# SLEEP QUESTIONNAIRE

Date: _____

Name: _____ Referring Provider: _____
Date of Birth: _____ Age: _____ Primary Care: _____
Height: _____ Weight: _____ Neck Size: _____ (inches)
Occupation: _____ Do you have a CDL/Pilots License? ❑Yes ❑No

## DESCRIBE YOUR SLEEP PROBLEM

_____
_____
_____
_____

**What other sleep behaviors has your bed partner noticed?** _____
_____

**Have you ever been evaluated by a sleep physician?** ❑Yes ❑No
Name: _____ Date: _____

**Have you ever had a sleep study?** ❑Yes ❑No
Location: _____ Date: _____

**Do you currently use any of the following?** (mark all that apply)
❑ CPAP ❑ BiPAP ❑ Oxygen ❑ Oral Appliance

**Which DME (durable medical supply) company do you use?**

## SLEEP HABITS

Bed time: _____ Amount of time it takes you to get to sleep: _____
Wake time: _____ Do you take naps? ❑Yes ❑No Length of naps: _____

**Do you have any of the following sleep problems?** (mark all that apply)

❑ Snoring
❑ Witnessed apnea (stop breathing at night)
❑ Morning headaches
❑ Excessive daytime sleepiness
❑ Wake up frequently
❑ Frequent urination at night
❑ Insomnia (can't sleep)
❑ Teeth grinding
❑ Sleep walking/talking
❑ Acting out dreams
❑ Hallucinations (seeing/hearing things that aren't real)
❑ Sleep paralysis (awake but can't move)
❑ Muscle weakness with strong emotion (example: trouble keeping your head up while laughing)

**Do you experience any of the following?**

❑Yes ❑No Leg twitching or kicking after getting to sleep
❑Yes ❑No Unpleasant or uncomfortable feeling in your legs that causes an urge to move them
❑Yes ❑No Is the urge worse when you are not moving?
❑Yes ❑No Does the urge go away after you move your legs?
❑Yes ❑No Does the urge happen mostly in the evening/night?
❑Yes ❑No Does the urge cause you stress or affect your life in any way?
❑Yes ❑No Do you know what is causing this urge to move your legs?

**Are there any disturbances to your sleep at night?** ❑Yes ❑No
Explain: _____

**Is your sleep environment comfortable for sleeping?** ❑Yes ❑No
Explain: _____

## EPWORTH SLEEPINESS SCALE

**Grade your tendency to fall asleep during the following situations based on how <u>you feel right now</u>.**
**0 = Never 1 = Slight chance 2 = Moderate chance 3 = High chance**

| **ACTIVITY** | **0** | **1** | **2** | **3** | |
|---|---|---|---|---|---|
| Sitting and reading | ❑ | ❑ | ❑ | ❑ | |
| Watching TV | ❑ | ❑ | ❑ | ❑ | |
| Sitting inactive in a public place | ❑ | ❑ | ❑ | ❑ | |
| As a passenger in a car for 30 minutes without a break | ❑ | ❑ | ❑ | ❑ | |
| Lying down to rest in the afternoon | ❑ | ❑ | ❑ | ❑ | |
| Sitting and talking to someone | ❑ | ❑ | ❑ | ❑ | |
| Sitting quietly after lunch | ❑ | ❑ | ❑ | ❑ | |
| In a car while stopping for a few minutes | ❑ | ❑ | ❑ | ❑ | TOTAL: _____ |

**Do you use any of the following?** (mark all that apply)
❑ Tobacco amount_____ ❑ Alcohol amount_____ ❑ Caffeine amount_____
❑ Pain medication_____ ❑ Sleep medication_____

**Have you had an ultrasound of your heart?** ❑Yes ❑No When/where: _____

**Do you have the following medical conditions?** (mark all that apply)

| | | |
|---|---|---|
| ❑ Cardiac arrhythmias | ❑ Reflux | ❑ Depression/anxiety |
| ❑ Congestive heart failure | ❑ Diabetes | ❑ Restless leg syndrome |
| ❑ High blood pressure | ❑ Asthma/COPD | ❑ ALS |
| ❑ History of stroke | ❑ Chronic pain | ❑ Other neurological disease |
| ❑ Atrial fibrillation | ❑ Fibromyalgia | ❑ Seizures/epilepsy |
| ❑ Irregular heart beat | | |

**SURGICAL HISTORY** (including nose & throat)

_____
_____
_____
_____
_____
_____

**MEDICAL HISTORY**

_____
_____
_____
_____
_____
_____

| **MEDICATIONS AND SUPPLEMENTS** (or attach a list): | **DOSE** | **# OF TIMES TAKEN PER DAY** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Pharmacy:** _____ **Phone:** _____

**ALLERGIES TO MEDICATIONS:** _____