CP Critical Care & Pulmonary Consultants, P.C.

SLEEP QUESTIONNAIRE

Name _____ DOB_____ Age_____

Height _____ Weight _____

Referring Dr._____Family Dr. _____

Describe in detail what your sleep problem is:

_____

_____

Have you had a Prior Sleep Study?_____
When and what setting are you on._____
How long has it been a problem? _____

Please Circle One:

Do you now have or have you ever had:	
High blood pressure?	Yes / No
Stroke?	Yes / No
Coronary Artery Disease	Yes / No
Other Heart problems?	Yes / No
Sinus Problems?	Yes / No
Tonsillectomy?	Yes / No
Nasal fracture?	Yes / No
Nasal surgery?	Yes / No
Diabetes Mellitus?	Yes / No

List all other medical problems:	**How long?**
1. _____	_____
2. _____	_____
3. _____	_____

List all medications:

_____ _____

_____ _____

Medication allergies:

_____

List all surgeries: **Year:**

_____ _____

_____ _____

_____ _____

ANSWER THE FOLLOWING QUESTIONS ON A SCALE FROM 0 TO 4

0= Not at all 2= Moderate 4=Very great

Please Circle A Number:

1. How great a problem do you have with sleepiness? (Feeling sleepy, struggling to stay awake during the daytime)?	0 1 2 3 4
2. How great a problem do you have with fatigue? (Tiredness, exhaustion, lethargy, even when you are not sleepy)?	0 1 2 3 4
3. How much trouble do you have falling asleep at night?	0 1 2 3 4
4. Do you snore?	0 1 2 3 4
5. Has your snoring worsened recently?	Y N
6. Do you hold your breath or stop breathing in your sleep?	0 1 2 3 4
7. Do you have gas, indigestion, or heartburn at night?	0 1 2 3 4
8. Do you have night sweats?	0 1 2 3 4
9. Do you wake up with a headache in the morning?	0 1 2 3 4
10. Do you wake up with a dry mouth?	0 1 2 3 4
11. Do you have trouble breathing through your nose?	0 1 2 3 4
12. How many times a night do you wake up to urinate?	0 1 2 3 4
13. Do you have difficulty breathing while lying down flat?	0 1 2 3 4
14. Do you have shortness of breath with exertion?	0 1 2 3 4
15. When you are sleeping, how often do you snort, gasp or wake up choking?	0 1 2 3 4
16. Are you a mouth breather?	0 1 2 3 4
17. Do you drink alcohol at night before bedtime?	0 1 2 3 4
18. Do you grind your teeth at night?	0 1 2 3 4
19. When you awaken from sleep, do you ever feel paralyzed, unable to move even though you are awake?	0 1 2 3 4
20. When someone startles you or makes you laugh, do you get weak, fall, or do your knees buckle?	0 1 2 3 4
21. While in the process of falling asleep, do you have vivid dreams or hallucinations? (Not all night long)	0 1 2 3 4
22. Do you have frequent uncontrollable bouts of sleep, sleep attacks, an irresistible urge to sleep?	0 1 2 3 4
23. Do you wake up gasping or short of breath?	0 1 2 3 4
24. Do your legs kick or twitch frequently during the night?	0 1 2 3 4
25. Do you have restless legs (crawling, itching or aching, an inability to keep your legs still)?	0 1 2 3 4
26. Do you have problems with memory or concentration?	0 1 2 3 4
27. Problems with impotence or lack of sexual interest?	0 1 2 3 4
28. Are you irritable?	0 1 2 3 4
29. Do you feel depressed?	0 1 2 3 4
30. Do you feel anxious?	0 1 2 3 4

31. Is your leg discomfort at night relieved by activity?	0 1 2 3 4
32. Do you have to fight sleep while driving?	0 1 2 3 4
33. Have you ever had a car wreck caused by sleepiness?	0 1 2 3 4
34. Do you wake up with headaches?	0 1 2 3 4
35. Are you refreshed when you get a full night of sleep?	Y N
36. Have you caused injury to yourself or others while sleeping?	0 1 2 3 4
37. Do you move in your sleep?	0 1 2 3 4
38. Do you have unusual movement while sleeping?	0 1 2 3 4
39. Do you sleep walk?	0 1 2 3 4
40. Do you talk when you sleep?	0 1 2 3 4
41. Do you wake up earlier than you would like?	0 1 2 3 4
42. Do you have nightmares on a regular basis?	0 1 2 3 4
43. Do you have trouble doing your job because of sleepiness or fatigue?	0 1 2 3 4

SLEEP HISTORY:

Usual bedtime on weekdays / workdays:	_____
Usual length of time to fall asleep:	_____
Usual wake up time:	_____
Average number awakenings in the night:	_____
Why do you wake up at night (pain, bathroom, hotflashes, etc)	_____
Average total sleep time:	_____
Do you feel refreshed or restored in the morning?	Yes / No
Do you nap during the day?	Yes / No
If yes, number of naps:	_____
Duration of naps:	_____
Are naps refreshing?	Yes / No
Usual bedtime on weekends / days off:	_____
Usual wake up time:	_____

Total sleep time per 24-hour day off:

_____How many hours of sleep do you need to feel rested?

_____

Are you refreshed if you get a full night of sleep? _____

SLEEP ENVIRONMENT:

Do you read in bed?	Yes / No
Do you watch television in bed?	Yes / No
Do you share the bed with anyone?	Yes / No
Does your bed partner have a sleep disorder?	Yes / No
Do you have pets in the bedroom?	Yes / No
What is the temperature in your bedroom?	_____
Do you sleep with the light on?	_____
Do you sleep with the radio on?	_____

SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired or fatigued? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to imagine how they would affect you. Use the following scale to choose the most appropriate number in 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**
Sitting and reading	0 1 2 3
Watching T.V.	0 1 2 3
Sitting, inactive in a public place (theatre, meeting, classroom)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down for a rest in the afternoon when circumstances permit	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after a lunch without alcohol	0 1 2 3
In a car, while stopped for a few minutes in traffic	0 1 2 3

SOCIAL HISTORY:

Have you ever smoked? Yes / No
If yes, for how many years? _____
Average number of packs per day? _____
Have you quit smoking? _____
How long ago? _____
What is your present occupation? _____
What are your work hours? _____
Do you drink caffeinated beverages? (coffee, tea, soda) _____
If yes, how much per day? _____
Do you drink alcoholic beverages? _____
If yes, how much per day? _____
Do you get regular exercise? How often? _____
Do you have any unusual eating habits? _____

FAMILY HISTORY:

Marital Status: Single Married Divorced Separated Widowed

Children: Number _____ Ages: _____ Health: _____

Mother: Living: Yes/No Age: _____ Health: _____

Father: Living: Yes/No Age: _____ Health: _____

Brothers: Ages: _____ Health: _____

Sisters: Ages: _____ Health: _____

Do any members of your family have sleep problems? If so, please describe:

_____
_____
_____

Now that you have completed our questionnaire, do you have any other comments you would like to add?

_____
_____
_____

I have reviewed:_____ Date:_____