TidalHealth Peninsula Regional

Sleep Questionnaire

Please complete prior to your scheduled sleep study. Answer as completely as possible and bring it with you. This will help us to understand your sleep problems.

Date________ Name____

Home phone #_________________ Cell #_________________ Work #_________________

Address____

DOB______ SS#_______________ Gender____ Height______ Weight______ Neck Size_____

Emergency Contact & phone #____

Referring Physician_______________________ Primary Physician_______________________

Describe the symptoms that brought you here.______________________________________

(example: poor quality sleep, snoring, daytime sleepiness, etc.)

How long have these symptoms been a problem? _____________________________________

About Your Sleep

Weekday bedtime_______ rise time______ *Weekend* bedtime______ rise time______

How long does it normally take you to fall asleep? ______________

How many times do you awaken during the night? ______________

Are these awakenings associated with (circle all that apply): *Snoring* *Gasping/choking*

Need to urinate *Nightmares* *Leg discomfort* *Anxiety* *Pain*

How do you feel when you awaken in the AM? _______________________________________

How long before you get out of bed? _________

In the morning do you have (circle all that apply): *Headache* *Dry mouth* *Sore throat*

Do you nap during the day? **Y** **N** If yes, # days a week? _____ For how long? ______

While sleeping are you aware that you, or have you been told that you: (Circle all that apply)

Snore *Choke* *Stop breathing* *Jerk/move legs* *Are restless* *Perspire heavily*

Name____ Date________

Circle as appropriate:

Do you dream? *Usually* *Sometimes* *Rarely* *No*

Do you have nightmares? *Often* *Sometimes* *Rarely* *No*

Do you: *Grind your teeth* *Sleep talk* *Sleep walk* *Yell out*

Do you ever have VERY vivid dreams? *Often* *Sometimes* *Rarely* *No*

Have you ever had a feeling of paralysis while awake, particularly when laughing, excited, or surprised? **Y** **N** Describe____

Do you ever awaken with a feeling of paralysis? *Often* *Sometimes* *Rarely* *No*

In what position(s) do you normally sleep? ____

Have you ever had a sleep study? **Y** **N** *When*_________ *Where?*____________________

What were the results? ____

Have you ever used CPAP therapy? **Y** **N**

If yes, when_________ For how long?___________ Settings____________

Have you ever used oxygen at night? **Y** **N** *Explain*________________________________

____

Sleepiness & other problems (circle all that apply)

Do you awaken tired, regardless of how much sleep you've had? **Y** **N** **S***ometimes*

Do you have difficulty staying awake during the day, esp. during meetings or at your desk?

Y **N** **S**ometimes Do you feel your work is affected by your sleepiness? **Y** **N**

Have you ever dozed off while driving? **Y** **N** When?

Do you have trouble concentrating/with your memory? **Y** **N**

Are you more irritable than you used to be? **Y** **N** Do you ever feel depressed*?* **Y** **N**

Have you had: *Decreased sexual interest* *Erectile dysfunction*

Do have a feeling of restlessness in your legs or arms when resting,

falling asleep, or during the day? **Y** **N** *Describe*____________________________

Name____ Date________

Habits affecting sleep

How much caffeine do you consume on an average day? ______________________________

Do you use over the counter aids to stay awake? If so, describe. ________________________

Do you take any sleep aids? **Y** **N** Dosage/frequency_____________________________

Do you exercise? **Y** **N** Note type and time of day ________________________________

Do you use tobacco? (circle all that apply) **Y** **N** *Cigarettes (____ packs per day)*

Quit date______________ *Cigars (frequency)____________* *Other________________*

Do you use alcohol: **Y** **N** What/how much/how often?______________________________

Are you a shift worker? **Y** **N** Explain____

Distractions in sleep environment (children, neighbors, phone calls, snoring spouse, etc.)

____

Medical history

Have you gained or lost weight? *Gained* *Lost* How much?_____ Over how long?_________

Do you have a history of: (circle all that apply and explain below)

High blood pressure *Heart problems* *Chest pain* *Stroke* *Head injury* *Seizures*

Shortness of breath *Lung disease* *Diabetes* *Arthritis* *Fibromyalgia* *Nasal/sinus problems*

Kidney problems *Depression* *Other psychiatric problems (name)*____________________

*Explanations & other medical history*____

____

____

*Surgeries & dates-don't forget tonsils & adenoids*____________________________________

____

*Medications & dosages*____

____

Name____ Date_________

This **Epworth Sleepiness Scale** is used to help identify your level of daytime sleepiness. Use the following scale to choose the most appropriate number for 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	______
Watching TV	______
Sitting inactive in public	______
Car passenger for an hour	______
Lying down in the afternoon	______
Sitting and talking to someone	______
Sitting quietly after lunch (no alcohol)	______
Stopped for a few minutes in traffic	______
Total	______

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