CRITICAL CARE & PULMONARY CONSULTANTS, P.C.

SLEEP QUESTIONNAIRE

Patient's Name: _____ Age: _____

Referring Doctor: _____ DOB: _____

Primary Provider: _____ Pts. Ht: _____ Wt: _____

Describe in detail what your sleep problem is:

How long has it been a problem?

Do you currently have or have you ever had: ***Select Yes/No:***	**YES**	**NO**
High blood pressure		
Sinus problems		
Heart Problems		
Stroke		
Tonsillectomy		
Nasal Surgery		
Surgery for Sleep Apnea		

List all other medical problems:		**How long?**
1.		
2.		
3.		
4.		
5.		

List all medications:	
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medication allergies:

List all surgeries:	Year:
1.	
2.	
3.	

Social History:	Answer:
Do you drink caffeinated beverages? (coffee, tea, soda)	
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 ☐

Siblings: Number _____ Ages: _____ Health: _____

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

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

ANSWER THE FOLLOWING QUESTIONS ON A SCALE FROM 0 TO 4

Please select a number: **0= Not at all 2= Moderate 4=Very great**	**0**	**1**	**2**	**3**	**4**
Difficulty falling asleep?					
Difficulty staying asleep?					
Problems waking up too early?					
Are you satisfied with your current sleep pattern?					
How worried/concerned are you about your current sleep?					
How noticeable to others is your sleep problem—					
interfering with your quality of life?					
Does your sleep problem interfere with daily functioning?					
Do you wake up refreshed?					
Do you snore?					
Is your snoring loud? YES/NO					
Have others notice you stop breathing during sleep?					
Are you tired or fatigued after sleep?					
Do you wake up with a headache in the morning?					
Do you have difficulty breathing while lying down flat?					
When you are sleeping, do you snort, gasp or wake up choking?					
When someone startles you or makes you laugh, do you get weak, fall, or do your knees buckle?					
While in the process of falling asleep, do you have vivid dreams or hallucinations? (Not all night long)					
Do you have frequent uncontrollable bouts of sleep, sleep attacks? an irresistible urge to sleep during the day. YES/NO					

MOVEMENTS DURING SLEEP **Please select a number:** 0=Not at All 2=Moderate 4=Very Great	0	1	2	3	4
When you awaken from sleep, do you ever feel paralyzed, unable to move even though you are awake?					
Do you have unusual movement while sleeping?					
Do you sleepwalk?					
Do you talk when you sleep?					
Have you caused injury to yourself or others while sleeping?					
Do you have restless legs (crawling, itching or aching, an inability to keep your legs still)?					
Do you have problems with memory or concentration?					
Do you feel depressed?					
Do you feel anxious?					
Do you grind your teeth at night?					
Do you have nightmares?					

SLEEP DURATION HISTORY	**DURATION**
Usual bedtime on weekdays / workdays:	
Usual length of time to fall asleep:	
Usual wake up time WEEKDAY/WEEKEND:	
Average number awakenings in the night:	
Why do you wake up at night (pain, bathroom? hot flashes)	
Average time asleep in 24 hours:	

NAPS	**YES**	**NO**
Do you nap during the day?		
Duration of naps:		
Are naps refreshing?		

NAPS	YES	NO
Total sleep time per 24-hour day off:		
How many hours of sleep do you need to feel rested?		

SLEEP ENVIRONMENT	YES	NO
Do you read in bed?		
Do you watch television, have radio on or lights on when trying to sleep?		
Do you share the bed with anyone?		
Does your bed partner have a sleep disorder?		
Do you have pets in the bedroom?		
Do you drink alcohol in the evening?		

EPWORTH 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	0	1	2	3
Sitting and reading				
Watching T.V.				
Sitting, inactive in a public place (theatre, meeting, classroom) As a passenger in a car for an hour without a break				
Lying down for a 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				