PATIENT SLEEP QUESTIONNAIRE

Patient name: _____________________________  Referring physician: ____________________________
Height: _________________________________  Usual bedtime: ________________ AM PM
Weight: _________________________________  Usual rise time: ________________ AM PM
Neck circumference: ____________________

PAST SLEEP MEDICAL HISTORY

Why did your doctor ask you to have this test?

What is your expectation of what will be done during this test? Is this test for observation or will you be using a PAP or dental device?

Have you had a sleep evaluation before?  □ No □ Yes
If yes, when and where?

Have you been diagnosed with sleep apnea?  □ No □ Yes

Do you currently use a CPAP or BIPAP machine?  □ No □ Yes
If yes, where did you get your machine? What is your current pressure and settings?

Do you currently use a dental device for OSA?  □ No □ Yes
If yes, where did you get your device? What are your current settings?

Do you take medication to help you sleep?  □ No □ Yes
If yes, what?

Are you a shift worker?  □ No □ Yes
If yes, what hours do you normally work?

CURRENT MEDICATIONS

Please list all prescription and non-prescription drugs including vitamins and sleep aids

________________________________________
________________________________________
________________________________________
________________________________________
________________________________________

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CHECK ALL THAT APPLY:

- I feel sleepy during the daytime
- I have been told I snore
- I have been told I stop breathing in my sleep
- I wake up gasping or short of breath
- I wake up at night coughing
- I get up more than once to use the bathroom
- I sometimes awaken with headaches
- I am hoarse or have a sore throat in the morning
- I wake up in the morning feeling unrefreshed
- I breathe mainly through my mouth
- I have difficulty breathing through my nose
- I have gained more than 20 lbs over the last 2 years
- I have difficulty falling asleep
- I wake up during the night and can’t get back to sleep
- I wake up thrashing or hitting and have hurt myself or my partner
- I act out my dreams
- I sleep walk
- I sleep talk
- I sleep eat (eating while asleep)
- I do unusual things in my sleep (For example: _______________________________)
- I grind my teeth when I sleep
- I wear a mouth guard for teeth grinding
- Sometimes I feel uncomfortable sensations in my legs at night and feel like I just have to move them
- I have been told that I kick at night
- I have experienced vivid dream-like scenes upon falling asleep
- I have experienced vivid dream-like scenes upon waking up
- Sometimes I feel unable to move when I’m waking up or falling asleep
- When I’m angry, surprised, or laugh, I feel like I’m going limp or about to fall

PAST MEDICAL HISTORY (check all that apply)

- Heart disease
- Diabetes
- High blood pressure
- Pulmonary hypertension
- Stroke
- Parkinson’s
- Alzheimer’s disease
- ADHD
- ALS
- Depression
- Acid reflux / GERD
- Thyroid disease
- Cancer
- Emphysema / COPD / Lung disease
- Epilepsy / seizures
- Asthma
- Other__________________________

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Do you smoke?  □ No  □ Yes  If yes, list amount and how often:

Do you consume alcohol?  □ No  □ Yes  If yes, list amount and how often:

PAST SURGICAL HISTORY (check all that apply)

□ Bariatric surgery  Date: ___/___/_______
□ Tonsillectomy  Date: ___/___/_______
□ Sinus surgery  Date: ___/___/_______
□ Sleep apnea surgery  Date: ___/___/_______
□ Other_________________________  Date: ___/___/_______

THE EPWORTH SLEEPINESS SCALE
How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? 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 number for each situation.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Chance of dozing</th>
<th>Circumstance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = Would never doze</td>
<td>0 1 2 3</td>
<td>Sitting and reading</td>
</tr>
<tr>
<td>1 = Slight chance of dozing</td>
<td>0 1 2 3</td>
<td>Watching television</td>
</tr>
<tr>
<td>2 = Moderate chance of dozing</td>
<td>0 1 2 3</td>
<td>Sitting, inactive in a public place (ie: theater or a meeting)</td>
</tr>
<tr>
<td>3 = High chance of dozing</td>
<td>0 1 2 3</td>
<td>As a passenger in a car for an hour without a break</td>
</tr>
<tr>
<td></td>
<td>0 1 2 3</td>
<td>Lying down to rest in the afternoon when circumstances permit</td>
</tr>
<tr>
<td></td>
<td>0 1 2 3</td>
<td>Sitting and talking to someone</td>
</tr>
</tbody>
</table>

Total score:_____________

0 1 2 3  Sitting quietly after a lunch without alcohol
0 1 2 3  In a car, while stopped for a few minutes in traffic

ABOUT LAST NIGHT (BEFORE YOUR SLEEP STUDY)

What time did you go to bed last night? ____________________________  AM  PM (circle one)

How long did it take you to fall asleep? ____________________________

What time did you wake up today? ____________________________  AM  PM (circle one)
During the day today, did you:

Take any naps?  □ No  □ Yes
What time(s) and how long?  

Drink any caffeinated beverages? (coffee, tea, soda, energy drinks)  □ No  □ Yes
What, how much, and what time(s)?  

Drink any alcoholic beverages?  □ No  □ Yes
What, how much, and what time(s)?  

Take any medication?  □ No  □ Yes
What, how much, and what time(s)?  

AFTER YOUR SLEEP STUDY
How long did it take you to fall asleep last night?  

Did you wake up during the study?  □ No  □ Yes
If YES, how many times did you wake?
What awakened you?  

How long altogether were you awake during the night?  

How many hours of sleep do you feel you’ve obtained?  

How well did you sleep here compared to home?

Do you feel refreshed this morning?  □ No  □ Somewhat  □ Yes
Comments:  

POST-TREATMENT QUESTIONS
Rate your overall difficulty using CPAP last night  □ None  □ Minor  □ Moderate  □ Extreme
Was it difficult sleeping with CPAP?  □ No  □ Yes
Was the CPAP mask comfortable?  □ No  □ Yes
Was the pressure comfortable?  □ No  □ Yes
Did you have nasal congestion last night?  □ No  □ Yes
   If yes, did this cause difficulty using CPAP?  □ No  □ Yes
Do you feel refreshed this morning after using CPAP compared to your usual night without CPAP?
   □ No  □ Somewhat  □ Yes
Comments:  