PATIENT SLEEP QUESTIONNAIRE

Rev. 2/28/2002

Sleep Services of America

Name: _____
Last First Middle

Address: _____
Street City State Zip

Home phone #: _____ Work phone #: _____

Date of Birth: ____/____/____ Sex: ❑ Female ❑ Male Age: _____ Height: _____ Weight: _____

Race: ❑ African-American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Native American ❑ Other _____

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Occupation_____ My normal work hours are: _____

Has there been any recent weight gain or weight loss? ❑ Yes ❑ No If yes, ❑ A gain of/ ❑ A loss of ____Lbs.

Health Care Professional who referred you to us for your sleep testing. (Doctor/ Physician's Assistant) and their specialty:_____

Medical History: ❑ High Blood Pressure ❑ Bypass surgery ❑ Heart Attack ❑ Congestive Heart Failure

❑ Asthma ❑ COPD (emphysema, bronchitis) ❑ Hiatal hernia ❑ Reflux ❑ Stroke ❑ Diabetes

❑ Thyroid Disease ❑ Tonsillectomy/ Adenoidectomy ❑Other (please comment) _____

Have you had any recent surgeries? Please list: _____

The following questions will help us understand more about you. These questions will also help the physician when they look at your sleep study. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months. Do not leave any question unanswered. You may add comments to any of your answers in the margin beside the question. **ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.**

Here's how to answer the questions using our number scale:

1 = *rarely or never* 2 = *sometimes* 3 = *often* 4 = *frequently* 5 = *always*

If your answer to any question is "no" please circle "no".

Your main complaint(s) is (are): ❑ Snoring ❑ My breathing stops ❑ I'm sleepy ❑ I talk or walk in my sleep
❑ I can't fall asleep ❑ Other (please comment)_____

How long have you had this problem? ❑ About _____ Months ❑ About _____Years

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

On average, how many times do you wake up during the night? _____ times. How long are you awake?_____

No matter how much sleep I get I wake up feeling tired.	No	1	2	3	4	5
Do you feel sleepy late at night, then receive less sleep due to a necessary early wake up time?	No	1	2	3	4	5
If you were able to sleep longer would you feel rested?	No	1	2	3	4	5
Do you have a problem with your performance at work because you're sleepy or tired?	No	1	2	3	4	5
Because of my poor sleep at night I feel fatigued or "washed out" during the day.	No	1	2	3	4	5
Have you fallen asleep at work?	No	1	2	3	4	5
Have you fallen asleep while driving?	No	1	2	3	4	5
Do you snore?	No	1	2	3	4	5
Does your snoring disturb others?	No	1	2	3	4	5
Do you hold your breath or gasp for air in your sleep?	No	1	2	3	4	5

1 = *rarely or never*	**2 = *sometimes***	**3 = *often***	**4 = *frequently***		**5 = *always***
I have trouble breathing a night.	No	1	2	3	4	5
I have asthma attacks during sleep.	No	1	2	3	4	5
I sweat excessively during the night.	No	1	2	3	4	5
I wake up in the morning with a headache.	No	1	2	3	4	5
I wake up with a sour/ bitter taste in my mouth or burning in my chest.	No	1	2	3	4	5
I have a problem falling asleep at night.	No	1	2	3	4	5
I awaken because of aches, pains and headaches.	No	1	2	3	4	5
Do you have trouble going back to sleep if you wake up during the night?	No	1	2	3	4	5
There are times when I must not fall asleep and I cannot stop myself.	No	1	2	3	4	5
I tend to fall asleep when not trying to, or in a place other than my bedroom.	No	1	2	3	4	5
I wake up absolutely unable to move.	No	1	2	3	4	5
I have muscle weakness or have fallen down due to emotional stress or laughter	No	1	2	3	4	5
I have a crawling, creeping feeling, or desire to move my legs which keeps me from falling asleep.	No	1	2	3	4	5
My legs seem to kick constantly during sleep.	No	1	2	3	4	5
I get frequent leg cramps	No	1	2	3	4	5
According to your bedpartner have you ever seemed to be acting out a dream while asleep?	No	1	2	3	4	5
According to your bedpartner, have you ever woke screaming in fear and acting agitated?	No	1	2	3	4	5
Do you now, or did you as a child, wet the bed?	No	1	2	3	4	5
Have you been a sleepwalker as an adult?	No	1	2	3	4	5
Do you now, or have you ever had seizures in your sleep?	No	1	2	3	4	5
Do you, or have you been told that you grind your teeth during the night?	No	1	2	3	4	5

Do you wear dentures? ❑Yes ❑ No

Have you ever had a sleep study before? ❑Yes ❑ No If yes, where? _____

Results of the study: _____

Do you have any relatives with sleep disorders? ❑Yes ❑No If yes, what? _____

Do you have significant stress in your life at the present time? ❑Yes ❑No If yes, please explain: _____

_____

Are you allergic to any medications that you are aware of? ❑Yes ❑No If yes, what? _____

PLEASE LIST YOUR MEDICATIONS, BOTH PRESCRIPTION AND OVER THE COUNTER

Medication	What For?	How Often?

PLEASE LIST YOUR INTAKE OF THE FOLLOWING *CAFFEINATED* BEVERAGES ONLY!!

Coffee		Per	Day	**Soda**		Per	Day	**Tea**		Per	Day
Beer		Per	Day	**Liquor**		Per	Day	**Chocolate**		Per	Day
Cigars		Per	Day	**Pipes**		Per	Day	**Cigarettes**		Per	Day

Sleep Services of America is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

THANK YOU FOR YOUR COOPERATION!