PULMONARY & CRITICAL CARE CONSULTANTS OF AUSTIN
1305 West 34th Street, Suite 400, Austin, TX 78705
Phone: 512-459-6599 Fax: 512-459-8496

Sleep Questionnaire

Name: _____ Sex: _____ Age: _____ Date:_____

Date of Birth _____ Height_____ Weight _____ Neck size _____

Referring Physician: _____ Primary Care MD: _____

Main Sleep Complaint(s)

☐trouble falling asleep ☐trouble remaining asleep___
☐excessive sleepiness during the day
☐snoring
☐unwanted behaviors during sleep, such as _____

☐Other, explain_____

_____

How long?_____

Prior Sleep Disorder Diagnosis or Studies

☐ I have a prior sleep diagnosis of _____
Prior sleep studies (where, when) _____
I am currently prescribed ☐CPAP or ☐Bilevel pressure. Settings _____
Oxygen during the ☐day or ☐ night _____liters per minute
☐Yes ☐No -- I have had surgery for a sleep disorder ☐UPPP ☐tonsillectomy ☐Other_____
☐Yes ☐No -- I use a dental device for sleep disordered breathing.

Sleep Pattern

Typical bedtime: _____weekday _____weekend
Typical awakening time: _____weekday _____weekend
Typical hours in bed: _____hours Typical hours of sleep: _____hours
Typical amount of time it takes to fall asleep: _____ hours
Typical number of awakenings per night: _____
Time it takes to fall back asleep after awakening _____
☐Yes ☐No -- My sleep pattern is irregular.
☐Yes ☐No -- I awaken early in the morning, still tired but unable to return to sleep.

Sleep Environment/Habits

Typical sleep position(s) ☐back ☐side ☐stomach ☐head elevated ☐in a chair
☐I sleep alone. ☐I share a bed with someone.

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My bedroom is ☐comfortable ☐noisy ☐too warm ☐too cold
☐Yes ☐No -- I have pets in the bedroom.
☐Yes ☐No -- I watch TV in bed prior to sleep.
☐Yes ☐No -- I read in bed prior to sleep.
☐Yes ☐No -- I work or study in bed .
☐Yes ☐No -- I drink alcohol prior to bedtime.
☐Yes ☐No -- I smoke prior to bedtime or when I awaken during the night.
☐Yes ☐No -- I eat a snack at bedtime.
☐Yes ☐No -- I eat if I awaken during the night.

Breathing
☐Yes ☐No -- I have been told that I snore. ☐loudly
☐Yes ☐No -- I have been told that I stop breathing while asleep.
☐Yes ☐No -- I have been told that I snore only when sleeping on my back.
☐Yes ☐No -- I have been awakened by my own snoring.
☐Yes ☐No -- I awaken at night choking or gasping for air.
☐Yes ☐No -- I awaken short of breath.
☐Yes ☐No -- I have trouble breathing when flat on my back.
☐Yes ☐No -- I have trouble breathing through my nose.
☐Yes ☐No -- I have morning headaches.
☐Yes ☐No -- I sweat a great deal at night.

Daytime Sleepiness
☐Yes ☐No -- I often feel drowsy during the day, more then I expect is normal.
☐Yes ☐No -- I feel unrefreshed or tired in the morning despite sleeping at night.
☐Yes ☐No -- I take daytime naps. How many? _____
☐Yes ☐No -- I have uncontrollable urges to fall asleep during the day.
☐Yes ☐No -- I have experienced lapses in time or blackouts.
☐Yes ☐No -- I have fallen asleep while driving.
☐Yes ☐No -- I performed poorly in school or work because of sleepiness.

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Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired. Use the following scale and indicate 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 a public place (e.g., a theater or meeting) ……	____
· As a passenger in a car for an hour without a break……	____
· Lying down to rest in the afternoon when circumstances permit…	____
· Sitting and talking with someone ……	____
· Sitting quietly after a lunch without alcohol ……	____
· In a car, while stopped for a few minutes in traffic……..	____
TOTAL (Range 0-24)	**____**

RLS

☐Yes ☐No -- I kick or jerk my legs excessively during sleep. ☐This bothers my bed partner.

☐Yes ☐No -- I experience a creeping-crawling or tingling sensation in my legs when I try to fall asleep.

☐Yes ☐No -- I experience an inability to keep my legs still prior to falling asleep.

☐Yes ☐No -- I experience a feeling of restlessness in my legs at night.

Orexin related

☐Yes ☐No -- I experience sudden muscle weakness in response to emotions such as laughter, anger, or surprise.

☐Yes ☐No -- I experience an inability to move while falling asleep or when waking up.

☐Yes ☐No -- I have experienced hallucinations or dreamlike images when falling asleep or waking up.

☐Yes ☐No -- I frequently dream during daytime naps.

Parasomnias

☐Yes ☐No -- I act out my dreams while asleep.

☐Yes ☐No -- I have frequent nightmares.

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☐Yes ☐No -- I talk in my sleep.
☐Yes ☐No -- I have sleep walked as an adult.

Miscellaneous (Circadian, GERD, Depression, Enuresis, Bruxism, Pain)
☐Yes ☐No -- I frequently travel across two or more time zones.
☐Yes ☐No -- I am more alert in the morning than evening.
☐Yes ☐No -- I am more alert in the evening than morning.
☐Yes ☐No -- I awaken alert in the morning earlier than it is time to get up.
☐Yes ☐No -- I frequently have heartburn or acid reflux at night.
☐Yes ☐No -- I feel depressed.
☐Yes ☐No -- Chronic pain interferes with my sleep.
☐Yes ☐No -- The need to urinate frequently interrupts my sleep.
☐Yes ☐No -- I grind my teeth in my sleep.
☐Yes ☐No -- I have bed wetting (enuresis).

Insomnia
☐Yes ☐No -- I have trouble falling asleep.
☐Yes ☐No -- Thoughts start racing through my mind when I try to fall asleep.
☐Yes ☐No -- I have trouble remaining asleep.
☐Yes ☐No -- I awaken frequently during the night.
☐Yes ☐No -- I have difficulty returning to sleep if I awaken during the night.

Habits
☐Yes ☐No -- I smoke cigarettes (or other tobacco) If yes, how much? _____
☐Yes ☐No -- I drink alcohol. If yes, how much and how often? _____
☐I drink caffeinated beverages during the day _____cups/bottles/cans ☐tea ☐coffee ☐soda per day

Social History
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed
Employment Status: ☐Employed: Occupation _____
☐Unemployed ☐Disabled ☐Student ☐Retired
☐Yes ☐No -- I regularly work night shifts
☐Yes ☐No -- I work rotating shifts, including night shift work

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Past Medical History

☐Hypertension ☐Coronary artery disease ☐Congestive heart failure
☐Stroke ☐Seizures ☐COPD/asthma
☐Diabetes ☐Cancer ☐Thyroid problems
☐Depression or anxiety ☐Alcoholism or chemical dependency
☐Sinus disease ☐Allergic rhinitis/nasal congestion ☐Nasal fracture
☐Reflux(GERD) ☐Stomach or colon problems
☐Fibromyalgia ☐Back or joint problems (arthritis)
☐Other _____
Female ☐Premenstrual Syndrome ☐Menopause
Male ☐Prostate problems ☐Erectile dysfunction
Prior surgeries _____
Weight change during the past year: ☐gained __ pounds ☐lost _____pounds

Current Medications (or ☐ listed on a separate sheet)

Medication	Dose	Times Per Day

Allergies:_____

Family History

Has an immediate blood relative had any of the following?
☐Obstructive sleep apnea ☐Narcolepsy ☐Other sleep disorder? _____

Date_____

PATIENT INFORMATION

SLEEP DISORDERS AND AUTOMOBILE DRIVING

You may have a sleep disorder. Sleep apnea or another sleep disorder may adversely affect your driving. People with sleep apnea or other sleep disorders often have a threefold increased rate of automobile crashes or other accidents. These accidents may cause serious injury or death to yourself or others.

If you have had an automobile crash or frequent near crashes due to sleepiness or inattention, **you should stop driving** and/or operating dangerous machinery until your sleep disorder has been treated and you no longer become sleepy or inattentive while driving. It is your responsibility not to drive if you are sleepy or inattentive while driving.

Until your treatment has begun, have your spouse or your friends drive you. If you must drive, limit your driving to essential trips. You should not drive for more than 20 minutes at a time, and you should not drive at night. If you have further concerns about your driving, talk to your health care provider.