SLEEP DISORDERS CENTER
SLEEP CLINIC PATIENT QUESTIONNAIRE

Please bring this completed questionnaire with you to your sleep clinic appointment.

Patient's Name:_____ Date:_____

Referring Physician: _____ Clinic Location:_____

Primary Care Provider: _____ Clinic Location:_____

1. Why are you being seen in the sleep clinic? _____
   _____
2. Have you been evaluated in a sleep clinic previously? ☐ YES ☐ NO
3. If so, please list clinic, dates, and diagnoses: _____
   _____
4. List dates and locations of prior polysomnograms *(Sleep Studies)*: _____
   _____
   If you previously had polysomnograms (Sleep Studies), please bring them with you to your appointment. Contact the Sleep Disorders Office if you need assistance obtaining the studies.
5. Have you previously been diagnosed with sleep apnea? ☐ YES ☐ NO
   a) If so, have you been treated with CPAP? ☐ YES ☐ NO
   b) Pressure settings, if known: _____
6. Have you had surgery for either snoring or sleep apnea? ☐ YES ☐ NO
   a) If yes, list type/dates/location: _____

I. TYPICAL SLEEP HABITS

1. What time do you typically go to bed on weekdays? ___:___ am/pm
2. How long does it take you to fall asleep? _____*(hours/min)*
3. What time do you typically awaken on weekdays? ___:___ am/pm
   a. Do you use an alarm clock/wake up call? ☐ YES ☐ NO
   b. Do you feel refreshed upon awakening? ☐ YES ☐ NO
4. What time do you typically go to bed on the weekend/days off? ___:___ am/pm
5. How long does it take you to fall asleep? _____*(hours/min)*
6. What time do you awaken on the weekend/days off? ___:___ am/pm
   a. Do you use an alarm clock/wake up call? ☐ YES ☐ NO
   b. Do you feel refreshed upon awakening? ☐ YES ☐ NO
7. How many times do you awaken on a typical night? _____
8. Do you have difficulty returning back to sleep? ☐ YES ☐ NO
9. Check typical causes for awakening at night:

☐ Snoring	☐ Pain	☐ Full bladder	☐ Noise
☐ Nightmares	☐ Worry	☐ Thirst/hunger	☐ Bed partner/kids/pets
☐ Night sweats	☐ Headache	☐ Heartburn	☐ Choking/gasping

☐ Please list other causes: _____

10. Do you nap intentionally? ☐ YES ☐ NO
    a) If yes, how many days per week? _____
    b) What time of day? _____
    c) How long are naps? _____
    d) Do you feel refreshed upon awakening from the nap? ☐ YES ☐ NO

How often do you or others notice the following? *(Please Circle)*:

	Almost never	Rarely *(once a month)*	Some *(once a week)*	Often *(2-4 times a week)*	Almost Always
1. Snoring	0	1	2	3	4
2. Breathing pauses when you sleep	0	1	2	3	4
3. Wake up choking or gasping from sleep	0	1	2	3	4
4. Wake up with shortness of breath	0	1	2	3	4
5. Wake up with dry mouth	0	1	2	3	4
6. Wake up with sore throat	0	1	2	3	4
7. Nasal/sinus congestion	0	1	2	3	4
8. Morning headaches	0	1	2	3	4
9. Wake to urinate 2 or more times per night	0	1	2	3	4
10. Heartburn interfering with sleep	0	1	2	3	4
11. Problems with fainting?	0	1	2	3	4
12. Light headed when standing?	0	1	2	3	4
13. Cold extremities?	0	1	2	3	4
14. Grind teeth while sleeping	0	1	2	3	4
15. Nightmares	0	1	2	3	4
16. Sleep walking	0	1	2	3	4
17. Sleep talking	0	1	2	3	4
18. Acting out dreams	0	1	2	3	4
19. Restlessness or discomfort in the legs If yes, is this worse at night? Y N If yes, is this relieved by movement? Y N	0	1	2	3	4
20. Kicking/jerking of legs while sleeping	0	1	2	3	4
21. Hallucinations when falling asleep or upon awakening	0	1	2	3	4
22. Momentary complete paralysis when falling asleep or upon awakening	0	1	2	3	4
23. **While awake,** do you have episodes of muscle weakness brought on by strong emotion	0	1	2	3	4

	None					"Earth Shattering"
24. How would you rank the intensity of your snoring on a scale of 0 to 5?	0	1	2	3	4	5

PLACE PATIENT LABEL HERE

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to circle the most appropriate response for each situation.

How likely are you to doze off or fall asleep *(not just feel tired)* **in the following situations?**

(Please Circle)

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

How often do you experience each of the following?

(Please Circle)

	Almost Never	Rarely *(once a month)*	Some *(once a week)*	Often *(2-4 times a week)*	Almost Always
1. I have trouble falling asleep	0	1	2	3	4
2. I wake up during the night and have difficulty getting back to sleep	0	1	2	3	4
3. I have frequent awakenings at night but **no** difficulty returning to sleep	0	1	2	3	4
4. I wake up too early in the morning and am unable to get back to sleep	0	1	2	3	4
5. I have difficulty waking in the morning	0	1	2	3	4
6. I do not get enough sleep	0	1	2	3	4
7. I am sleepy during the day	0	1	2	3	4
8. Daytime fatigue is a problem for me	0	1	2	3	4

II. REVIEW OF SYSTEMS *Check all boxes that apply to you:*

NEUROLOGICAL	GASTROINTESTINAL	EAR/NOSE/THROAT
☐ Headaches	☐ Difficulty swallowing	☐ Hearing loss
☐ Dizzy spells	☐ Nausea or vomiting	☐ Ear aches
☐ Seizures	☐ Diarrhea	☐ Sinus pain
☐ Fainting	☐ Constipation	☐ TMJ pain or clicking
☐ Memory loss	☐ Bloody or black stools	☐ Nasal congestion
☐ Numbness/tingling	☐ Abdominal pain	☐ Nasal drainage
☐ Weakness	☐ Heartburn	☐ Nasal polyps
HEART	☐ Vomiting blood	☐ Nose bleeds
☐ Chest pain	**MUSCULOSKELETAL/SKIN**	☐ Mouth sores
☐ Palpitations	☐ Joint pain/swelling	☐ Hoarseness
☐ Swelling of feet	☐ Muscle pain	**EYES**
LUNG	☐ Back pain	☐ Visual changes
☐ Shortness of breath	☐ Neck pain	☐ Eye pain
☐ Coughing	☐ Rash	**ENDOCRINE**
☐ Coughing up blood	**ALLERGY/IMMUNOLOGY**	☐ Excessive thirst
☐ Wheezing	☐ Seasonal allergies	☐ Heat/cold intolerance
KIDNEY/BLADDER	☐ Eczema	☐ Hot flashes
☐ Urinate frequently	**GENERAL**	**BLOOD**
☐ Painful urination	☐ Fever	☐ Anemia
☐ Blood in urine	☐ Night sweats	☐ Easy bruising/bleeding
☐ Difficulty urinating	☐ Loss of appetite	**PSYCHIATRIC**
☐ Urinary incontinence	☐ Unexpected weight loss	☐ Anxiety/nervousness
☐ Sexual difficulty	☐ Weight gain	☐ Depression/ sadness
		☐ Irritability / moodiness

III. ALLERGIES

List all previous reactions to medications:

Medication	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	

IV. MEDICATIONS

List medications you currently take *(please include "over the counter", vitamins, and herbal remedies)*:

Medication	Dose	Times Per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Have you taken any medications *(prescription/over the counter)* to help you sleep? ☐ YES ☐ NO

If ***yes***, please list medication, dates taken and effectiveness:

Medication	Date taken	Effectiveness

V. PAST MEDICAL HISTORY

1. In general, would you say your health is: *(Please check)*
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
2. What is your current weight?_____ Height?_____ Collar size *(men)*?_____
   Weight one year ago?_____ At age 20?_____

3. Have you had any of the following medical conditions? *(Check appropriate boxes)*

HEART DISEASE
- ☐ Heart failure
- ☐ Heart attack
- ☐ Angina
- ☐ Atrial fibrillation
- ☐ Arrhythmia
- ☐ High blood pressure

GASTROINTESTINAL
- ☐ Liver disease
- ☐ Stomach ulcers
- ☐ Reflux disease
- ☐ Colitis

NEUROLOGY
- ☐ Stroke or TIA's
- ☐ Parkinson's disease
- ☐ Seizure
- ☐ Spinal cord injury
- ☐ Head injury

LUNG DISEASE
- ☐ COPD/Emphysema
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Pneumonia

MUSCULOSKELETAL
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Spine/back surgery

KIDNEY / BLADDER
- ☐ Kidney failure
- ☐ Enlarged prostate

EAR/NOSE / THROAT
- ☐ Chronic sinusitis
- ☐ Seasonal allergy
- ☐ Nasal surgery
- ☐ Tonsillectomy

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety
- ☐ Dementia
- ☐ Alcoholism

ENDOCRINE
- ☐ Diabetes:
- ☐ Thyroid disease

MISCELLANEOUS
- ☐ Cancer
  Type: _____
  Metastatic? ☐ YES ☐ NO
- ☐ Peripheral vascular disease
- ☐ HIV/AIDS
- ☐ Anemia
- ☐ Blood clots
- ☐ Major trauma_____
- ☐ Chronic fatigue syndrome
- ☐ Leukemia or lymphoma

1. Please describe *(with date and location)* any prior nasal, oral, throat, jaw, head or neck surgeries: _____
   _____
2. Please list any past surgeries or illnesses not mentioned above: _____
   _____
   _____

VI. SOCIAL HISTORY

Marriage Status:
- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Domestic partner

Children:
- ☐ None
- ☐ Yes, but not living with me
- ☐ Yes, living with me

Ages: _____

Work Status:
- ☐ Full time employment
- ☐ Part time employment
- ☐ Retired
- ☐ Unemployed
- ☐ Self-employed
- ☐ Disabled
- ☐ Student

PLACE PATIENT LABEL HERE

1. Occupation *(Brief description)*: _____
2. Does your partner sleep in the same room? ◯YES ◯NO ◯DOES NOT APPLY
3. How often do you drink alcoholic beverages?
   - ◯ Never
   - ◯ Less than once a month
   - ◯ Less than once a week
   - ◯ Less than one drink a day
   - ◯ 1-2 drinks a day
   - ◯ More than 2 drinks a day

4. Tobacco Use:
   - ◯ Never
   - ◯ Current Smoker: # Years of smoking: ____ Average # packs/day: _____
   - ◯ Never
   - ◯ Former Smoker: Quit date: _____ Approx # of years smoked: _____

   Average # packs/day: _____

5. Please list any past or current recreational drug use *(marijuana, cocaine, etc.)*:
   _____
6. How many caffeine-containing beverages do you consume on a typical day?
   a. Coffee_____ Tea_____ Coca-Cola/Mountain Dew _____
7. What time would you typically consume your last caffeinated drink? ___:___am/pm

VII. FAMILY HISTORY

1. Does anyone in your immediate family (parents, sibling or children) have the following medical conditions? *Please indicate **F** for father, **M** for mother, **S** for sibling and **C** for child*. Circle all that apply

SLEEP DISORDER	CANCER	PSYCHIATRIC
☐ Sleep apnea **F, M, S, C**	☐ Breast cancer **F, M, S, C**	☐ Anxiety/depression **F, M, S, C**
☐ Snoring **F, M, S, C**	☐ Colon cancer **F, M, S, C**	☐ Alcoholism **F, M, S, C**
☐ Narcolepsy **F, M, S, C**	☐ Prostate cancer **F, M, S, C**	**NEUROLOGY**
☐ Restless legs syndrome **F, M, S, C**	☐ Other: **F, M, S, C**	☐ Parkinson's Disease **F, M, S, C**
ENDOCRINE	**HEART DISEASE**	☐ Stroke **F, M, S, C**
☐ Diabetes **F, M, S, C**	☐ Arrhythmia **F, M, S, C**	☐ Seizure **F, M, S, C**
☐ Thyroid disease **F, M, S, C**	☐ Heart attack/angina **F, M, S, C**	**OTHER**
LUNG DISEASE	☐ High cholesterol **F, M, S, C**	☐ Liver disease **F, M, S, C**
☐ Emphysema **F, M, S, C**	☐ High blood pressure **F, M, S, C**	☐ Kidney failure **F, M, S, C**
☐ Asthma **F, M, S, C**	☐ Heart failure **F, M, S, C**	☐ Blood clots **F, M, S, C**

2. Other conditions not listed: _____
_____
_____

VIII. INSOMNIA

1. Do you have problems getting to sleep or staying asleep? ☐ YES ☐ NO
   a. If no, you may stop here.
   b. If yes, please continue answering the following questions:

2. Please rate the current, *(i.e. the last 2 weeks)* SEVERITY of your insomnia problem(s):

	None	Mild	Moderate	Severe	Very
1. Difficulty falling asleep	○ 0	○ 1	○ 2	○ 3	○ 4
2. Difficulty staying asleep	○ 0	○ 1	○ 2	○ 3	○ 4
3. Problem waking up too early	○ 0	○ 1	○ 2	○ 3	○ 4

	Very Satisfied				Very Dissatisfied
1. How SATISFIED or DISSATISFIED are you with your current sleeping pattern?	○ 0	○ 1	○ 2	○ 3	○ 4
	Not at all Interfering	**A Little**	**Somewhat**	**Much**	**Very Much Interfering**
2. To what extent do you consider your sleep problem to INTERFERE with your daily functioning? *(i.e., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)*	○ 0	○ 1	○ 2	○ 3	○ 4
	Not at all Noticeable	**Barely**	**Somewhat**	**Much**	**Very Noticeable**
3. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?	○ 0	○ 1	○ 2	○ 3	○ 4
	Not at all	**A Little**	**Somewhat**	**Much**	**Very Much**
4. How WORRIED or DISTRESSED are you about your current sleep problem?	○ 0	○ 1	○ 2	○ 3	○ 4

Thank you for taking the time to complete this questionnaire.

Patient Signature	Print Name	Date
Reviewers Signature	Print Name	Date

PLACE PATIENT LABEL HERE