after a lunch without alcohol | ____________ |
| In a car while stopped for a few minutes in traffic | ____________ |
| **TOTAL** (add all responses): | ____________ |

# Restless Leg Syndrome Questionnaire

1. Do you have sensations in your legs you would describe as "achy," "creepy, crawly," "itchy'" or painful?

   □ **Yes** □ **No** If yes, describe____________________

2. Would you say that you sometimes are restless or feel the need to pace or get up and walk around?

   □ **Yes** □ **No** If yes, describe____________________

3. Do these symptoms start or become worse when you are resting?

   □ **Yes** □ **No** If yes, describe: __________________

4. Does moving give you some relief?

   □ **Yes** □ **No** If yes, describe: __________________

5. Do your symptoms get worse in the evening, especially when you are lying down?

   □ **Yes** □ **No** If yes, describe: __________________

## X PLEASE SIGN THE FOLLOWING:

_________________________ _________________________ __________

Patient Signature Printed Name Date

Advanced Sleep Centers

# SLEEPINESS AND FATIGUE RATING SCALE (Average for Entire Day)

| | 0 | 25 | 50 | 75 | 100 |
|---|---|---|---|---|---|
| **SLEEPINESS:** | Extremely sleepy | Somewhat sleepy | Neither | Somewhat Alert | Very Alert |
| | <----------------------------------- | | | | -----------------------------------> |
| **FATIGUE:** | Extremely fatigued | Somewhat fatigued | Neither | Somewhat energetic | Very energetic |

**PATIENT:______________________________WEEK ENDING:__________NEXT APPT:__________**

*Instructions: Fill out each box for an entire week, indicating your sleep and awake periods during the night, and rating your sleepiness and fatigue from 0, extremely sleepy or fatigued, to 100 , very alert or energetic (refer to the scale above). Examples of entries are found below:*

## COMPLETE AFTER GETTING OUT OF BED IN THE MORNING:

| Day/Date | Naps: Time & Sleep Time | Stressors/Alcohol/Medications | Time you went to bed | Time it took you to fall asleep | # of times awake | Amount of time awake* | Time you got up | Total sleep time | Sleepiness Rating | Fatigue Rating |
|---|---|---|---|---|---|---|---|---|---|---|
| Tuesday 6/10/12 | 2:30 pm 1 hour | Late for work, 1 beer 8 pm, ambien 10 mg at 9 pm | 11 pm | 30 min. | 2 | 45 min. | 6 am | 7 hours | 70 | 35 |
| | | | | | | | | | | |
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| | | | | | | | | | | |

*Amount of time awake: All the time you spent awake during the night, from the first time you awakened until the time you got out of bed.