Sleep Medicine Questionnaire

THE POLYCLINIC

Please bring this completed questionnaire with you to your sleep medicine appointment. Our sleep medicine staff strives to understand your sleep symptoms, which may be complex in nature. Thank you for taking the time to complete this documentation.

Your full name: ______________________ Date of your clinic visit: ____________

Date of birth: __________ Current age: __________ Are you right or left handed: __________

Name of physician who referred you to us: ______________________

Name of primary care physician (if different from above): ______________________

Name(s) of other health providers to whom our clinical information should be sent:

____

Please circle the main symptoms for which you seek help from our Sleep Clinic.

Snoring **Sleepiness** **Breathing pauses** **Restless legs** **Insomnia**

Other: ______________________

Have you been evaluated in a sleep clinic in the past? **YES** **NO**

If "yes," please complete this section and provide for us copies of any available previous written sleep study reports and evaluations.

If "no," please skip this section and go to "your breathing patterns during sleep."

If so, where and when? ______________________

Were you diagnosed with obstructive sleep apnea? **YES** **NO**

Please list any other diagnoses: ______________________

Have you been treated with a CPAP machine? **YES** **NO**

Are you still using CPAP? **YES** **NO**

If not, why not? ______________________

Pressure setting: __________ Your medical equipment company: ______________________

Have you had snoring or sleep apnea surgery? **YES** **NO**

If yes, list dates/location: ______________________

If still using CPAP, please answer the below questions in the context of your CPAP use.

Your Breathing Patterns During Sleep:

How loud is your snoring?

NO SNORING **MILD** **MODERATE** **LOUD** **VERY LOUD**

Can the snoring be heard in rooms outside your bedroom? **YES** **NO**

Does the snoring disturb the sleep of those around you? **YES** **NO**

Does the snoring force your bed partner to sleep elsewhere? **YES** **NO**

Has anyone ever told you that you have witnessed breathing pauses during sleep? **YES** **NO**

Has anyone told you that you sound like you're choking or gasping during sleep? **YES** **NO**

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If you have difficulties falling back to sleep once awakened, please indicate roughly how long it may take for you to fall back to sleep:

YOUR TYPICAL SLEEP SCHEDULE:

What time do you typically go to bed on weekdays? ___:___ a.m./p.m.
What is the earliest you go to bed on weekdays? ___:___ a.m./p.m.
What is the latest you go to bed on weekdays? ___:___ a.m./p.m.
How long does it take you to fall asleep? ____________

What time do you typically awaken on weekdays? ___:___ a.m./p.m.
What is the earliest you arise from bed on weekdays? ___:___ a.m./p.m.
What is the latest you arise from bed on weekdays? ___:___ a.m./p.m.
Do you use an alarm clock or wake up call? **YES** **NO**

What time do you typically go to bed on days off? ___:___ a.m./p.m.
What is the earliest you go to bed on days off? ___:___ a.m./p.m.
What is the latest you go to bed on days off? ___:___ a.m./p.m.
How long does it take you to fall asleep? ____________

What time do you typically awaken on days off? ___:___ a.m./p.m.
What is the earliest you arise from bed on days off? ___:___ a.m./p.m.
What is the latest you arise from bed on days off? ___:___ a.m./p.m.
Do you use an alarm clock or wake up call? **YES** **NO**

How many times do you **recall awakening** in the middle of the night, on average, for any reason? Feel free to give a range. ________ times per night

Checkmark which symptoms, if any, you have when you awaken in the middle of the night *(please check all that apply)*:

	Snoring or snorting		Pain, discomfort		Bedroom noise		**Other:**
	Nightmares		Worry		Thirst/hunger		Bedpartner/kids/pets
	Leg kicking		Headache		Heartburn		Choking/gasping

How many times per night do you awaken at night due to a full bladder? ____________________

Do you nap intentionally? **YES** **NO**

If yes, how many days per week, on average? ____________
What time of day? ____________
How long are naps? ____________

If you have insomnia, please answer these 2 questions:

How many hours do you estimate you spend awake in bed per night? ____________
How many hours do you spend asleep, total, per night? ____________
Have you ever taken any medications (prescription or over-the-counter) to **help you sleep**? **YES** **NO**
Is so, please list all medications to help you sleep, when taken, and general effectiveness:

____

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YOUR PAST MEDICAL HISTORY:

Current weight __________ Weight two years ago __________ Weight, age 18 ___________

Height __________________ Collar size (men) ______________

Occupation (brief description): ___________________________________

Sleep History	YES	NO
Parasomnias:		
Sleep walking, nightmares or REM behavior disorders		
Vivid dreams		
Sleep talking		

Motor	YES	NO
RLS symptoms or kicking at night		

Narcolepsy Symptoms	YES	NO
Hallucinations, paralysis or cataplexy symptoms		
Nocturia		

Past Medical History	YES	NO
Psychiatric:		
Panic		
Anxiety		
Depression		
Nasal/Oral trauma		
Tonsilectomy		
Adenoidectomy		
GERD		
Chest pain		
Shortness of breath		
Seasonal allergies		
Dry skin		
Claustrophobia		
New enviroments		

How many pillows do you normally sleep on? ____________________

Family History	YES	NO
Snoring		
Sleep Apnea		

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Have you had any of the following medical conditions? (check appropriate boxes)

	Heart
	Heart attack
	Palpitations
	History of angina
	Atrial fibrillation
	Other arrhythmia
	Swelling of feet
	High blood pressure
	Heart failure
	Lung
	Shortness of breath
	Cough
	Emphysema
	Chronic bronchitis
	Asthma
	Eyes
	Visual changes
	Eye pain

	Gastrointestinal
	Stomach ulcers
	Reflux disease
	Liver disease
	Colitis
	Abdominal pain
	Heartburn
	Neurological
	Headaches
	Memory loss
	Parkinson's disease
	Stroke
	Seizure
	Spinal cord injury
	Head injury
	Tonsillectomy
	Kidney
	Kidney failure

	Ear / Nose / Throat
	Chronic sinusitis
	Seasonal allergy
	Nasal surgery
	Tonsillectomy
	TMJ pain or clicking
	Nasal congestion
	Nasal drainage
	Musculoskeletal
	Fibromyalgia
	Rheumatoid arthritis
	Osteoarthritis
	Spine/back surgery
	Joint pain swelling
	Muscle pain
	Back pain

	Endocrine
	Heat/cold intolerance
	Hot flashes
	Diabetes
	Thyroid disease
	Psychiatric
	Anxiety/Nervousness
	Depression/Sadness
	Alcoholism
	Other
	Cancer (what kind?)
	Anemia
	High cholesterol
	Major trauma
	Chronic fatigue syndrome
	Sexual difficulty
	Urological
	Enlarged prostate
	Bedwetting
	Nocturia

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP (NOT JUST FEEL TIRED) IN THE FOLLOWING SITUATIONS?

	No Chance	Rare Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (like a theater or a meeting)	0	1	2	3
Riding as a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3
At the dinner table	0	1	2	3
While driving	0	1	2	3

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MODIFIED F.O.S.Q

1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

2. Do you generally have difficulty remembering things because you are sleepy or tired?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

3. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

4. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

5. Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

6. Has your relationship with family, friends, or work colleagues been affected because you are sleepy or tired?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

7. Do you have difficulty watching a movie or video because you become sleepy or tired?
1.Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4.No**

8. Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

9. Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

10. Has your mood been affected because you are sleepy or tired?
1. Yes, extreme **2. Yes, moderate** **3. Yes, a little** **4. No**

Score: ___________ **Patient Name:** Last, First____

DOB: ____________ **MRN:** ______________ **Today's Date:** _______________

Thank you again for taking the time to fill out this document. Doing so will make your clinic visit with your doctor more efficient. Feel free to use the space below to write down other issues you might have regarding your sleep. Also, you may ask your bed partner to write additional comments here as well.