Heart & Lung Associates, P.C.

Sleep Disorder Center

PATIENT SCREENING QUESTIONNAIRE

Do you go to bed at a regular time every night? Yes ___ No___ What time? _____
Do you wake up at a regular time every day? Yes ___ No___ What time? _____
On the average, how many hours do you sleep each night? _____
How long does it normally take for you to fall asleep after bedtime? _____
While in bed, do you read? Yes___ No ___ and/or watch TV? Yes ___ No ___
Do you take naps? Yes___ No___ If so, what times? _____ for how long? _____
Do you smoke? Yes ___ No ___ How much? _____ How long? _____
Do you drink alcohol? Yes ___ No ___ What/how much/how often/time of day? _____
Do you use caffeine? Yes ___ No ___ What/how much/how often/time of day? _____
Has anyone observed you snoring? Yes ___ No ___ Not Sure ____
If yes, do you snore every night? Yes ___ No ___ Not Sure ____
On a scale of 1-10, 10 being the loudest, how loud do you snore?
Has anyone observed you having pauses in your breathing at night? Yes ___ No ___
How long do these pauses last? _____ How long has this occurred? _____
Do you have daytime sleepiness? Yes ___ No ___and/or fatigue? Yes ___ No ___
Do you have leg jerks at night? Yes ___ No ___
Do have morning headaches? Yes ___ No ___
Do have shortness of breath at night? Yes ___ No ___
Do have night sweats? Yes ___ No ___
Do you wake with a sore throat Y/N Dry mouth Y/N Nasal congestion Y/N
Has your bed partner been forced into another room because of your snoring? Yes ___ No ___
Have you experienced impotence or decreased libido? Yes ___ No ___
Do you have difficulty driving due to your sleepiness? Yes ___ No ___

BRING THIS QUESTIONNAIRE TO YOUR DOCTOR OR SLEEP SPECIALIST TO UNDERSTAND IF YOU ARE AT RISK FOR A SLEEP DISORDER

Patient Name_____

Have you ever fallen asleep while driving? Yes ___ No ___ How many times? _____
Is your weight stable? Yes ___ No ___
Have you gained weight ___ or lost weight ___? # of pounds ____ Over what course of time? ____
Do you wet the bed (enuresis)? Yes ___ No ___
Do you have difficulty falling or staying asleep? Please specify. _____
_____
Does chronic pain interfere with your sleep? Yes ___ No ___ On a scale of **1-10**, 10 being most severe, rate your pain: _____ **Why** do you have pain? _____
_____
Do you have difficulty sleeping away from home? Yes ___ No ___
Do you have hallucinations while falling asleep or upon awakening? Yes ___ No ___
Do you ever have sudden unexplained, involuntary or inappropriate sleep attacks? Yes ___ No__
Do you dream during these attacks? Yes ___ No ___
Do you have total body paralysis while falling asleep or upon awakening? Yes ___ No ___
Do you have severe muscular weakness elicited by strong emotions (cataplexy)? Yes ___ No ___
Has your nose ever been broken? Yes ___ No ___ How and when? _____
Do you have a deviated septum? Yes ___ No ___
Have your Tonsils been removed? Yes ___ No ___ Have your Adenoids been removed? Yes ___ No ___
Have you had surgery to remove the uvula (UPPP)? Yes ___ No ___
Have you had any other nasal or throat surgery? Yes ___ No ___ Explain _____
Do you have Gastroesophageal Reflux Disorder (GERD) Y/N Hypertension (High Blood Pressure) Y/N
Chronic Obstructive Pulmonary Disease Y/N Asthma Y/N Diabetes Y/N Depression Y/N
Do you have any additional comments or observations? _____
_____
Do you have any drug allergies? _____

EPWORTH SLEEPINESS SCALE:

How likely are you to doze off or fall asleep in the following situations: (circle one)
Scale: 0 = would never doze 1 = slight chance 2 = moderate chance 3 = high chance

SITUATIONS	**SCALE**
Sitting and talking to someone	0 1 2 3
Sitting inactive in a public place	0 1 2 3
Sitting quietly after lunch without alcohol	0 1 2 3
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
In a car while stopped in traffic	0 1 2 3
As a passenger in a car	0 1 2 3

Patient Name_____

Severity of Daytime Sleepiness Scale

Mild: Unwanted sleepiness or involuntary sleep episodes occur during activities that require little attention. Examples include sleepiness that is likely to occur while watching television, reading, or traveling as a passenger. Symptoms produce only minor impairment of social or occupational function.

Moderate: Unwanted sleepiness or involuntary sleep episodes occur during activities that require some attention. Examples include uncontrollable sleepiness that is likely to occur while attending activities such as concerts, meetings, or presentations. Symptoms produce moderate impairment of social or occupational function.

Severe: Unwanted sleepiness or involuntary sleep episodes occur during activities that require more active attention. Examples include uncontrollable sleepiness while eating, during conversation, walking, or driving. Symptoms produce marked impairment in social or occupational function.

Is your level of sleepiness: None ___ Mild ___ Moderate ___ Severe ___ ?
(Refer to Sleepiness Scale above.)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING BELOW
OR PROVIDE A LIST THAT CAN BE COPIED.
INCLUDE NON-PRESCRIPTION DURGS AND/OR VITAMINS.

Name of Medication	Dose - mg/day and time of day you take it	For how long have you taken this medication?	Reason you are taking this medication.

Date: _____ B/P: _____ Pulse: _____ SaO_2: _____

_____ _____
Sleep Physician - Signature Date

Sleep Questionnaire

Problems with sleep are very common and can contribute to your daytime fatigue. Please answer the following questions about your sleep.

Name: _____ Date: _____

Sleep Habits

1 How much sleep do you usually get each night? _____

2 What time do you usually go to bed? _____

3 What time do you usually wake up? _____

4 How long does it usually take you to fall asleep? _____

5 How often do you usually wake up at night? _____

6 Why do you awaken at night? (check off all that apply)

___ I don't know
___ I'm worried about something
___ Children or other family members awaken me
___ I need to urinate
___ I have muscle spasms
___ I experience pain (other than spasms)
___ Other (please describe)

_____
_____

7 Have you ever had severe inability to sleep (insomnia)? ___ Yes ___ No ___Don't Know
Do you feel excessively sleepy during the day?..... ___ Yes ___ No ___ Don't Know
Do you fall asleep even though you're trying not to?..... ___ Yes ___ No ___Don't Know
Do you usually feel refreshed after a typical night of sleep? ___Yes ___No ___Don't Know
Do you have headaches when you awaken in the morning? ___Yes ___No ___Don't Know
Do you snore?..... ___ Yes ___ No ___ Don't Know
Do you thrash about in your sleep?..... ___ Yes ___ No ___ Don't Know
Do you frequently drink alcohol in the evening..... ___ Yes ___ No
Do you drink any caffeinated beverages in the evening?. ___ Yes ___ No
Do you nap during the day?..... ___ Yes ___ No ___ Unable
How many naps do you usually nap?..... _____
How long do you usually nap?..... _____

Do you feel rested after daytime naps?..... ___ Yes ___ No ___ Sometimes