

ADULT SLEEP QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Sex: _____ Date of birth: _____

Address: _____
Street City State Zip Code)

Email: _____ Phone: _____

REFERRING PHYSICIAN

Name: _____ Phone: _____ Fax: _____

PRIMARY INSURANCE

Insurance Name: _____ IPA/Medical Group: _____

Subscriber ID: _____

Insurance Type:

- HMO MCAL MCAL HMO CCS PPO
 EPO POS Other: _____

SECONDARY INSURANCE (IF APPLICABLE)

Insurance Name: _____ IPA/Medical Group: _____

Subscriber ID: _____

Insurance Type:

- HMO MCAL MCAL HMO CCS PPO
 EPO POS Other: _____

PRIMARY SLEEP COMPLAINTS

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 PATTERNS

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: _____ hours

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.

My bedroom is: comfortable noisy too warm too cold

Yes No I have pets in the bedroom.

Yes No 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 than I expect is normal.
- Yes No I feel unrefreshed or tired in the morning despite sleeping at night.
- Yes No I take I 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.

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.

Please mark "✓" as appropriate:	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
	0	1	2	3
1. Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sitting, inactive in a public place (e.g., a theater or meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sitting and talking with someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sitting quietly after lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In a car, while stopped for a few minutes in traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL SCORE:				

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 leg still prior to falling asleep.
- Yes No I experience the feeling of restlessness in my legs at night.
- 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 on my dreams while asleep.
- Yes No I have frequent nightmares.
- 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 bedwetting (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?
 Yes No 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 nights shiftwork.

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 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 disorders? _____

STOP BANG QUESTIONNAIRE

Please answer the following questions below to determine if you might be at risk for Obstructive Sleep Apnea

Do you snore loudly (*louder than talking or loud enough to be heard through closed doors*)? Yes No

Do you often feel tired, fatigued, or sleepy during daytime? Yes No

Has anyone observed you stop breathing during your sleep? Yes No

Do you have or are you being treated for high blood pressure? Yes No

Body Mass Index Calculator: Height: _____ Inches Weight: _____ lbs

BMI = _____

Is your BMI more than 35Kg/m² Yes No

Are you more than 50 years old? Yes No

Is your neck circumference >16 inches (40cm)? Yes No

Is your neck size larger than 43cm if male or 41cm if female? Yes No

Hint: To obtain an accurate measurement, measure around your Adams apple OR answer Yes if your collar size is greater than XL.

Is your gender male? Yes No

SCORE: _____

FUNCTIONAL OUTCOMES OF SLEEP QUESTIONNAIRE (FOSQ-10)

Some people have difficulty performing everyday activities when they feel tired or sleepy. The purpose of this questionnaire is to find out if you generally have difficulty carrying out certain activities because you are too sleepy or tired.

In this questionnaire, when the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off", or that you feel the urge to take a nap. These words do not refer to the tired or fatigued feeling you may have after you have exercised.

Directions

Please put a "✓" in the box for your answer to each question. Select only one answer for each question. Please try to be as accurate as possible. All information will be kept confidential.

Please mark "✓" as appropriate:	Yes, extreme	Yes, moderate	Yes, a little	No
	1	2	3	4
1. Do you have difficulty concentrating on the things you do because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you generally have difficulty remembering things, because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have difficulty finishing a meal because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have difficulty working on a hobby (for example, sewing, collecting, gardening) because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have difficulty doing work around the house (for example, cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have difficulty getting things done because you are too sleepy or tired to drive or take public transportation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have difficulty taking care of financial affairs and doing paperwork (for example, writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have difficulty performing employed or volunteer work because you are sleepy or tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOTAL SCORE				