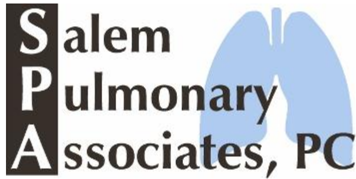

801 Mission Street SE, Salem, OR, 97302, Phone: 503 588 3945Fax: 503 588 0256

Sleep Medicine Questionnaire

Name:	___________________________	Primary Care Physician:	___________________________
Date of Visit:	___________________________	Referring Physician:	___________________________
Age:	___________________________	Height:	___________________________
Occupation:	___________________________	Weight:	___________________________

The purpose of this questionnaire is to get adequate information of the nature of your sleep problem. Please complete and be as thoroughly as you can.

What are your problems: (Check all that apply)

[ ] Snoring	[ ] Trouble breathing while asleep	[ ] Hold breath while asleep
[ ] Gasp or Choke	[ ] Problem falling asleep	[ ] Hard to stay asleep
[ ] Tired & fatigue	[ ] Sleepy during the day	[ ] Moving a lot while asleep
[ ] Legs move	[ ] Acting out dreams	[ ] Partner asked to seel help

Other:____

Sleep History:

How long have you had these problems? [ ] > 1 year [ ] 6-12 months [ ] 1-6 months [ ] 1 month

How these problems affected:				
	quality of life	[ ] a lot	[ ] somehow	[ ] a little
	Social life	[ ] a lot	[ ] somehow	[ ] a little
	Work performance	[ ] a lot	[ ] somehow	[ ] a little
	Relationship with partner	[ ] a lot	[ ] somehow	[ ] a little

Have you ever had sleep evaluations: [ ] yes [ ] no

If yes: specify. Where?______________________ When:____

Have you had any treatment for your sleep problems: [ ] yes [ ] no

If yes: specify. ____

Are you using any sleep medicine or sleep aids: [ ] yes [ ] no

If yes: list the medications: ____

____

How often *you or others* have noted that you?

Snore:	[ ] none	[ ] occasionally	[ ] a lot
Snore loudly that others complains:	[ ] none	[ ] occasionally	[ ] a lot
Awaken from sleep feeling short of breath, choking or gasping:	[ ] none	[ ] occasionally	[ ] a lot
Stop breathing while sleeping:	[ ] none	[ ] occasionally	[ ] a lot
Have morning headache:	[ ] none	[ ] occasionally	[ ] a lot
Have dry month upon awakening or sore throat:	[ ] none	[ ] occasionally	[ ] a lot
Sweat profusely at night:	[ ] none	[ ] occasionally	[ ] a lot
Have heart palpitation at night:	[ ] none	[ ] occasionally	[ ] a lot

Have nightmares or night terrors:	[ ] none	[ ] occasionally	[ ] a lot
Act out dreams:	[ ] none	[ ] occasionally	[ ] a lot
Walk in your sleep:	[ ] none	[ ] occasionally	[ ] a lot
Do anything else unusual while “asleep”:	[ ] none	[ ] occasionally	[ ] a lot
Unable to move or totally paralyzed when waking up or falling asleep:	[ ] none	[ ] occasionally	[ ] a lot
Have vivid dreams while waking up or falling asleep:	[ ] none	[ ] occasionally	[ ] a lot

Have constant rhythmic move, twitch, or jerk of your legs	[ ] none	[ ] occasionally	[ ] a lot
Feel restless, agitated or uncomfortable at bedtime	[ ] none	[ ] occasionally	[ ] a lot

Do you feel an urge to move your legs?	[ ] yes	[ ] no
Does it happen only in the evening?	[ ] yes	[ ] no
Does it happen only when relaxed?	[ ] yes	[ ] no
Does it get better with moving or walking?	[ ] yes	[ ] no
Does it disturb sleep or falling asleep?	[ ] yes	[ ] no
How often do these happen?	[ ] daily	[ ] few days per week

Do you feel tired exhausted during the day?	[ ] none	[ ] occasionally	[ ] a lot
Awaken feeling tired or unrefreshed:	[ ] none	[ ] occasionally	[ ] a lot
Get sleepy while driving:	[ ] none	[ ] occasionally	[ ] a lot
Have trouble at work or school because of sleepiness:	[ ] none	[ ] occasionally	[ ] a lot
Feeling irritable:	[ ] none	[ ] occasionally	[ ] a lot
Having memory problems:	[ ] none	[ ] occasionally	[ ] a lot

Have you had a car accident or close to have: [ ] none [ ] occasionally [ ] a lot

Fall asleep involuntarily or suddenly or in awkward situations: [ ] none [ ] occasionally [ ] a lot

Experience sudden weakness, buckling of knees or facial heaviness when

Laughing, scared, angry or crying: [ ] none [ ] occasionally [ ] a lot

Sleep Habits:

At what time do you usually go to bed? On workdays? ______ On non-workdays? ______

When do you wake up? On workdays? ______ On non-workdays? ______

When do you get out of bed? On workdays? ______ On non-workdays? ______

How long does it take to fall asleep? __________

How often do you wake up at night? __________ times ,

Why do you wake up at night? [ ] trouble breathing [ ] go to the bathroom [ ] Leg movement and discomfort

[ ] pain [ ] others:____

How long does it take to fall back asleep? ________

Do you feel refreshed in upon awakening? [ ] yes [ ] no

How many hours of sleep do you estimate you have every night? ________ hours

Do you take a nap during the day? [ ] yes [ ] no

If yes: how many hours do you nap? _______ hours

Do you sleep: [ ] alone [ ] with partner

Do you feel depressed or sad? [ ] yes [ ] no

Do you anxious before bedtime? [ ] yes [ ] no

Do you worry a lot around bedtime? [ ] yes [ ] no

Do you watch TV before bed time? [ ] yes [ ] no

Do you read before bed time? [ ] yes [ ] no

Do you work on computer before bedtime? [ ] yes [ ] no

Do you drink caffeinated products: [ ] yes [ ] no

If yes: specify [ ] Coffee [ ] Tea [ ] Soft drink

When? [ ] Morning [ ] Afternoon [ ] Evening [ ] Bedtime

Do you drink alcohol? [ ] yes [ ] no

If yes: what type? _______________ How much?

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Circle the number that applies the most

0 - would never doze

1 - slight chance of dozing

2- moderate chance of dozing

3- high chance of dozing

Sittings and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (theater or meeting)	0	1	2	3
As a passenger in a car	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	0	1	2	3
In a car, stopping in traffic	0	1	2	3

Total: _____________

Past Medical History:

[ ] Heart Disease [ ] Heart Attack	[ ] Heart Failure	[ ] Irregular heart beats	[ ] Angina
[ ] High blood pressure	[ ] Stroke	[ ] high cholesterol	[ ] Blood vessel problems
[ ] Reflux disease	[ ] Stomach ulcer	[ ] liver problem	[ ] Hiatal hernia
[ ] asthma	[ ] COPD	[ ] Emphysema	[ ] Allergy
[ ] Diabetes	[ ] Thyroid problem	[ ] Anemia	[ ] Fatigue
[ ] Headache	[ ] Seizure	[ ] Neuropathy	[ ] Tremor
[ ] joint pain/arthritis	[ ] fibromyalgia	[ ] depression	[ ] Anxiety
[ ] Panic attacks	[ ] other: ____		

Past Surgical History: list all type of surgeries you had

Type of surgery	year	Type of surgery	year
-------------------	-------	-------------------	-------
-------------------	-------	-------------------	-------
-------------------	-------	-------------------	-------

Social History:

Marital Status: [ ] S [ ] M [ ] D

Occupation: ___________________________________

Smoking: [ ] yes [ ] no if yes: How much? ___________ pack/day _________ years

Family History: **Does any family member have the following problems? Check all that apply and Relationship**

Condition	Relationships	Condition	Relationships
[ ] Narcolepsy	_______________	[ ] Sleep Walking	________________
[ ] Obstructive sleep apnea	_______________	[ ] Restless leg syndrome	________________
[ ] Snoring	_______________	[ ] Insomnia	________________
[ ] Acting out dreams	_______________	[ ] Hypertension	________________
[ ] Heart problem	_______________	[ ] Diabetes	________________
[ ] Stroke	_______________	[ ] Fatigue	________________

Medications: **list all the medications, with doses and frequency**

Medications	Dose & frequency	Medications	Dose & frequency
-------------------	--------------------------------	--------------------	---------------------------------
-------------------	--------------------------------	--------------------	---------------------------------
-------------------	--------------------------------	--------------------	---------------------------------
-------------------	--------------------------------	--------------------	---------------------------------

Allergies: **list all drug allergies.**

____

____

Review of systems: **check all that apply**

Constitutional

[ ] weight gain if any, how much:________ lb [ ] weight loss if any, how much : _________ lb

[ ] Night Sweat [ ] fever [ ] chills [ ] Fatigue [ ] change in appetite

Head, Ears, Eyes, Throat

[ ] vision changes [ ] hearing loss [ ] headache [ ] Nose congestion [ ] runny nose

[ ] post nasal drip [ ] rhinitis [ ] sore throat [ ] neck swelling [ ] oral thrush

[ ] nose bleed

Heart

[ ] chest pain [ ] Rapid heart rate [ ] irregular heart beat [ ] leg swelling

Lung

[ ] shortness of breath [ ] cough and sputum [ ] trouble breathing laying flap [ ] coughing up blood

Gastrointestinal

[ ] abdominal pain [ ] nausea /vomiting [ ] heartburn [ ] diarrhea [ ] constipation

[ ] indigestion [ ] bloating [ ] vomiting blood [ ] blood in stools [ ] swallowing problem

Genital and urinary

[ ] blood in urine [ ] voiding so often [ ] burning with urine [ ] kidney stone

[ ] erectile dysfunction

Musculoskeletal

[ ] joint pain or swelling [ ] back pain [ ] muscle pain or weakness [ ] leg cramps

Skin

[ ] skin rash [ ] skin cancer [ ] sensitive skin

Hematology

[ ] bleeding tendency [ ] anemia [ ] blood clots in legs [ ] blood clots in lung

Blood vessels

[ ] leg pain with walking [ ] blocked or narrowed arteries

Neurology

[ ] headache [ ] paralysis [ ] passing out [ ] balance problem [ ] dizziness

[ ] trouble walking [ ] forgetful [ ] tremors [ ] numbness

Endocrine

[ ] heat intolerance [ ] cold intolerance [ ] excessive thirst [ ] hot flushes

Psychiatry

[ ] hallucination [ ] nightmares [ ] depressed [ ] nervous or tense

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For Doctor Use:

Rest of review of system is otherwise negative

Reviewed questionnaire with patient

Signature:______________________________ Date:__________________________

Bed Partners Questionnaire:

Let you partner fill this part if possible

Have you seen your partner have the following behaviors or problem?

Snoring	[ ] yes	[ ] no	Stops breathing while sleeping	[ ] yes	[ ] no
Grinding his teeth	[ ] yes	[ ] no	Sleep talks	[ ] yes	[ ] no
Sleep walks	[ ] yes	[ ] no	Acting out on dreams	[ ] yes	[ ] no
Gasping for air	[ ] yes	[ ] no	Twitch or moves arms/leg	[ ] yes	[ ] no
Falls asleep while talking	[ ] yes	[ ] no	Falls asleep while driving	[ ] yes	[ ] no
Tired all the time	[ ] yes	[ ] no	Wakes up tired	[ ] yes	[ ] no

Other events that are important

For Doctor Use:

Reviewed questionnaire

Signature:________________________________ Date:____________________________