ST. LUKE'S
Sleep Center

ST. LUKE'S EPISCOPAL HOSPITAL
SLEEP CENTER
SLEEP DISORDER QUESTIONNAIRE

PATIENT INFORMATION:

Name: **Date**:

Sex: M F **Age:** **Date of Birth:**

Marital Status: ***Single*** ***Married*** ***Divorced*** ***Widowed***

Occupation:

Height: **Weight:** **Neck size:**

Primary Physician: **Referring Physician**:

1. My Main Sleep Complaint(s) is:
   - ❑ "My snoring disturbs my bed partner"
   - ❑ "I have been told I stop breathing when I sleep"
   - ❑ "I fall asleep unintentionally"
   - ❑ "I have a hard time falling asleep at night or staying asleep at night"
   - ❑ "I am tired and sleepy during the day"
   - ❑ "My bed partner says I jerk my legs at night"
   - ❑ "I wake up gasping for air"
   - ❑ "I have unwanted behavior during sleep" Explain:
   - ❑ Other: _____
     _____
2. How long have you had your sleep problem?_____
3. Have you had a previous sleep study performed? YES NO
   If yes, when and where?_____
   Physician:_____
4. Are you currently on CPAP therapy? YES NO
   If yes: What is your current CPAP setting?_____
   Does your mask fit comfortably? YES NO
   Do you use your CPAP every night? YES NO
   How long? ____hrs____min
   Do you feel that you are benefiting from CPAP? YES NO
5. Have you recently gained weight? YES NO
   If yes, how much?_____

6. Do you smoke? YES NO

If so, how much? _____

7. How many caffeinated beverages on average do you consume in a day? _____

Caffeinated Beverage	Daily Consumption
Coffee	
Tea	
Sodas	

8. How many alcoholic beverages on average do you consume in a week? _____

Alcohol Beverage	Weekly Consumption
Wine	
Beer	
Mixed drink	

9. Do you suffer from allergies? YES NO
10. Do you suffer from chronic nasal congestion? YES NO
11. Have you had nose or sinus surgery? YES NO

If yes, when?_____

12. Do you have and/or are you currently being treated for:

High Blood Pressure?	YES	NO
Irregular Heartbeat?	YES	NO
Angina?	YES	NO
Heart Attack?	YES	NO
Emphysema?	YES	NO
Congestive Heart Failure (CHF)?	YES	NO
Diabetes?	YES	NO
Asthma?	YES	NO
Low Thyroid?	YES	NO
Low Potassium?	YES	NO
Low Calcium?	YES	NO
Polio?	YES	NO

13. Please list any other major medical problems and surgeries:

_____

_____

_____

ST. LUKE'S
Sleep Center

14. Please list any prescription medication that you are taking:

_____

_____

_____

15. Please list any over-the-counter medication that you are taking:

_____

16. Any known allergic reactions to medication and/or food? YES NO

***If yes, please name the medication(s) and food(s) you are allergic* to**:

_____

---

1. **Usual Sleep Schedule**:

	WEEKDAYS	WEEKENDS
a. What time do you usually go to bed?	_____	_____
b. What time do you usually wake up?	_____	_____

2. **Naps:**
   a. Do you take naps during the day? YES NO
   ***If yes, how many?*_____*How long is your typical nap?* _____**
   b. Are the daytime naps refreshing? YES NO
3. Do you work night or rotating shifts? YES NO
   ***If yes, what shifts do you work?* _____**
4. Do you have trouble falling asleep at night? YES NO
   ***Why, and how long does it take you to fall asleep?*_____**
5. Do you have trouble staying asleep? YES NO
6. Do you have trouble falling back to sleep once awakened? YES NO
7. Do you worry that you will not be able to sleep? YES NO
8. Do you feel that you have to try hard to fall asleep? YES NO
9. Do you take any medications to help you fall asleep? YES NO
   ***If so, name?*_____ *How much?* _____**
   ***How many times a week?*_____**
10. Do you suffer from pain that interferes with your sleep? YES NO
    ***Please describe* _____**
    _____

ST. LUKE'S
Sleep Center

11.	Have you seen a psychologist or psychiatrist for your sleep problem?	YES	NO
12.	Have you ever been told that you snore?	YES	NO
13.	Rate your snoring: ***MILD*** ***MODERATE*** ***LOUD*** ***VERY LOUD***		
14.	Does your snoring disturb others?	YES	NO
15.	Have you ever been told that you stop breathing in your sleep?	YES	NO
16.	Do you wake up choking or gasping for air?	YES	NO
17.	Do you ever awaken suddenly feeling short of breath?	YES	NO
18.	Do you wake up with dry mouth or a sore throat?	YES	NO
19.	Do you have a headache when you wake up in the morning?	YES	NO
20.	Do you sweat at night?	YES	NO
21.	Do you feel refreshed upon awakening in the morning?	YES	NO
22.	Do you experience discomfort in your legs such as crawling and/or an achy feeling in your legs that compels you to move them or walk?	YES	NO

23.	Do your legs jerk before and during sleep?	YES	NO
24.	Do you grind your teeth at night?	YES	NO
25.	Does heartburn interfere with your sleep?	YES	NO
26.	Do you have frequent nightmares?	YES	NO
27.	Do your dreams interfere with your sleep?	YES	NO
28.	Have you walked in your sleep?	YES	NO
29.	Do you talk in your sleep?	YES	NO
30.	Have you ever injured yourself or a bed-partner acting out your dreams?	YES	NO
31.	Do you dream when you take naps?	YES	NO
32.	Do you experience vivid life-like dreams upon falling asleep or waking up?	YES	NO

33.	Have you ever found yourself unable to move for a short time upon awakening or falling asleep?	YES	NO
34.	Have you ever experienced sudden muscle weakness:		
	i. When laughing vigorously	YES	NO
	ii. When becoming angry	YES	NO

35. Have you experienced sleep attacks or sudden onset of sleep? YES NO
36. Do you feel tired during the day? YES NO
37. Have you "dozed off" or fallen asleep while driving? YES NO
38. Have you fallen asleep while at work / school? YES NO

If you have any additional comments or information that you feel may be helpful. Please describe them.

_____

_____

THE EPWORTH SLEEPINESS SCALE

Please indicate how likely you would be to doze off or fall asleep in the following situations, in contrast to just feeling tired. These situations refer to your usual way of life in recent times. Even if you have never done or have not recently done some of these things try to work out how they would have affected you.

SITUATIONS (Please circle ONLY ONE number for each situation)

	0	1	2	3
Sitting and reading?	NEVER	SLIGHT	MODERATE	HIGH
Watching T.V.?	NEVER	SLIGHT	MODERATE	HIGH
Sitting inactive in a meeting, Seminar or theater, etc.?	NEVER	SLIGHT	MODERATE	HIGH
As a passenger in a car for one hour?	NEVER	SLIGHT	MODERATE	HIGH
Lying down to rest in the afternoon?	NEVER	SLIGHT	MODERATE	HIGH
Sitting and talking with someone?	NEVER	SLIGHT	MODERATE	HIGH
Sitting quietly after lunch?	NEVER	SLIGHT	MODERATE	HIGH
In a car while stopped at a traffic light?	NEVER	SLIGHT	MODERATE	HIGH

TOTAL POINTS: _____/ 24