Sleep Disorders Patient Questionnaire

Chest Medicine of Cullman- Dr. Warner

Name _____ *Today's Date*_____
*Date of Birth*_____*Age* _____

*Referred by Doctor*_____*or* ☐ *Self-referred*

Please briefly describe ***your*** **main complaint** (whether it involves your sleep or pertains to your daytime functioning):

Please briefly describe **your *bedmate's* main compliant** about your sleep or daytime functioning, if applicable:

What, if anything, has been recommended and/or have you tried to help with your sleep problem(s)?

Medications: (*Ambien, Klonopin, Benadryl, Tylenol PM, Ativan, Xanax, Unisom, Provigil, Ritalin, Nuvigil, Adderall*) others (list):

Sleep-Related Surgeries (Nasal surgery, Tonsils, UP3, etc.) or **Dental Device**:

Sleep Studies Have you had a previous sleep study? Yes No
If so, When and where?_____. If YES, YOU must request a copy before your appointment- *see instructions below.*
Do you currently use CPAP at night? Yes No
CPAP setting____ ( ) I don't know. ( ) Used CPAP in past but not now.

Oxygen Have you had an overnight oxygen test? Yes No
What physician ordered it?_____
Do you currently sleep with oxygen? Yes No Since_____

Thank you for allowing us to assist you! In order to expedite your visit we ask you to do ALL of the following before coming:

☆ **Complete this sleep questionnaire packet - including your medications listed**

☆ **Copies of ALL previous sleep studies** performed by any doctor other than Dr. Warner**. Please bring a copy study with you in hand! You must call the sleep lab where these were performed to get a copy of the study a or have it faxed to us before your appointment.**

☆ **Bring all your Insurance cards**

THESE ITEMS MUST BE BROUGHT WITH YOU TO YOUR FIRST OFFICE VISIT.

SLEEP HISTORY

1. During the work week, what time, on average, do you go to bed?_____
   Wake up?_____.
   How long does it take you to fall asleep on average? ____min/hrs.
   How many hours of sleep do you get?___

2. On weekends/days off work, what time do you go to bed?_____
   Wake up?_____ How many hours of sleep do you get?___

3. How many times do you awaken during your sleep?____
   Usual causes?_____(*for example, to urinate, short of breath, body jerking, heartburn, not sure....)*

4. How many hours of sleep do you need to feel 'good'? ___ or
   ☐ "I never feel rested no matter how much sleep I get"

5. What is your neck/collar size (dress shirt....for example 17 ½):
   _____inches or ☐ don't know

6. Please rate on a scale from **zero (0) to ten (10)**, with 0 not sleepy at all and 10 being most sleepy,
   How sleepy are you? : 0--1—2—3—4—5—6—7—8—9--10

7. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.
Use this scale to choose 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	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place- for example, a theater, church 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	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car while stopped in traffic	0	1	2	3
Add all 8 numbers together for your **Total:**				

Please rate how often you: (place an ***X*** in the appropriate column)	**Never**	**Sometimes**	**Frequently**
Have been told you *snore*			
Snore *loudly* enough that other complain			
Been told you have *stopped breathing* during sleep			
Have awakened from "*snorting*" in your sleep/feeling *choked*			
Have *dry mouth i*n the mornings			
Have *morning headaches*			
Heartburn/ Use antacids			
Use *nasal sprays/ decongestants*			
Sweat excessively at night			
Have *concentration* difficulties/*memory* problems			
Sleepy or Fall asleep while *driving*			
Fall asleep if *not* active			
Fall asleep *during active tasks*			
Take *naps* during the day			
Collapse or Feel the immediate *uncontrollable* urge to sleep when you have a strong *emotion* (i.e., laughing, very mad, surprised, etc)			
Blink eyes, *jaw drops*, feel knees *buckle*, or arms *weak* when you laugh and/or are mad, happy or surprised			
Experience *vivid dreamlike scenes* just upon awakening or falling asleep			
Are *unable to move or speak* for a few moments after waking up			
Have been told your *legs jerk* every 20 seconds or so throughout the night			
Have been told you *act out your violent dreams* or nightmares by hitting, swinging your arms/legs or yelling			
Are *unable to fall asleep* in 15 minutes or less			
Wake up during the night and *can't get back to sleep*			
Wake up one or two hours *early* in the morning			
Feel sad or *depressed*			
Have *anxieties* (for example, worries about family or financial problems)			
Awakened by *pain* during the night			
Have morning jaw pain/*grind teeth* during sleep			
Sleep walk or sleep talk			
Have nighttime *seizures*			
Bedwetting currently			

Please begin the first Sunday after this is received and complete for 2 weeks. Bring to your doctor's appointment with the completed Sleep History Questionnaire and completed Patient Information Sheet.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
How long did it take you to fall asleep?							
How many times did you wake up during the night?							
How many hours were you awake last night?							
Overall, how many hours did you sleep?							
Did you wake up earlier than you wanted to?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
On a scale of 1 to 5, how did you feel when you woke up?	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed
Did you take any naps today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you do any of the following?	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise
On a scale of 1 to 5, how did you feel during the day?	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
How long did it take you to fall asleep?							
How many times did you wake up during the night?							
How many hours were you awake last night?							
Overall, how many hours did you sleep?							
Did you wake up earlier than you wanted to?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
On a scale of 1 to 5, how did you feel when you woke up?	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed	☐ 1 - Tired ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Refreshed
Did you take any naps today?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Did you do any of the following?	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise	☐ Consume Caffeine ☐ Drink Alcohol ☐ Exercise
On a scale of 1 to 5, how did you feel during the day?	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic	☐ 1 - Sluggish ☐ 2 ☐ 3 ☐ 4 ☐ 5 - Energetic