Southwest Medical Group Sleep Department
Phone: (970)564-2678 Fax: (970)565-2487
Office Hours 8:00am-4:30pm Monday-Thursday

ACCREDITED FACILITY MEMBER

SLEEP QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____/_____/_____

Referring Physician: _____ Clinic Location: _____

Occupation *(Brief description)*: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed

Does your partner sleep in the same room? _____

Coffee: Amount _____ Within 2 hours of sleep _____

Tea: Amount _____ Within 2 hours of sleep _____

Energy Drinks: Amount _____ Within 2 hours of sleep _____

Soda: Amount _____ Within 2 hours of sleep _____

Smoker: □ No □ Never □ Quit, when _____ (i.e. 1995)
□ Yes Packs per day _____ Years _____ (i.e. 10 years)

Alcohol: □ No □ Yes

Beer_____ Wine_____ Liquor_____

Within 2 hours of Sleep_____

Why are you being seen in the sleep clinic? _____

Have you been evaluated in a sleep clinic previously? YES NO

If so, please list clinic, dates, and diagnoses: _____

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.

Have you previously been diagnosed with sleep apnea? YES NO

If so, have you been treated with CPAP? YES NO

Pressure settings, if known: _____

Have you had surgery for either snoring or sleep apnea? YES NO

If yes, list type/dates/location: _____

TYPICAL SLEEP HABITS

What time do you typically go to bed on weekdays? _____

How long does it take you to fall asleep? _____

What time do you typically awaken on weekdays? _____

Do you use an alarm clock/wakeup call? YES NO

Do you feel refreshed upon awakening? YES NO

What time do you typically go to bed on the weekend/days off?

How long does it take you to fall asleep?

What time do you awaken on the weekend/days off?

Do you use an alarm clock/wakeup call? YES NO

Do you feel refreshed upon awakening? YES NO

How many times do you awaken on a typical night?

Do you have difficulty returning back to sleep? YES NO

Check typical causes for awakening at night:

Snoring_____ Full Bladder_____ Noise_____ Nightmares_____ Worry_____

Thirst/hunger_____ Night sweats_____ Headache_____ Heartburn_____

Choking/gasping_____ Bed Partner/kids/pets____

Please list other causes: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired?
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 choose the most appropriate number for each situation.

0 = would never dose 1= slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

SITUATION	CHANCE OF DOZING			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g., a theater or meeting)	0	1	2	3
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

(redrawn from Johns, MW, Sleep 1991, 14.40)

Epworth Sleepiness Scale Score: _____/24

		YES	NO
S	**Snoring:** Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?		
T	**Tired:** Do you often feel tired, fatigued or sleepy during the daytime?		
O	**Observed:** Has anyone observed you stop breathing during your sleep?		
P	**Blood Pressure:** Do you have or are you being treated for high blood pressure?		
B	**BMI:** BMI more than 35kg/m^2		
A	**Age:** Age over 50 years		
N	**Neck Circumference:** Neck Circumference greater than 40cm (15.7 inches)		
G	**Gender**: Are you a male?		
	TOTAL YES:		

Anesthesiology2008; 108:812-2

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

NEUROLOGICAL
- ☐ Headaches Dizzy
- ☐ spells Seizures
- ☐ Fainting Memory loss
- ☐ Numbness/tingling
- ☐ Weakness

HEART
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling of feet

LUNG
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Wheezing

KIDNEY/BLADDER
- ☐ Urinate frequently
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Urinary incontinence
- ☐ Sexual difficulty

GASTROINTESTINAL
- ☐ Difficulty swallowing
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody or black stools
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Vomiting blood

MUSCULOSKELETAL/SKIN
- ☐ Joint pain/swelling
- ☐ Muscle pain
- ☐ Back pain
- ☐ Neck pain
- ☐ Rash

ALLERGY/IMMUNOLOGY
- ☐ Seasonal allergies
- ☐ Eczema

GENERAL
- ☐ Fever
- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Unexpected weight loss
- ☐ Weight gain

EAR/NOSE/THROAT
- ☐ Hearing loss Ear
- ☐ aches Sinus
- ☐ pain
- ☐ TMJ pain or clicking
- ☐ Nasal congestion
- ☐ Nasal drainage
- ☐ Nasal polyps
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Hoarseness

EYES
- ☐ Visual changes
- ☐ Eye pain

ENDOCRINE
- ☐ Excessive thirst
- ☐ Heat/cold intolerance
- ☐ Hot flashes

BLOOD
- ☐ Anemia
- ☐ Easy bruising/bleeding

PSYCHIATRIC
- ☐ Anxiety/nervousness
- ☐ Depression/ sadness
- ☐ Irritability / moodiness

FAMILY HISTORY

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
- ☐ Sleep apnea **F, M, S, C**
- ☐ Snoring **F, M, S, C**
- ☐ Narcolepsy **F, M, S, C**
- ☐ Restless legs syndrome **F, M, S, C**

ENDOCRINE
- ☐ Diabetes **F, M, S, C**
- ☐ Thyroid disease **F, M, S, C**

LUNG DISEASE
- ☐ Emphysema **F, M, S, C**
- ☐ Asthma **F, M, S, C**

CANCER
- ☐ Breast cancer **F, M, S, C**
- ☐ Colon cancer **F, M, S, C**
- ☐ Prostate cancer **F, M, S, C**
- ☐ Other: **F, M, S, C**

HEART DISEASE
- ☐ Arrhythmia **F, M, S, C**
- ☐ Heart attack/angina **F, M, S, C**
- ☐ High cholesterol **F, M, S, C**
- ☐ High blood pressure **F, M, S, C**
- ☐ Heart failure **F, M, S, C**

PSYCHIATRIC
- ☐ Anxiety/depression **F, M, S, C**
- ☐ Alcoholism **F, M, S, C**

NEUROLOGY
- ☐ Parkinson's Disease **F, M, S, C**
- ☐ Stroke **F, M, S, C**
- ☐ Seizure **F, M, S, C**

OTHER
- ☐ Liver disease **F, M, S, C**
- ☐ Kidney failure **F, M, S, C**
- ☐ Blood clots **F, M, S, C**

INSOMNIA

1. Do you have problems getting to sleep or staying asleep? YES NO
   - If no, you may stop here.
   - 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

MEDICATIONS

MEDICATION	**DOSEAGE** (MG, MCG, ETC)	**FREQUENCY** (Once a day, Twice a day, etc)	**TAKEN FOR:**

ALLERGIES

MEDICATION	**REACTION** (Rash, Shortness of Breath, etc)