Sleep Study Questionnaire

Name: _____ Date: _____
Last First MI

Address: _____
City State Zip

Phone: _____ Birthdate: _____ Height: _____ Weight: _____

Family Doctor: _____ Doctor Who Sent You: _____

Insurance Name & Number: _____

What is the main sleep problem you have (chief complaint)? _____

_____

Please tell us about your sleep by circling one number after the following questions. Do the best you can to pick the one that best describes yourself. At the end of the questions, you can write anything else you want us to know.
Circle one: **1 = never 2 = rarely 3 = occasionally 4 = frequently 5 = always**

MY SLEEP HISTORY:

1. Do you fall asleep when you are supposed to be awake?	1	2	3	4	5
2. Is your bedtime a different time every night?	1	2	3	4	5
3. Do you have trouble going to sleep at bedtime?	1	2	3	4	5
4. Once you sleep, do you have trouble staying asleep?	1	2	3	4	5
5. Did anyone ever tell you that you snore?	1	2	3	4	5
6. Do you snore more on your back than in other positions?	1	2	3	4	5
7. Do you snore only with nose problems once in a while such as colds?	1	2	3	4	5
8. While you are asleep, does anyone see pauses in your breathing?	1	2	3	4	5
9. When you wake up, do you feel refreshed and ready to go?	1	2	3	4	5
10. When you wake up, do you feel fine but get tired in only a few hours?	1	2	3	4	5
11. Have you accidentally fallen asleep at work?	1	2	3	4	5
12. I fell asleep driving and had a 'close call' or drifted out of my line.	1	2	3	4	5
13. I fell asleep driving and had an accident.	1	2	3	4	5
14. Do you have trouble concentrating when you are supposed to be awake?	1	2	3	4	5

BLESSING HOSPITAL

15. Do you take a nap when you don't want to (accidentally fall asleep)?	1	2	3	4	5
16. Do you take naps on purpose?	1	2	3	4	5
17. Are you tired enough to cause problems with your friends/family/work?	1	2	3	4	5
18. I wake up more than once to go to the bathroom.	1	2	3	4	5
19. Do you wake up with a headache?	1	2	3	4	5
20. Do you have any problems breathing through your nose most of the year?	1	2	3	4	5
21. Do you have problems breathing through your nose only with allergy season?	1	2	3	4	5
22. Do you have any problems with sinus drainage?	1	2	3	4	5
23. Does any stomach burning wake you up?	1	2	3	4	5
24. Do you wake up from nightmares?	1	2	3	4	5
25. Do you talk in your sleep?	1	2	3	4	5
26. Do you walk in your sleep?	1	2	3	4	5
27. Did anyone ever tell you that you kicked and hit him/her in your sleep?	1	2	3	4	5
28. Do your legs feel restless and hard to keep still when you are trying to go to sleep?	1	2	3	4	5
29. Do you know or did anyone tell you that you jerk your legs in your sleep?	1	2	3	4	5
30. Do you feel more depressed or 'have the blues' lately?	1	2	3	4	5
31. Have you experienced confusion recently?	1	2	3	4	5
32. Do you have vivid dream-like pictures when you are drifting off to sleep?	1	2	3	4	5
33. Did you ever wake up feeling like you could not move as if you were paralyzed?	1	2	3	4	5
34. If you are holding something, do you drop it if you laugh or are angry?	1	2	3	4	5
35. Do you drink alcohol to help you sleep at night?	1	2	3	4	5
36. Do you take any medicine to help you sleep at night?	1	2	3	4	5
37. Do you work rotating shifts (e.g. alternating day, evening, or night shifts)?	1	2	3	4	5
38. Do you think your main sleep problem is insomnia?	1	2	3	4	5
39. Does anyone keep you from sleeping well when you want to sleep?	1	2	3	4	5
40. Does your neighborhood keep you from sleeping well?	1	2	3	4	5
41. Do pets or noises keep you from sleeping well?	1	2	3	4	5
42. Do you go to sleep, but then wake up too early and can't go back to sleep?	1	2	3	4	5
43. I like to have a snack before I go to bed.	1	2	3	4	5
44. Before going to sleep, I like to read, watch TV or listen to the radio in bed.	1	2	3	4	5

45. I wake up gasping for air.	1	2	3	4	5
46. I have awakened choking at night.	1	2	3	4	5
47. I wake up with chest pain, chest pressure, palpitations, or chest tightness.	1	2	3	4	5
48. I wake up wheezing.	1	2	3	4	5
49. I keep coughing at night and it keeps bothering my sleep.	1	2	3	4	5
50. For some reason, I can sleep better if I'm away from home.	1	2	3	4	5
51. I grind my teeth when I sleep.	1	2	3	4	5
52. I'm a restless sleeper and I thrash around a lot.	1	2	3	4	5
53. I keep having the same frightening nightmare.	1	2	3	4	5
54. I feel pain a lot and this keeps me from getting good sleep.	1	2	3	4	5
55. I have seizures.	1	2	3	4	5
56. I have a habit of rocking my body until I fall asleep.	1	2	3	4	5
57. I wake up hungry and have a snack before I can go back to sleep.	1	2	3	4	5
58. I worry too much at night to sleep well at all.	1	2	3	4	5
59. When I was a child or teenager, I had trouble staying awake in school.	1	2	3	4	5
60. I hurt my head enough to pass out. In other words, I was knocked out.	1	2	3	4	5
61. I have thought about committing suicide.	1	2	3	4	5

Write in your own words anything you want us to know about your sleep that we didn't ask you:

_____

_____

_____

_____

_____

Medications: Include how much and how often you take them.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Over the counter medications or vitamins:

1. _____
2. _____
3. _____

Allergies to medications and describe what happened:

_____

_____

_____

_____

Past Medical History (this means any medical problems):

Check any that you know you have now or have had in the past.

- ☐ Did you have your tonsils out?
- ☐ Do you have hay fever or problems with allergies affecting your nose a lot?
- ☐ Hoarseness or any vocal cord problems
- ☐ Emphysema or chronic bronchitis
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Hiatal hernia
- ☐ Neuromuscular disease (e.g. Parkinson's, Multiple Sclerosis, Stroke)
- ☐ Fibromyalgia (a lot of muscle aches & pains)
- ☐ Chronic back pain
- ☐ Thyroid problems
- ☐ Kidney disease
- ☐ Clinical depression
- ☐ Water retention such as swollen ankles
- ☐ Did you have nose or sinus surgery?
- ☐ Do you always seem to have sinus problems (not allergies)?
- ☐ Asthma
- ☐ Heart disease (coronary artery disease)
- ☐ Heart irregularity or heart rhythm problem
- ☐ Pulmonary hypertension (high lung pressure)
- ☐ Ulcer
- ☐ Epilepsy or seizures
- ☐ Arthritis
- ☐ Diabetes
- ☐ Blood problems (anemia or polycythemia)
- ☐ Are you on kidney dialysis?
- ☐ Psychiatric problem NOT related to depression
- ☐ Obesity (being overweight)

Social History:

Do you or have you ever smoked cigarettes, cigars, vape, marijuana, or chewed tobacco? ☐ Yes ☐ No

If yes, then please state how old you were when you started: _____

How much a day do you or did you use? _____

Did you quit? _____ How long ago did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No

I only drink on rare social occasions. ☐ Yes ☐ No

If regularly, then please state how much in one week: _____

Have you abused drugs or used street drugs within the last 2 years? ☐ Yes ☐ No

Do you drink coffee, pop, or tea with caffeine in it? ☐ Yes ☐ No

How much a day?

Circle One: Married Single Divorced Living with a Partner Widow(er)

Are you having any problem with the people you live with (e.g. stress, not getting along)? ☐ Yes ☐ No

Do you work? ☐ Yes ☐ No

What is your job? _____

Is your job causing a lot of stress? ☐ Yes ☐ No

Describe your work hours: _____

Do you have pets? ☐ Yes ☐ No

If yes, are there any allergy problems that might be due to your pets? ☐ Yes ☐ No

Do your pets keep you up at night? ☐ Yes ☐ No

Do you have any feather pillows or down comforters? ☐ Yes ☐ No

Does pain keep you awake at night? ☐ Yes ☐ No

If yes, then what kind of pain? _____

What is your normal bedtime? _____ What is your normal waking time? _____

On average, how many hours of sleep do you get on most nights? _____

On your days off, how many hours of sleep do you get on most nights? _____

How long have you had problems with your sleep? _____ months _____ years

How many times do you wake up at night for more than 10 minutes at a time? _____

If you keep changing shifts at work, what is your schedule? _____

Family History:

Any family history of sleep apnea, narcolepsy or any other sleep problems? ☐ Yes ☐ No

If yes, please describe: _____

If your parents are still alive, describe their age and health and if not, what caused their death:

_____

Any family history of heart or lung disease and if so, please describe what and how the person is related:

_____

Anything else in your family history that you want us to know? _____

Review of Systems:

Eyes:	☐ itchy or watery	☐ floppy eyelids	☐ red or dry
Nose & Throat:	☐ runny nose	☐ sore throat	☐ stuffy nose
Glands:	☐ low sugar	☐ high sugar	☐ thyroid problems
Lungs:	☐ wheezing	☐ coughing	☐ short of breath
Heart:	☐ chest pain	☐ chest pressure	☐ palpitations
Stomach:	☐ heartburn	☐ acid coming up my throat	☐ nausea
Bladder/Kidneys:	☐ have to go to the bathroom too much		☐ blood in urine
Muscles & Joints:	☐ muscles hurt	☐ joints hurt	☐ joints stiff
Brain & Nerves:	☐ forgetful	☐ migraines	☐ double vision
Mental Outlook:	☐ anxious	☐ panic attacks	☐ very depressed
Skin:	☐ bluish fingernails	☐ cold hands/feet	☐ numbness of hands or feet

Epworth Sleepiness Scale

Rate your sleepiness as:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Example: If you are sitting and reading and feel that you have a high chance of dozing off, put a 3 in the box to the right.

Situation	**Chance of Dozing**
Sitting and reading	
Watching TV	
Sitting inactive in a public place (such as in a theater or in 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 (add the above numbers)	